

**Kent & Medway  
Domestic Homicide Review  
Overview Report  
Jason/2016**

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**Commissioned by:  
Kent Community Safety Partnership  
Medway Community Safety Partnership**

**Review Completed: 9 March 2017**

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# 1. Introduction

- 1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Jason Davis, a resident of Town A, Kent prior to his death on 16 May 2016. On that day, an ambulance crew went to Jason's flat, following a call from Michael Lyons. They found Jason's body: he had died from head injuries.
- 1.2 Kent Police were called and Michael was arrested on suspicion of murdering Jason. He was subsequently charged with Jason's murder.
- 1.3 At his trial in November 2016, Michael pleaded guilty to Jason's manslaughter and this plea was accepted by the prosecution. In January 2017, he was sentenced to 10 years imprisonment.
- 1.4 This DHR examines the contact and involvement organisations had with Jason (a white British man, aged 51 years) and Michael (a white British man, aged 38 years), between 1 January 2012 and Jason's death.
- 1.5 The key reasons for conducting a Domestic Homicide Review (DHR) are to:
  - a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims;
  - b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change;
  - c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
  - d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
  - e) Contribute to a better understanding of the nature of domestic violence and abuse; and
  - f) Highlight good practice.
- 1.6 This Review began on 7 July 2016, following the decision by Kent Community Safety Partnership (CSP) that the case met the criteria for conducting a DHR. It was completed on 9 March 2017.
- 1.7 Michael Lyons was arrested on the day of Jason's death and was subsequently charged with his murder. The Crown Prosecution Service (CPS) requested that no contact was made with members of Jason or Michael's family before the conclusion of Michael's criminal trial.

- 1.8 This report has been anonymised and all the personal names contained within it, except the members of the DHR Panel, are pseudonyms.

## 2. Terms of Reference

- 2.1 The Review Panel met first on 29 July 2016 to consider draft Terms of Reference, the scope of the DHR and those organisations that would be subject of the review. The Terms of Reference were agreed subsequently by correspondence and form [Appendix A](#) of this report.

## 3. Methodology

- 3.1 The detailed information on which this Overview Report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Jason and/or Michael. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.
- 3.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a senior manager of that organisation before being submitted to the DHR Panel. Neither the IMR author nor the senior manager had any involvement with Jason or Michael.
- 3.3 In addition to IMRs, a number of agencies provided information during interviews with the Independent Chairman.

## 4. Involvement of Family Members and Friends

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

Name	Relationship to:	
	Jason Davis	Michael Lyons
Peter Davis	Father	
Marilyn Dyson	Aunt	
Brian Rowse	Friend	
Sarah Clark		Girlfriend
Lisa Hughes		Daughter

- 4.2 The Independent Chairman wrote to those named above in August 2016, setting out the purpose of the review and explaining he would make further contact following the trial of Michael Lyons. These letters were delivered personally by the Kent Police Family Liaison Officer. A copy of the Home Office DHR leaflet for family members was included with those letters. Two family members replied to the letter stating they wanted no involvement in the DHR process.
- 4.3 The Independent Chairman wrote to the remaining family members and to Jason's friend in February 2017, following Michael's sentencing and the completion of the overview report. He offered to meet them to discuss the DHR process and listen to any views and concerns they had. Although the addresses were current at the time of writing, there were no responses to these letters.

## **5. Contributing Organisations**

- 5.1 Each of the following organisations completed an IMR:
- Kent Police
  - Kent County Council Adult Services
  - Town A Clinical Commissioning Group
  - Kent & Medway NHS and Social Care Partnership Trust
  - Kent Community Health NHS Foundation Trust
  - East Kent Hospitals University NHS Foundation Trust
  - South East Coast Ambulance Service NHS Foundation Trust
- 5.2 The contact Kent Community Health NHS Foundation Trust had with Jason and Michael was not relevant to the DHR and is not included in this report.
- 5.3 In addition to IMRs, the Independent Chairman interviewed representatives of the following agencies and prepared a written report on each for the Review Panel:
- Oasis Domestic Abuse Service
  - Town A Borough Council - Housing Department
  - Victim Support
- 5.4 The National Probation Service, which was not involved with Jason or Michael during the period covered by this DHR, provided an extensive chronology of earlier involvement. This provided useful background information.

- 5.5 This DHR is the first to be commissioned in Kent in which the victim and perpetrator were of the same sex. It is also the first in which the victim had been referred to the Multi-Agency Risk Assessment Conference (MARAC).

## 6. Review Panel Members

- 6.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with Jason and/or Michael. It also included a senior member of Kent County Council Community Safety Team.

- 6.2 The members of the panel were:

Wendy Bennett	Town A Clinical Commissioning Group
Deborah Cartwright	Oasis Domestic Abuse Service
Angie Chapman	Kent Police
Tina Hughes	National Probation Service
Carol McKeough	Kent County Council Adult Social Services
David Naylor	Victim Support
Paul Pearce	Independent Chairman
Shafick Peerbux	Kent Community Safety
Vikki Perry	Town A Borough Council, Communities & Housing Department
Cecelia Wigley	Kent and Medway NHS & Social Care Partnership Trust

## 7. Independent Chairman and Author

- 7.1 The Independent Chairman and author of this overview report is a retired senior police officer who has no association with any of the organisations represented on the panel and who has not worked in Kent. He has experience and knowledge of domestic abuse issues and legislation, and an understanding of the roles and responsibilities of those involved in the multi-organisation approach to dealing with domestic abuse.
- 7.2 The Independent Chairman has a background in conducting reviews (including Serious Case and Safeguarding Reviews), investigations, inquiries and inspections. He has carried out senior level disciplinary investigations and presented at tribunal. He has completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.



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

- 8.1 Kent Police voluntarily referred the case of Jason's death to the Independent Police Complaints Commission (IPCC). The IPCC decided the case was suitable for Kent Police to investigate locally. This was done and the IPCC were notified subsequently that there was no evidence of misconduct by any police officer or member of police staff.

## **9. Publication**

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

## **10. Background Information**

### **10.1 Jason Davis**

- 10.1.1 Jason was 51 years old at the time of his death and the little known about his early years is based on recorded disclosures he made to organisations subject of this DHR.
- 10.1.2 Jason lived with his mother in her house in Town A in the years leading up to her death in early 2013. He said he began caring for her when he was 14 years old, although it is not clear why this was so. His mother's death had a major impact on his life; by then he had been an alcoholic for several years.
- 10.1.3 Jason was openly homosexual and had experienced bullying and harassment because of this. He stated on one occasion he had suffered a violent assault and rape when he was in his teens and there were five perpetrators.
- 10.1.4 In 2008, Jason received a 12-month prison sentence, suspended for 24 months, for assaulting an elderly female friend of his mother's. A condition attached to the sentence was that, for its duration, he was not allowed to stay overnight at his mother's house. At some time after the expiry of this prohibition, he moved back in with her and was living with her at the time of her death.
- 10.1.5 During the period of his suspended prison sentence, the National Probation Service recorded Jason said he had five CSEs and 18 computing certificates, including for web design, and one which classed him as a 'Using Computer Expert'. It also records he had past retail management experience. However, by the time Jason gave this

information (March 2008), he had significant alcohol issues and there is no record he worked again before his death.

- 10.1.6 It seems that Jason's relationship with his mother was volatile during the later years of her life. Both were heavy drinkers and she reported that he could be verbally aggressive towards her. After her death, Jason told a professional that he had beaten his mother while she was alive. There is no record that she ever complained of this and organisations supporting her have no record of her suffering from injuries.
- 10.1.7 His mother's house was provided by the local authority and when she died, Jason applied for succession of tenancy. He was granted this but although it gave him the right to continued tenancy, it did not allow him to continue living in the house. He successfully bid for a flat in the same area of Town A and he lived there until his death.
- 10.1.8 After his mother's death, Jason had a troubled life, including continued harassment and assault by Michael.

## 10.2 Michael Lyons

- 10.2.1 Michael was 38 years old at the time of Jason's death. He had less involvement with organisations involved in this DHR than Jason. There are few records of his early years, although like Jason, his mother had a history of alcohol abuse.
- 10.2.2 In 2010, he was sentenced to 12 months imprisonment for assault occasionally actual bodily harm. In January 2011, he was being considered for release from prison on a home detention curfew (HDC). National Probation Service (NPS) records state that because three of Michael's four previous convictions related to violent offences committed against previous partners, a HDC would not be suitable if he proposed living with a partner. Michael therefore had a history as a domestic abuse perpetrator before the period covered by this DHR.
- 10.2.3 When he spoke to a Probation Officer shortly after his release from prison, Michael said he was living with his grandparents in Town A, but within a few days he moved in with a female friend. He said he had been released from custody with anti-psychotic and anti-depressant medications, which indicated he had a mental health condition. He referred to his pre-sentence alcoholism, which he wanted to address because he wished to rekindle a relationship with an ex-girlfriend.

- 10.2.4 Michael's NPS Offender Manager was concerned because he continued to comment about wanting to harm an ex-partner and his co-defendant in the assault for which he was imprisoned. This was a continuing theme in the weeks following his release from prison.
- 10.2.5 Although Michael expressed an interest in getting a job, within a couple of months of his release he was drinking again. It was around this time it was first recorded that Michael was living with Sarah Clark, his girlfriend at the time of Jason's death. It is unclear whether this relationship continued throughout that period.
- 10.2.6 In September 2011 at his last appointment with his Offender Manager, it is recorded that Michael was remaining on medication to address '*...bipolar disorder and mental health issues*'. During the period of probation supervision, there is no record of Jason's name in discussions with his Offender Manager.
- 10.2.7 In summary, NPS records show that before the period covered by this review Michael had a history of being a violent domestic abuse perpetrator, he was an alcoholic and suffered from mental health issues, including bipolar disorder.

### 10.3 Relationship Between Jason and Michael

- 10.3.1 The first record connecting Jason to Michael was in February 2010, when Kent Police attended a domestic incident between them. Jason said he had known Michael for about 20 years, although it is not recorded how they met. Jason added they had had a one-night stand some months previously, but they were not in a relationship.
- 10.3.2 The commonly held understanding of the term 'one-night stand' is a single act of sexual intimacy. The cross-government definitions of domestic abuse in place in 2010 and currently (see [Appendix B](#)) use the term 'intimate partners'. This term is not further defined to establish whether a single intimate act between two people makes them intimate partners.
- 10.3.3 In 2010, Kent Police treated an incident between Michael and Jason as domestic abuse, in which Jason was the victim, based on him telling them about the one-night stand. Having done this, Kent Police should have treated any future incidents, in which either was a victim at the hands of the other, as domestic abuse.
- 10.3.4 None of the organisations involved in this DHR have any record that Jason and Michael ever lived together. There is no disclosure by either of

them that they had an intimate relationship beyond the one-night stand Jason spoke of six years before his death. It is the intimacy on that occasion that causes the subsequent abuse suffered by Jason at the hands of Michael to fit the definition of domestic abuse current at the time of his death. It became evident while carrying out this DHR, that if intimacy had not taken place, there may have been grounds for conducting a Safeguarding Adult Review under S.44 of the Care Act 2014 following Jason's death.

- 10.3.5 Following the incident described above, it is not known whether Jason had any contact with Michael until after the death of his mother. After that event, Jason began reporting assaults and harassment, as well as behaviour amounted to control and coercion, by a person he described either as a friend or ex-partner. Jason did not always disclose the identity of the person but by cross-referencing the records of the organisations involved in this review, it is possible to establish the perpetrator was invariably Michael. It is from the point when he begins speaking about this domestic abuse that the actions of organisations become relevant to this DHR.

## **11. The Facts and Analysis of Organisations' Involvement**

### **11.1 Introduction**

- 11.1.1 This section sets out facts and analysis of the involvement Jason and Michael had with organisations between 1 January 2012 and Jason's death. The facts are based on IMRs submitted by, or interviews with, those organisations. The analysis is based on the facts, and from it come conclusions, recommendations and lessons learned.
- 11.1.2 This section includes abbreviations, acronyms and references to terms familiar to professionals working in relevant organisations, but which may need further explanation for other readers. In such cases, the reader is referred to the glossary in [Appendix C](#), where more detail is provided.

### **11.2 Kent Police**

- 11.2.1 Before the start of the period covered by this DHR, both Jason and Michael had criminal convictions. Neither were convicted of any offences between January 2012 and Jason's death.
- 11.2.2 In February 2010, Kent Police attended a domestic incident in which Jason was the victim and Michael the perpetrator. During the next four

years, the only recorded incident linking them happened in March 2013, when each was the victim of an assault arising out of a single incident.

- 11.2.3 In July 2014, an ambulance crew attended Jason's flat. He told them he had been assaulted by an unnamed friend. When police attended, he denied he had been assaulted, saying he had been involved in a verbal altercation with a friend. He then asked the police to leave. It was noted he had superficial facial injuries but he would not discuss the matter further.
- 11.2.4 During the following month, Michael made several calls to Kent Police from Jason's flat. Although the calls related to incidents involving himself, they were of sufficient frequency to suggest that he was visiting Jason's flat frequently.
- 11.2.5 In one of the calls, Michael reported he had been threatened by a third party. During this call, Jason also spoke to the police call handler and disclosed he had been assaulted by Michael a couple of months previously. It is not clear whether this referred to the earlier occasion when he had denied being assaulted. Kent Police did not record or investigate his allegation against Michael.
- 11.2.6 In September 2014, Jason called Kent Police reporting he had been assaulted by a friend, who he had been '*...beaten up by*' three times previously. The call taker recorded that he was very upset and hard to understand. Police attended, as did SECAMB, and Jason named Michael as the perpetrator. The police recorded that Jason had been punched and had facial injuries. The record also states he was drunk and repeatedly punching himself in the head. Michael was not present.
- 11.2.7 The police officer who attended this incident worked in Kent Police's Roads Policing Unit. He asked for the case to be allocated to a local officer for investigation. Five days later, a police officer went to Jason's flat to investigate the assaults. He recorded that Jason had no recollection of calling the police to the incident. Jason said Michael had not assaulted him; he had injured himself. He added that he had mental health issues. The officer recorded that Michael was present during the visit and he denied being there when Jason's injuries were caused. It was not recorded whether each was spoken to separately.
- 11.2.8 No further action was taken; the case was closed and filed as '*Not amounting to notifiable crime*'.

- 11.2.9 In April 2015, Michael again called Kent Police from Jason's flat. He wished to complain about pornographic material being sent to him at Jason's address. He was aggressive to the call taker throughout their conversation.
- 11.2.10 During the same call, Jason spoke to the call taker. He asked for police to attend and remove Michael from his house because he was *'throwing things around and punching things'*. He then said Michael had stopped doing this but he still wanted the police to attend to remove him. The call taker recorded that Jason was very fearful of Michael and refused an offer to text the call reference number to his phone, for fear of Michael seeing it. Jason then added that Michael assaulted him the previous Sunday and that he still had bruising. He said *'...he would deny this if asked by officers.'* What Jason was reporting was domestic abuse; there was evidence of controlling and coercive behaviour by Michael.
- 11.2.11 Prior to the deployment of an officer to Jason's flat, Kent Police received a call from Town A Borough Council (ABC). Jason had contacted ABC asking for a contractor to attend as *'...[Jason] claims Michael has taken his keys and he fears his life and wants council to install new locks for him.'* The member of staff from ABC added Jason was intoxicated.
- 11.2.12 A police officer attended and spoke to Jason; Michael was no longer present. The officer subsequently recorded on the computerised police log, known as [STORM](#), *'Although there is a [domestic abuse] marker on [Genesis](#) for Davis and Lyons, this relates to a report [in 2011] which was ultimately deemed not to be domestic abuse as Davis and Lyons had a one-night stand six years [previously] but no intimate relationship. Davis corroborated this today, saying that he and Lyons are just friends. This is therefore not a domestic.'*
- 11.2.13 A few hours later, Jason called Kent Police. The call taker recorded that he did not want to make allegations against Michael and that ABC were attending later to change the locks.
- 11.2.14 The following month, May 2015, a police officer attended Jason's flat after he had reported a burglary. The officer recorded that there had been no burglary. He submitted an intelligence report about Jason's vulnerability, noting that an Adult Protection referral had been made on a previous occasion in 2013. The referral that the officer alluded to was not in relation to Jason but to his mother but having identified his vulnerability, an opportunity was missed by not submitting a safeguarding alert to Kent County Council Adult Services (KCCAS) on this occasion.

- 11.2.15 On 11 June 2015, a Detective Sergeant (DS1) from the [Central Referral Unit \(CRU\)](#), co-located with Kent County Council Adult Services (KCCAS) Central Duty Team (CDT), provided information in response to an enquiry from the CDT. He stated that in 2010, Michael was named as a partner of Jason and that Michael was also known to have female partners. He mentioned the incident in September 2014, but did not include the incident that occurred in April 2015, two months previously, when an intelligence report had been submitted about Jason's vulnerability.
- 11.2.16 DS1 also described Michael as having a long police record including harassment, assault and sexual assault on a minor, adding that Michael had been released from prison in 2011.
- 11.2.17 The co-location of Kent Police and the KCCAS CDT in the CRU ensures that information can be passed between professionals who have a close working relationship. To give the best support to vulnerable people, it is important that when information is shared, all the details held by each agency are provided.
- 11.2.18 At the end of June 2015, an Independent Domestic Violence Adviser (IDVA) referred Jason to the Town A Multi-Agency Risk Assessment Conference (MARAC). The reasons for the referral are detailed in Section 11.9 below. The single action arising from the MARAC, which was held on 6 August, was assigned to Kent Police. It was to, *'Carry out [a joint visit] with IDVA regarding offences.'*
- 11.2.19 The police officer who attended the MARAC was the domestic abuse single point of contact ([DASPOC](#)) in the Kent Police [Combined Safeguarding Team \(CST\)](#) and this officer was assigned the action. The DASPOC recorded that they spoke to the IDVA who had made the MARAC referral. The IDVA told them that Jason had *'...made it clear that he doesn't want other agencies involved in and certainly doesn't want to report any offences to police.'* The DASPOC also recorded that they gave the IDVA their contact details, so that if Jason changed his mind, the IDVA could contact them *'...for offences to be reported.'* Given that the DASPOC had been at the meeting when the action had been agreed, it is surprising that this officer was a party to not implementing it.
- 11.2.20 The MARAC referral stated that, *'Jason has received injuries on several occasions following these beatings but is too scared of Michael to report it to the police.'* There is a difference between a victim not wanting to report an offence, as in the previous paragraph, and being too scared to do so as described in the MARAC referral.

- 11.2.21 The DASPOC, as a trained member of a Kent Police Public Protection Team, would have known that fear of the perpetrator is one of the main reasons why domestic abuse victims do not report criminal offences to the police. Kent Police should be making every effort to increase the confidence of domestic abuse victims in reporting crime to them. Their involvement in this should be positive; it should not place responsibility on other agencies to engender confidence in victims. In cases that have been referred to the MARAC, where there is information that the victim is too frightened to report domestic abuse to them, Kent Police must actively seek to engage with them. **(Recommendation 1)**
- 11.2.22 KCCAS records show that on 2 July 2015, a Detective Sergeant (DS2) contacted them and said that although he had not seen the MARAC referral, he did not feel Jason's case met MARAC criteria. Although he had access to the [Genesis](#) entry that showed Jason and Michael had had an intimate encounter, DS2 said he needed confirmation that they had been more than just friends, adding that he did not feel that it was a case for the [CST](#). He subsequently signed off the report that confirmed the action assigned to Kent Police at the MARAC would not be completed.
- 11.2.23 The MARAC referral relating to Jason met the relevant criteria and the information about his intimate encounter with Michael was available to DS2. Kent Police must ensure that Public Protection Unit supervisors have considered all the available information before making decisions about MARAC actions and that they record their rationale. **(Recommendation 2)**
- 11.2.24 During September 2015, Jason made four calls to Kent Police. None were relevant to issues involving Michael but they evidenced his vulnerability due to alcohol and mental health problems. Although there were repeated calls within a short time, on none of these occasions was there a record that an adult safeguarding referral had been considered.
- 11.2.25 At the end of November 2015, a salesman who had called at Jason's flat was sufficiently concerned about an injury to his face to call SECamb. Jason was taken to the acute hospital in Town A. When police officers saw him there, Jason disclosed he had been assaulted by Michael at his home. He did not want to discuss what had happened, although he said Michael '*...effectively forces his way in*'. A police officer recorded that Jason was hitting himself and that he was '*a very vulnerable individual.*' Jason refused to expand on the assault allegation and the officer completed an intelligence report on [Genesis](#). The assault allegation was not recorded as a crime.



- 11.2.26 The following day, Jason contacted Kent Police about the assault. He said it was Michael who had assaulted him. The [STORM](#) record states that *'...[Jason] was scared of Michael [who] had said that he would kill him if he reported it to the police. [Jason] states that he does want to report it now although he is scared if he is doing the right thing.'*
- 11.2.27 Because of this call, a police officer recorded a crime of assault occasioning actual bodily harm and submitted a [crime report](#). The officer then made a lengthy entry on [STORM](#) to the effect that he did not believe the assault had taken place. He added that he gave Jason safety advice, which Jason refused on the basis that however he protected his flat, Michael *'...would only come through anyway.'* The officer added that, *'I do not feel the alarm would be necessary – he has a landline and mobile, and clearly is not shy about calling the police – it appears the issue is more to do with his drinking.'*
- 11.2.28 A further entry is made by the officer which states, *'A recent MARAC assessment listed [Jason] as high risk, however I do not agree with this. [Jason] does not appear to be at risk of serious harm, if anything it appears to be minor disagreements between heavy drinkers.'*
- 11.2.29 The crime report was reviewed by a Kent Police Inspector who stated that *'...[Jason] is less than a credible witness and there is no chance of a prosecution. [He] leads a life which tends to lead to confrontation primarily through drink and police intervention would certainly not effect [sic] this. I note how many times he has been a victim of crime, or at least claimed to be. I note the evidence of self-harming also.'* The crime report was filed without any further action being taken.
- 11.2.30 The comments by the Inspector do not reflect empathy, an understanding that Jason was a victim of domestic abuse or an appreciation that the reason for him not reporting offences might be (and was) his fear of Michael. The tone of the comments is indicative of the start of victim blaming - when an organisation starts to consider that a person is a problem, rather than a victim.
- 11.2.31 In January 2016, Kent Police went to the acute hospital in Town A to see Jason, who had been taken there from home by SECamb. He had told the ambulance crew that he had been assaulted by Michael (the scenario being the same as two months earlier). The officers attending knew about the MARAC referral (referrals are flagged on [STORM](#) for 12 months) and noted that Jason's injuries amounted to actual bodily harm. He was very intoxicated. An Inspector updated the STORM record stating that Jason

had been assaulted by a named suspect and once his welfare had been established, efforts were to be made to arrest Michael.

- 11.2.32 One of the officers attending updated the STORM record: *'This is not domestic related. [Jason] has got injuries but refusing to state how he got these.'* A crime report was created and closed, no action was taken in relation to Michael. It appears that the officer ignored the inspector's instructions to arrest Michael but there is no recorded rationale for doing this.
- 11.2.33 Five days later, Jason contacted Kent Police about this assault allegation. Further information was recorded on [STORM](#) and the [crime report](#) was reopened. He telephoned Kent Police again the following day and repeated his allegations against Michael. A police officer visited him and discussed safety planning with him. The officer then referred the case by email to the [DASPOC](#) in the [CST](#); the officer who had attended the MARAC. In the email, the officer reported that Jason had said he had never been in a relationship with Michael.
- 11.2.34 The [DASPOC](#) did not take any action because the referral was not marked domestic abuse and because there was no substantive offence, it did not fit the criteria for a re-referral to the MARAC. This was incorrect in as much as there was a substantive offence – an assault. The crime report was again closed without further investigation or contact with Michael.
- 11.2.35 Not only was Michael not arrested, he was not spoken to about the allegation of assault made by Jason. There was a failure to identify that this was part of a pattern of domestic abuse, over a long period, which included a MARAC referral.
- 11.2.36 The Kent and Medway MARAC Operating Protocol and Guidelines (OGP) define a criterion for what constitutes a repeat MARAC case, when a re-referral should be made:
- A repeat MARAC case is one which has been previously referred to a MARAC and at some point in the 12 months from the date of the last referral a further incident is identified which, if reported to police, would constitute criminal behaviour.*
- 11.2.37 This criterion was met and Jason should have been re-referred to the MARAC. The [DASPOC](#) knew the history of the first referral, having been at the MARAC meeting when the case was discussed. She also knew that Jason was likely to withdraw his allegation of assault by Michael

because he was frightened of reprisals. Kent Police must ensure that officers working in Public Protection Units have an in depth understanding of how best to provide support to victims of domestic abuse.

**(Recommendation 3)**

- 11.2.38 In March 2016, Brian Rowse, Jason's ex-long-term partner, contacted Kent Police reporting concerns about Jason. He said he believed Jason was being threatened by Michael, who he (Jason) feared. Brian had been trying to contact Jason without success. Kent Police visited Jason's flat that day but got no reply. The following day a call handler spoke to him by telephone: he said he had been asleep and there were no problems. He was then visited by officers and he said he was '*completely fine*' and did not disclose any offences.
- 11.2.39 There is no record that Brian was updated or asked to call again if he had further concerns. This was a missed opportunity to find out more about Jason's situation from a third party who described himself as a friend.
- 11.2.40 On 1 April 2016, Jason called Kent Police. He said he had been drinking all day and in the morning Michael came to his flat and put a Stanley knife to his throat. When police officers attended, Jason retracted his allegation and said he had a verbal argument with Michael and wanted his key back.
- 11.2.41 Police officers then went to Michael's home, took the key from him and told him not to return to Jason's address. They returned the key to Jason. This incident was acknowledged as domestic abuse because of the previous relationship between the two. A [DASH](#) risk assessment was attempted but Jason refused to answer questions. A safety plan was discussed with him and he was signposted to other agencies. There is no record that the officers spoke to Michael about the allegation that Jason had made.
- 11.2.42 The officers attending graded the [DASH](#) risk assessment as Standard but this was reviewed by their supervisor and regraded as Medium, based on the history between Jason and Michael. This was the first time in the period covered by this DHR that Kent Police had completed a DASH risk assessment for Jason.
- 11.2.43 Kent Police attended three incidents following Jason's case being heard at the MARAC; in each the repeat referral criterion was met. In none of the cases was a referral made, including the occasion when it was recognised that Jason was a domestic abuse victim. Kent Police must ensure that an understanding of the MARAC repeat referral criterion

forms part of their domestic abuse training programme.

**(Recommendation 4)**

- 11.2.44 This was the last contact that Kent Police had with Jason before 17 May 2016, when Michael contacted them to report that he had found Jason in his flat, cold and covered in blood.
- 11.2.45 As Kent Police's involvement with Jason developed, the issue of whether he was a victim of domestic abuse was inconsistent. In 2010, Jason told a police officer that he had had a one-night stand with Michael. Because of that disclosure of an intimate relationship, albeit brief, the incident being dealt with at that time was correctly recorded as domestic abuse. The record was made on [Genesis](#); any officer dealing with the subsequent incident between the two would have been able to see this if they researched the system.
- 11.2.46 In April 2015, an officer acknowledged that the 2010 incident had been recorded as domestic abuse but decided, as there had been no subsequent intimate relationship, that an alleged assault by Michael on Jason was not domestic abuse. This was not correct; once there has been an intimate relationship between two people, it is not undone by time. The incident in 2010 and all subsequent incidents in which Michael assaulted, harassed, controlled or coerced Jason, met the definition of domestic abuse. This is something that needs to be reinforced in Kent Police's domestic abuse training programme. **(Recommendation 5)**
- 11.2.47 Even if there had been no intimate relationship between them, Jason's alcoholism, combined with assaults, control and coercion by Michael, made him vulnerable. In one case, this was explicitly identified by an officer, but no safeguarding alert was ever made to KCCAS. This contrasts with the referrals made by ambulance service personnel (see Section 11.7). Kent Police must ensure that police officers and police staff who may have contact with vulnerable people understand when safeguarding alerts should be made to KCCAS. **(Recommendation 6)**

11.3 Kent County Council Adult Service (KCCAS)

- 11.3.1 KCCAS provide adult social care services throughout Kent. A Central Duty Team (CDT) receives safeguarding referrals and carries out initial consultations/enquiries for people who do not have open cases with KCCAS.
- 11.3.2 KCCAS were involved with Jason during 2012 and 2013 when he was caring for his mother, who was suffering from cancer. They were primarily

supporting her needs and although their contact with Jason during that period corroborates his drink problems, it is not relevant to this DHR. At the time of his mother's death, neither had an open case with KCCAS.

- 11.3.3 Following his mother's death, KCCAS's first involvement with Jason was in April 2015, when they received a vulnerable person referral from SECAMB. The referral stated that a friend entered Jason's flat almost daily against his wishes and occasionally assaulted him. When Jason asked him to leave, this friend refused to do so.
- 11.3.4 A safeguarding alert was raised and Jason was telephoned by a KCCAS Specialist Case Manager, four days after the referral. He said he did not want any support from social services in relation to safeguarding issues and that he was receiving support from his GP for his mental health needs.
- 11.3.5 In June 2015, KCCAS received another vulnerable person referral from SECAMB. He had again disclosed that a friend entered his property almost every day against his wishes. He said his friend was called Michael but would not give his surname. He added that this friend had a key to the property and refused to return it. He again disclosed that Michael occasionally assaulted him.
- 11.3.6 A Contact and Assessment Officer from the KCCAS [Area Referral Management Service \(ARMS\)](#) telephoned Jason at home on the day the referral was received. He was very guarded and it was clear that he could not speak openly. He was asked if Michael was present and he replied yes. He asked that any future calls be made after 5pm. Due to the nature of the safeguarding concerns, the case was transferred to the Central Duty Team (CDT).
- 11.3.7 An initial risk assessment was carried out by a Senior Practitioner in the CDT. Jason's case was assessed as requiring a multi-agency approach involving Kent Police, because it was likely that criminal offences had been committed. The risk to Jason was rated as substantial. Over the following three days, checks were made with other agencies including Kent Police and KMPT. The latter confirmed that they had dealt with Jason the previous month but they did not have an open case relating to him.
- 11.3.8 Kent Police provided information that in 2010, Jason and Michael were partners. Due to this information, KCCAS correctly treated it as a case of domestic abuse.

- 11.3.9 On 17 June 2015, an Assessment Officer (AO) from the CDT telephoned Jason at home and spoke to him. He said both he and Michael had bipolar disorder and that Michael came to his flat daily at 6am, staying until his girlfriend picked him up at 4:30pm. Michael let himself in with a key. Jason added that he had had his locks changed four times to stop Michael getting in the flat but when he was not able to gain access, he continually rang the communal bell. This caused problems with neighbours, so Jason gave him another key. He said Michael would assault him when he (Michael) got drunk.
- 11.3.10 When asked about contacting the police, Jason said he was too frightened to press charges. When asked about the possibility of taking out a harassment order, he again said he was too frightened of Michael to do this. He agreed that KCCAS could make a referral to the IDVA service but added that Michael monitored all his letters and movements. He said Michael assaulted him about once a month and he considered that Michael, who he had known since he (Michael) was about eight years old, controlled every part of his life.
- 11.3.11 The AO was not qualified to carry out a [mental capacity assessment](#) and had she been, this could not have been completed in a telephone conversation. However, she felt that Jason had the mental capacity to make informed decisions about his safety needs.
- 11.3.12 On 19 June 2015, the AO contacted the IDVA service, who confirmed that they would accept a referral for Jason. The AO then telephoned Jason, and after confirming that he was on his own, advised him that the referral had been accepted.
- 11.3.13 On 29 June 2015, the AO spoke to the IDVA who was dealing with Jason's case. She received an update from the IDVA, who stated that she believed '*...the situation was a time bomb waiting to go off*' and that she considered Jason to be at high risk. The case was then transferred within KCCAS from the CDT to the Town A Care Management Team, where the Safeguarding Adults Coordinator agreed to be the Designated Senior Officer (DSO) for Jason's case.
- 11.3.14 KCCAS did not disclose the full information contained in the safeguarding form to Kent Police because of Jason's resistance to police involvement. They explained their reasons for this to Kent Police, which were that Jason had been clear that he did want to involve the police and that although he was at risk of significant harm, he was considered to have the mental capacity to make the decision about his safeguarding

- 11.3.15 It is a fundamental presumption that a person has mental capacity unless the contrary is shown. Chapter 2, Statutory Principle 3 of the Mental Capacity Act 2005 Code of Practice states '*A person is not to be treated as unable to make a decision merely because he makes an unwise decision.*' A mental capacity assessment is way in which a decision is taken about whether a person is capable of making decisions. It is a formal process, which must be carried out by a suitably qualified person.
- 11.3.16 The KCCAS professional in this case was not qualified to carry out a mental health assessment, so she could not have decided that he lacked mental capacity. She decided, using her professional judgement and based on her contact with him, that she did not have sufficient doubts about his mental capacity to consider an assessment. She was experienced and had received training in the provisions the Care Act 2014. Having made that decision, she was right to accede to his wish not to involve the police.
- 11.3.17 On 29 July, a KCCAS Specialist Case Manager, who had been nominated as the Inquiries Officer (IO) for Jason's case, spoke to the IDVA and offered to arrange a joint visit to see Jason. There is no record that this took place.
- 11.3.18 On 6 August, the DSO attended the MARAC and recorded a summary of the discussions and actions relating to Jason:
- Police to make direct contact with [Jason] regarding his allegations which are of a criminal nature. They will provide information about non-molestation orders and injunctions.
  - Case manager can attempt to offer a social care assessment via the GP surgery as he attends there weekly.
  - Care manager to:
    - Check if Jason open to [the mental health] team as GP implied
    - Arrange an appointment to see Jason at the surgery
    - Liaise with Kent Police (Public Protection Unit) re the outcome of the meeting with Jason
    - Liaise with the IDVA
- 11.3.19 The MARAC meeting was not minuted and this is discussed in Section 12 below. In the absence of minutes, the DSO's summary of the meeting is the fullest account of what decisions were taken.
- 11.3.20 On 6 October, the IO spoke to Jason's GP. She then sent an email to the IDVA asking for an update about any contact made with Jason, advising



that his GP was asking for this. She did not receive a response and sent a further email to the IDVA on 23 November. She received a response the same day; the IDVA told her that Jason had disengaged with the service.

- 11.3.21 The IO contacted the GP surgery liaison care manager. It was agreed that the IO would try to arrange a meeting with Jason at the surgery and provide him with information about Broken Rainbow, which at the time was a support group for LGBT victims of domestic abuse.
- 11.3.22 On 2 December, further information was received by KCCAS from a staff nurse at the acute hospital in Town A, who had noticed that Jason had a black eye when he attended the hospital for an unrelated medical condition. He said a friend had caused the injury but he could not remember when. Jason had refused police involvement.
- 11.3.23 On 10 December, the IO met Jason at his GP surgery after his doctor's appointment. He engaged with her and said he felt stronger and more able to stand up to his friend, who he named as 'Michael Lyons'. He added that Michael still had his keys, so he didn't wake up the neighbours when attempting to get access. He also said Michael lived '*at his own place with his girlfriend*'.
- 11.3.24 Jason added that he had a friend whose mother was poorly and there might be a chance that he could move in there. He said he was not drinking as much now but was not interested in working. He denied having been to the hospital recently or being hit by Michael. He declined any further input from KCCAS. The IO gave him her contact details in case he changed his mind.
- 11.3.25 On 7 January 2016, the IO emailed the IDVA to provide an update on her meeting with Jason at the surgery. She said she was also writing to his GP asking him to monitor the situation as she (the IO) was retiring. She wrote to the GP and included information about Broken Rainbow and the KCCAS Adult Community Team's (ACT) phone number, which could be given to Jason during one of his regular medication reviews. She asked the GP to alert the ACT should he feel that Jason needed help or support from KCCAS. She did not update SECamb, the initial referrer. Although the ambulance crew who initiated the referral are not named in it, an update could have been sent to the SECamb Safeguarding Team.
- 11.3.26 On 23 January 2016, a third safeguarding alert relating to Jason was sent by SECamb to KCCAS. It initially went to the [ARMS](#) and because Jason's case is still open to the ACT based in Town A, it was forwarded to



their duty email box. This email was not read and the DSO for Jason's safeguarding case had not seen it until it was found during research for this DHR. She said had she been aware of it she would at least have prioritised making a call to Jason to see if he would accept any help from KCCAS.

- 11.3.27 The first involvement that KCCAS had with Jason, was a month after the provisions of the Care Act 2014 came into force. Kent and Medway Safeguarding Adults Board had done a lot of work prior to the implementation of the Act to ensure that adults safeguarding procedures were compliant with it and that staff were aware of these. They published the [Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway](#), which contains comprehensive guidance and which is regularly updated.
- 11.3.28 [Section 42 of the Act](#) requires that where a safeguarding alert is received and the adult appears to have both care and support needs, a statutory enquiry will be invoked. In such circumstances, a Designated Senior Officer (DSO) will be appointed. The DSO may delegate the task of making or causing enquiries, to an experienced practitioner who has received an appropriate level of training, and has relevant experience and knowledge, to be the Inquiries Officer (IO).
- 11.3.29 Following the second referral of Jason to KCCAS by SECamb in June 2015, KCCAS took the decision to make enquiries of Kent Police but not to make a referral to them because of Jason's resistance. This was in accordance with the statutory principles of the Mental Capacity Act 2005.
- 11.3.30 Following Jason's referral to the IDVA service and the feedback received, after an IDVA had spoken to Jason, a Section 42 enquiry was invoked by KCCAS and appropriate staff were put into the DSO and IO roles to manage his case. This was the right decision; those appointed were suitably senior and qualified.
- 11.3.31 The DSO attended the MARAC on 6 August 2015; she did not delegate attendance. This shows that KCCAS were treating Jason's case seriously. Kent Police attended this meeting and therefore the decision about whether KCCAS should make a referral to them was no longer relevant – they received all the information at the meeting.
- 11.3.32 There is evidence that the DSO and IO took active roles in attempting to provide Jason with support. The IO made an ultimately successful attempt to meet Jason at a neutral venue, which was very positive. It was indicative

of the IO's proactive approach to contacting other organisations and is an example of good practice.

- 11.3.33 In January 2016, the information received from the acute hospital in Town A about Jason being assaulted by Michael met the criterion for a repeat referral of his case to the MARAC (see 11.3.36 above). There is no record that KCCAS considered a repeat referral or that they discussed the possibility with Jason. KCCAS must ensure that staff who might work on cases involving domestic abuse are aware of the criterion for the repeat referral of a case to the MARAC. **(Recommendation 7)**
- 11.3.34 The failure to action the third SECamb adults safeguarding referral was the result of an email being sent within KCCAS and not read. Given how seriously KCCAS had taken the previous referrals, there is little doubt that had this email been read, safeguarding actions would have resulted. It cannot be said that this would have resulted in a different outcome for Jason but the failure to action it had potentially serious consequences.
- 11.3.35 The failure to redirect this email may seem an isolated incident but an Adult Safeguarding Review published in 2015 identified a similar issue within KCCAS. KCCAS must ensure that they have a robust system for communicating safeguarding information within their organisation and to other organisations. **(Recommendation 8)**
- 11.3.36 All organisations now rely heavily on email communication. Although on this occasion the problem arose in KCCAS, it is one that other organisations should note.
- 11.4 Town A Clinical Commissioning Group (GP Practice)
- 11.4.1 Jason was registered with a GP surgery in Town A during the period covered by this DHR. During this time, he saw the same GP on all but one of the 37 occasions that he went there. The national average for GP visits is about four per year, so Jason's attendance was about three times this.
- 11.4.2 During the same period, Jason also called the GP out of hours service (OOH) 28 times. The OOH service was provided by two organisations commissioned by the NHS: IC24 and Harmoni. Jason's GP records contain information about each of his contacts with the OOH service and when he called 111, the non-emergency NHS number.
- 11.4.3 Most of the agencies involved in this review refer to Jason suffering from bipolar disorder but there is no evidence that he had been diagnosed with

this condition. He told his GP that he was suffering from it: his GP did not diagnose it and he was not qualified to. Jason was not referred to KMPT (the secondary mental health service providers) for this condition and there is no evidence that their staff ever confirmed it, although he did tell a psychiatric nurse that he had the condition, '*...which was being managed by his GP*'.

- 11.4.4 Jason was suffering from chronic alcohol abuse and he had symptoms of alcoholic neuropathy. He also suffered depression and suicidal ideation. During many of his contacts with his GP and the OOH service, he was suffering from the effects of excessive alcohol consumption.
- 11.4.5 In August 2014, Jason presented to his GP with a black eye and said he had been assaulted. He declined to discuss this any further. GP records show that in the previous April, he had called 111 reporting that a friend had tried to strangle him.
- 11.4.6 In April 2015 Jason called 111 twice reporting assaults; during the second he said his nose had been broken. Two days later, he went to his GP suffering from a black eye. He was advised to attend A&E for an x-ray, which he did five days later.
- 11.4.7 In July 2015, his GP was asked to provide information about Jason to inform a MARAC meeting. The requested stated that Jason, '*...is known to be at high risk of murder.*' The GP provided a report, which explained that Jason's anxiety and depression were first diagnosed in 1985 when he was 21. The first record of him being a victim of assault was in 1986 and there had been a total of eight reports of assault to date. Jason had a history of recurrent depression with deliberate self-harm and overdose. The report confirmed his alcohol dependence. He was being prescribed painkillers and these prescriptions were monitored. He was prescribed lorazepam, which Jason was having difficulty weaning himself off.
- 11.4.8 In December 2015, Jason went to his GP with a black eye but denied that he had been assaulted, saying that he had hit his face accidentally when opening a cupboard door. There is no record of any safeguarding advice being given or of a safeguarding alert being made
- 11.4.9 On 25 January 2016, Jason was seen by his GP and said he had been assaulted by someone at home. The GP records state, '*Reported to police and social services involved. Advised.*' It is not clear whether the reports referred to in this record were made by Jason or the GP; neither Kent Police nor KCCAS have a record of contact from either. What advice was given is not recorded.

- 11.4.10 In February 2016, Jason asked for a prescription for Fortisip, a high protein supplement for the management of disease related malnutrition. Although he did not fit the criteria for being prescribed dietary supplements, he was given a one-off prescription. The request was further evidence of his vulnerability.
- 11.4.11 He was seen by his GP in March suffering from a minor medical condition. He was again seen in April when no specific condition was recorded. It was noted that he was not engaging with the CMHT. He was advised to *'contact his support worker.'* He did not have a support worker, although he may have told his GP that he did.
- 11.4.12 He was last seen by his GP on 5 May, a fortnight before his death complaining of excessive daytime sleepiness. He was referred for blood tests.
- 11.4.13 Jason saw his GP and called the OOH service many times during the last two and a half years of his life, the period where he was suffering abuse from Michael. He reported a wide range of physical health conditions, which were dealt with appropriately.
- 11.4.14 As a chronic alcoholic, Jason had vulnerabilities. If his GP had any doubts about the significance of assaults that Jason had suffered before July 2015, he can have had no doubt about it after he was asked to provide a report for the MARAC meeting. This could not have been more explicit; it stated that Jason was *'...known to be at high risk of murder.'*
- 11.4.15 Twice subsequently, Jason presented with injuries. On the first occasion this was a black eye which he said was caused accidentally. His GP records include the call he made to 111 five days earlier, during which he said it had been caused by an assault but this may not have been added to the records until after his visit.
- 11.4.16 On the second occasion, the injury was clearly the result of an assault. It appears that Jason may have told his GP that he had reported the matter to the police and social services. On both occasions, there were grounds for the GP to consider making a safeguarding alert to KCCAS. There is no record that this consideration was made following either consultation.
- 11.4.17 In addition to general safeguarding, the MARAC OPG sets out a specific criterion for what constitutes a repeat MARAC case (see paragraph 11.2.36 above). The second occasion when Jason presented to his GP with an injury, he said it was an assault. This met the criteria for a repeat MARAC case. The OPG goes on to say that *'Any agency may identify*

*this further incident (regardless of whether it has been reported to the police).*

- 11.4.18 Jason's GP knew that Jason had been considered by the MARAC in the previous 12 months but he did not refer him as a repeat case following this assault. This might have been because he was unaware of this criterion. Clinical Commissioning Groups (CCG) should ensure that GPs are aware of the MARAC process, including the criterion for referring repeat cases. **(Recommendation 9)**
- 11.4.19 Michael was registered at a GP surgery in Town A (not the one with which Jason was registered) throughout the period covered by this DHR. During this time, he was seen 16 times, about the national average for GP attendance. There is no record of him contacting the OOH service.
- 11.4.20 Michael also had alcohol abuse issues. Most of the contact that he had with his GP related to physical health conditions for which he was treated or given advice. On one occasion, in 2012, he was prescribed medication for depression. There is no record of him being diagnosed or treated for bipolar disorder during the period covered by this review.
- 11.4.21 There is nothing in Michael's GP records to suggest he was either a victim or perpetrator of domestic abuse and there is no mention of Jason.
- 11.4.22 It is worth noting that there were issues in gaining access to both Jason and Michael's GP records for this DHR for different reasons.
- 11.4.23 Because Jason had died, his GP practice had sent his records for archived storage. GP records are now stored by a third-party private contractor following a person's death. This was a recent development at the time of trying to retrieve these records and the process was slow. The contractor did not know about the DHR requirement for records. NHS England should ensure that the contractor responsible for storing archived GP records is aware of the requirement to provide the records in a timely manner when requested for a DHR. **(Recommendation 10)**
- 11.4.24 Access to Michael's GP records was delayed because the GP practice was concerned about whether disclosure would breach medical confidentiality. This concern is not unusual because many GP practices have still not been involved in a DHR. This is a national issue and some CCGs have produced guidance for GP practices about this. CCGs in Kent and Medway should provide guidance to GPs about providing records when requested as part of a DHR, taking account of Section 10 of

the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. **(Recommendation 11)**

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

- 11.5.1 KMPT provides secondary mental health services throughout Kent and Medway. It is delivered in the community by [Community Mental Health Teams \(CMHT\)](#) and [Crisis Resolution Home Treatment Teams \(CRHTT\)](#). KMPT provides outpatient and inpatient services and treatment in their own hospitals; they also have liaison psychiatry staff in acute hospitals.
- 11.5.2 During the period covered by this DHR, KMPT was involved with Jason on numerous occasions, usually following his attendance at the A&E department of the acute hospital in Town A. There is one record of KMPT contact with Michael.
- 11.5.3 Jason first contacted the [CRHTT](#) in April 2013, when he was experiencing grief following the death of his mother. He was referred to the [CMHT](#), who contacted him by telephone two days later. He described his issues to a psychiatric nurse and agreed to a routine appointment at a KMPT clinic. He did not attend and attempts to contact him by telephone were unsuccessful. He was sent a letter asking him to contact the [CMHT](#) to arrange a new appointment, to which he did not respond.
- 11.5.4 Jason's next contact with KMPT was in June 2013 at the acute hospital in Town A, where he was assessed by a psychiatric nurse following his attendance at A&E. He had gone there because an unnamed friend was concerned about the amount of prescription drugs that he (Jason) had taken.
- 11.5.5 During his assessment, Jason agreed that his main issue was excessive alcohol consumption. He was accepting of a referral to Turning Point, a social enterprise organisation commissioned to provide alcohol support services in the area where he lived. He was also given a follow-up appointment with the [CMHT](#).
- 11.5.6 Later in June, Jason was contacted by the [CRHTT](#) after he had called an ambulance and a paramedic was concerned about his mental health. He said his partner had not been supportive following his mother's death and he decided to end the relationship. He was reminded of his appointment with the [CMHT](#). He did not attend this appointment and was sent a letter advising him to rearrange it.

- 11.5.7 During the next 10 months, Jason was seen on six occasions by KMPT nurses following his attendance at A&E. No mental health conditions were diagnosed. On one occasion, a subsequent attempt was made by the [CMHT](#) to contact him by letter but he did not respond.
- 11.5.8 At the beginning of May 2014, Jason's GP contacted the [CMHT](#) requesting a psychiatric assessment of Jason, who was expressing suicidal thoughts due to low mood. The [CMHT](#) had difficulty contacting Jason but they received calls from a friend, who on one occasion gave his name as Michael, expressing concerns about him. After missing one appointment, Jason was seen at the end of June 2014 where an assessment indicated that his main issue was excessive alcohol consumption. He accepted a referral to Turning Point and his case was closed by KMPT.
- 11.5.9 In July 2014, the [CRHTI](#) were contacted by a paramedic who was attending a call to Jason's flat. Jason spoke to a psychiatric nurse and he accepted the need to liaise with Turning Point. A further referral was made to the [CMHT](#).
- 11.5.10 At the end of July, a psychiatric nurse carried out an initial telephone screening interview with Jason and visited him at home the following day. It was agreed that a referral would be made to Turning Point. He was given information about counselling services and he was told that an appointment would be made with a psychiatrist once alcohol detox had been completed.
- 11.5.11 An additional contact number for Jason was required for the Turning Point referral and Michael, who had identified himself as Jason's best friend, agreed that his number could be used.
- 11.5.12 In September 2014, following receipt of vulnerable adult referral from SECAMB, Jason was spoken to on the telephone by a KMPT social worker who stressed the importance of him working with Turning Point. During a further call a few days later, Jason said he had not engaged with Turning Point. There was no further contact with him and in March 2015 his case was closed by KMPT.
- 11.5.13 Between May and September 2015, there were several telephone conversations between Jason and psychiatric nurses. There was no diagnosis of a mental health condition; Jason's primary issue was excessive alcohol consumption. During this period, he again said he was happy to engage with Turning Point and he was given contact numbers.

- 11.5.14 In October 2015, the CRHTT contacted Jason by telephone following contact from Kent Police, who had attended his flat. There was no indication of mental health problems and contact numbers for Turning Point were again provided because Jason said he had consumed at least three litres of cider and an unspecified amount of wine. When spoken to by a KMPT social worker the following day, Jason said his problem was with alcohol. He said he felt supported by an unnamed friend and declined further involvement with mental health services. He again said he would contact Turning Point.
- 11.5.15 On 30 January 2016, Jason was assessed by a psychiatric nurse at A&E, where he had been taken by ambulance following an overdose of prescription drugs. He said he overdosed after being upset by a friend's behaviour, naming the friend as Michael. During this assessment, the nurse noted that both of Jason's eyes had evidence of old bruising. He was not asked about this, which showed a lack of professional curiosity.
- 11.5.16 It was identified that alcohol was again the main issue. He had no suicidal thoughts and he was discharged from mental health services. This was the last contact that KMPT had with Jason.
- 11.5.17 When follow-up appointments were made, Jason did not attend. He disclosed during his first contact with the CMHT that he had bipolar disorder, which he said was being managed by his GP.
- 11.5.18 During the period covered by this DHR, Jason's mental health was assessed on several occasions by psychiatric nurses, most often following his attendance at A&E. He was never assessed as having a mental health condition and because he did not attend appointments made for him with the CMHT, he was not seen by a psychiatrist. When he missed appointments, this was followed up in line with KMPT's non-attendance policy.
- 11.5.19 A consistent theme throughout Jason's involvement with KMPT is excessive alcohol consumption. There are numerous references to him being referred to Turning Point; an enquiry made with that organisation during research for this DHR showed no record of Jason.
- 11.5.20 Jason did not tell KMPT staff anything that would have indicated he was a victim of domestic abuse or any other form of violence. He was given advice and encouragement to seek help for his alcoholism but he could not have been compelled to do this. He disclosed nothing that should have prompted an adult protection referral to KCCAS. KMPT's dealings with Jason were appropriate.



- 11.5.21 Michael's single contact with KMPT was in October 2015, when he was seen by a psychiatric nurse at A&E, where he'd been taken following an overdose of Oramorph. He denied suicidal intent and declined assessment.
- 11.6 East Kent Hospitals University NHS Foundation Trust (EKHUFT)
- 11.6.1 EKHUFT is the NHS hospital trust that covers Town A. All the involvement that Jason and Michael had with the trust during the period covered by this DHR was in the A&E department of an acute hospital.
- 11.6.2 Between 1 January and 2012 and his death, Jason either attended or was taken by ambulance to A&E on 35 occasions. His attendance in May 2012, was the first since 2010. Following this, his visits became more frequent.
- 11.6.3 As detailed in Section 11.5 above, on several occasions when he attended A&E he was referred to liaison psychiatry, which is provided by KMPT. This showed that EKHUFT staff were considering his wider welfare.
- 11.6.4 Jason made several disclosures to doctors and hospital staff, including that he was an alcoholic and a drug user. He admitted having been in prison for violence. On one occasion, following the death of his mother, he told hospital staff that he beat her while she was alive. Although it is known that they had a turbulent relationship, there is no other evidence to support this. He disclosed that he was the victim of a historical rape committed by five men, which he did not want disclosed to *'the authorities.'*
- 11.6.5 Jason was frequently suffering from the effects of excessive alcohol consumption when he was at A&E. In March 2014, he was brought there by ambulance having self-harmed by cutting his wrists. This was a serious injury and he was admitted as an inpatient. He subsequently underwent surgery at a specialist hospital. The hospital recorded that Jason had been *'Dared by a friend to do it.'* It also recorded that he *'Does this to gain attention. Will do it again.'*
- 11.6.6 When Jason was admitted on this occasion, he was assessed using the SMaRT Plus Pathway Tool, which EKHUFT uses to highlight risks that hospital staff should be aware of when treating patients. This identified Jason as a 'probable danger to himself or others' based on him having been admitted following serious self-harm. The assessment is specifically designed to cover a person's stay in hospital.

- 11.6.7 Jason's last attendance at the hospital, in January 2016, was due to him having taken an overdose of prescription medication. The hospital record states *'Suicide attempt with 25 pills.'*
- 11.6.8 On six occasions when attending the hospital, Jason disclosed that he had been assaulted. Each time, the perpetrator was known to him. On the first occasion, in March 2013, he named the perpetrator, who was not Michael. Subsequently, he referred to the assailant as either a friend or an ex-partner, until January 2016, when it was recorded that he, *'States Michael abuses him as a friend and is violent'*.
- 11.6.9 There is no record that Jason described his relationship with his assailant in a way that suggested the assaults were part of a pattern of domestic abuse. However, there is no record that A&E asked him any questions about the abuse he was suffering. The fact that a patient discloses they are being subjected to abuse or violence should raise professional curiosity enough to ask them about it – the hospital may be the only place that they feel safe enough to speak. If they provide more information, it may be appropriate to raise a safeguarding referral or contact the police.
- 11.6.10 Michael's only recorded attendance at A&E during the period covered by this review was in October 2015 following an overdose of Oramorph. He was referred to liaison psychiatry.
- 11.7 South East Coast Ambulance Service NHS Foundation Trust (SECAMB)
- 11.7.1 SECAMB manage 999 emergency calls and 111 non-emergency calls made to the NHS in Kent, Sussex and Surrey. Both types of call might result in an ambulance being dispatched or in the call being dealt with in an alternative way. SECAMB staff, who include emergency call takers, health advisers and clinical advisers, manage calls and make decisions as to the most appropriate response.
- 11.7.2 Jason became well known to SECAMB following his first call to them in October 2013. In the 12 months preceding his death, they had 40 contacts with him, when he made calls to both 999 and 111. During this period, he was classified as a frequent caller, the criteria for which are:
- Someone aged 18 or over who makes five or more emergency calls relating to individual episodes of care in a month, or 12 or more emergency calls related to individual episodes of care in three months from a private dwelling.*

- 11.7.3 Not all the calls that Jason made resulted in an ambulance response. On many occasions, telephone advice was given by health or clinical advisers. None of his contacts related to a life-threatening emergency. His calls covered a wide range of things, from hiccups and an insect bite to self-harm and assault. The most minor issues were the sort that most people would manage themselves; overall the calls describe a man who felt vulnerable.
- 11.7.4 In August 2014, following an ambulance crew attending a domestic abuse incident in which Jason had sustained injuries to his face and hand, a safeguarding alert was made to KCCAS.
- 11.7.5 In April 2015, Jason disclosed during a 111 call, that a friend was coming to his house in the middle of the night and being physically abusive. This friend would not return his key and was eating Jason's food, leaving nothing for him. Jason did not want this information passed to the police but SECamb made a second safeguarding alert to KCCAS.
- 11.7.6 A third vulnerable person referral was submitted after Jason was taken to A&E by ambulance in January 2016. It followed Jason's disclosure that Michael was entering his property and assaulting him on an almost daily basis.
- 11.7.7 The service provided by SECamb to Jason was in all cases appropriate. They gave telephone advice when dealing with minor matters and dispatched an ambulance where necessary. Paramedics and other ambulance crew made correct decisions about whether to take Jason to hospital. The referrals made to KCCAS indicate that SECamb staff have a clear understanding of their role in safeguarding vulnerable people and there are examples of good practice.
- 11.7.8 During the period covered by this DHR, SECamb had no relevant contact with Michael.
- 11.8 Town A Borough Council Communities and Housing Department (ABC)
- 11.8.1 When his mother died, Jason applied to ABC for continued tenancy. He stated in his application that he had issues with visual impairment, drug and alcohol misuse, and he needed help to bid for properties. In July 2013, he accepted tenancy of a flat, which he lived in until his death. He was in receipt of full housing benefit; his rent was paid directly to ABC.

- 11.8.2 When Jason spoke to an ABC Tenant Participation Officer (TPO) in September that year, he said he was happy in the area. He had met his neighbours and knew about the local police officer and PCSO. He added that he had not had any experience of domestic violence, homophobia or harassment due to disability, racial harassment or antisocial behaviour.
- 11.8.3 The following month, ABC records show that the locks on his flat were changed. The reason was not specified.
- 11.8.4 In April 2014, Jason approached two ABC staff who are conducting a routine estate inspection close to the block of flats where he lived. In a brief conversation with them, he said he did not have any concerns. He said he lived in the area for several years and liked it.
- 11.8.5 ABC's only record of Jason suffering domestic abuse was his referral to the MARAC in June 2015. ABC Communities & Housing Department is a member of Town A MARAC and receives an invitation to all meetings. These are usually attended by the same Housing Options Officer but at the meeting where Jason's case was discussed, this person was on leave. Due to staffing levels, it was not possible for another officer from the department to attend.
- 11.8.6 ABC's Domestic Abuse Coordinator (DAC) attended the meeting, following which she sent an email to the Housing Area Manager (HAM) responsible for the estate on which Jason lived. The DAC stated that Jason had been identified as a high risk domestic abuse victim and there were concerns that the perpetrator was still entering his flat. She added that the police wanted to speak to Jason about whether he wanted to report any offences. They were looking for a safe way to contact him. She asked the HAM if he could assist. She also advised him to contact the named IDVA who was supporting Jason.
- 11.8.7 The HAM replied to the DAC, offering to arrange a room where Jason could meet the police. He asked the DAC if she was in a position to change the locks to Jason's flat and if she knew who the perpetrator was. In her reply, the DAC stated that it would be the responsibility of the Communities & Housing Department to change locks if this were necessary. She added that she did not know who the perpetrator was.
- 11.8.8 The HAM then emailed the IDVA, including the email trail between him and the DAC, asking if she needed his assistance. The IDVA replied that she had been unable to contact Jason and based on previous experience she was certain he would not agree to a meeting. She added that she would contact the HAM if the situation changed.

- 11.8.9 In January 2016, ABC again changed the locks at Jason's flat; the reason for doing so is not recorded.
- 11.8.10 It was positive that the DAC, who attends all MARAC meetings, updated the HAM. He was unfamiliar with the MARAC process and was unsure what he was being asked to help with. Based on the information he was given in the first email from the DAC, his offer to provide a meeting room was a positive response. He also contacted the IDVA. It would be good practice for ABC to ensure that HAMs are familiar with the Kent and Medway MARAC Operating Protocol and Guidelines. This would not only assist in cases such as this, but might result in them identifying, during their day-to-day work, a person who should be considered for MARAC referral.
- 11.8.11 Town A Borough Council must ensure that their Housing Area Managers are understand the provisions of the Kent and Medway MARAC Operating Protocol and Guidelines and how to make MARAC referrals.  
**(Recommendation 12)**
- 11.8.12 If the Housing Options Officer had attended the MARAC as she usually did, she would probably have had a clearer understanding of the support that the Communities & Housing Department could offer Jason. She could either have implemented this herself or provided more clarity to the HAM. ABC should consider nominating an officer who will attend the MARAC in the absence of the Housing Options Officer.  
**(Recommendation 13)**
- 11.9 Oasis Domestic Abuse Service
- 11.9.1 Oasis are one of four charitable organisations that form the Kent Domestic Abuse Consortium (KDAC). KDAC provides domestic abuse support services across Kent. Oasis provides services in Thanet and East Kent.
- 11.9.2 During 2015, KDAC were running a trial of a duty desk, to which organisations could refer domestic abuse victims. Referring organisations were not required to carry out a [DASH](#) risk assessment. The Duty Desk was staffed by an Independent Domestic Violence Adviser (IDVA) from one of the member organisations of KDAC, on a rotating basis. When a referral was received, the IDVA would try to contact the victim and carry out a [DASH](#) risk assessment.
- 11.9.3 If the first attempt to contact the victim was unsuccessful, further attempts would be made. The referral would remain with the KDAC service staffing

the Duty Desk at the time it was received. This could mean, as it did in Jason's case, that the service dealing with the referral might not cover the area where the victim lived.

- 11.9.4 Jason was referred to the KDAC Duty Desk by KCC Adult Services (KCCAS) on 19 June 2015, when it was being staffed by an Oasis IDVA. The referral stated that Jason was experiencing physical and emotional abuse, as well as harassment, perpetrated by his ex-partner Michael. The referral also included information that both Jason and Michael were diagnosed as having bipolar disorder and alcohol dependency. In addition, there was information that KCCAS had received from Kent Police, including that Michael was well known to them.
- 11.9.5 Oasis have recognised that although the referral contained information about Jason, they did contact KCCAS to find out additional details about his involvement with them.
- 11.9.6 The IDVA staffing the duty desk at the time of the referral attempted to contact Jason by telephone within 24 hours, but she got no reply. She understood that attempts to contact Jason should be made during the evening because Michael was known to spend all day in Jason's flat. In line with the policy outlined above, the IDVA receiving the referral retained ownership of it and spoke to Jason on 30 June.
- 11.9.7 She found him to be extremely frightened, to the point that he believed Michael would kill him if he made any reports to the police. He was offered safety planning advice and support, which included contacting the police and his housing provider. He declined both.
- 11.9.8 Jason explained that he lived alone and was experiencing continual physical and emotional abuse that he could not do anything about. He said the locks of his flat had been changed four times, but each time Michael had intimidated him into handing over a key. Jason said since his relationship with Michael had ended, Michael had begun a relationship with a woman, which was current. Each day, Michael would let himself into Jason's flat at about 6:30am and would stay until about 4pm, treating Jason's property as his own.
- 11.9.9 The IDVA carried out a [DASH](#) risk assessment, recording a score of 13. To be graded as high risk, based solely on the [DASH](#) score, a score of 14 is required. The professional carrying out the assessment can use their judgement to assess a person with a lower score as high risk and the IDVA did so in this case.

- 11.9.10 The assessment of Jason as high risk caused the IDVA to make a referral on 30 June to Town A MARAC. The background risk issues faced by Jason were set out clearly and concisely in the referral form. It identified threats to kill and strangulation as risks, amongst others.
- 11.9.11 The IDVA called Jason multiple times during July and made brief contact with him twice. She remembers that he was not keen to accept support. The IDVA made these calls from home, where she did not have access to the computerised database which is accessible to all KDAC IDVAs. She did not subsequently record them on the database. Attempting to contact victims outside working hours indicates how committed IDVAs are in supporting domestic abuse victims. However, it is important that all contact is recorded on the database to ensure that anyone who looks at the victim's record subsequently has a full picture.
- 11.9.12 KDAC should remind IDVAs when attempts to contact victims, whether successful or not, cannot be recorded contemporaneously on the database, full and accurate records of the time and content of calls should be made and added to the database at the earliest opportunity.
- (Recommendation 14)**
- 11.9.13 The MARAC meeting at which Jason's case was discussed was held on 6 August. The Oasis IDVA who had received the referral, spoken to Jason and carried out the [DASH](#) risk assessment, did not attend the meeting. This was because another KDAC organisation (Rising Sun) covered Town A and attended the MARAC there. A Rising Sun IDVA went to the meeting; she had a copy of the referral and the research document completed by the Oasis IDVA, as well as access to the (incomplete) computer record of the contact with Jason.
- 11.9.14 The attendance at the MARAC by an IDVA, who was briefed on Jason's case but who had not dealt with it, created an incongruence in decision-making between the Oasis IDVA's opinion of risk and that of the attending IDVA. This is not a criticism of either IDVA, it is a process issue, which arose because the IDVA staffing the duty desk would retain any referral they received, even if it related to victims living in other parts of Kent. If a case, such as Jason's, was referred to a MARAC, it could involve considerable time and expense if the original IDVA attended the meeting. It might also mean that more than one IDVA is present at a MARAC, which would not be the best use of limited resources.
- 11.9.15 Oasis records, based on information provided to them by the IDVA who attended the MARAC, show there were three actions from the meeting:

1. All agencies to utilise positive engagement strategies.
  2. Police to arrange a visit that could be accompanied by an IDVA.
  3. Town A Borough Council to investigate the possibility of securing the property or arranging a move.
- 11.9.16 The action sheet prepared following the MARAC meeting only lists the second of these. The issue of minute taking and recording actions is considered in Section 12 below.
- 11.9.17 The reason why the action was not implemented is considered in detail from the Kent Police perspective in Section 11.2 above. The decision not to hold a joint meeting was made because of concern that an assertive attempt by the police to engage would increase his risk.
- 11.9.18 The Oasis IDVA was not present at the MARAC meeting where the action was agreed, so had no input into it. Considering her greater personal involvement with Jason's case and her subsequent agreement not to make a joint visit, she might have highlighted the potential for increased risk and argued against making it an action. This is an example of why the IDVA with the greatest personal knowledge of the case should attend the MARAC meeting.
- 11.9.19 The principle of retaining a case is sound but it is weakened if the IDVA with the greatest knowledge of it does not attend the MARAC meeting. KDAC have identified that it was an issue in this case. KDAC members must agree a process that ensures the IDVA who has the greatest knowledge of a case attends the MARAC meeting when it is discussed.  
**(Recommendation 15)**
- 11.9.20 Following the MARAC meeting, the Oasis IDVA attempted to contact Jason by telephone on five occasions during August and September. There was no meaningful interaction with him; he was either unable to talk, ended the call, someone else answered or there was no reply.
- 11.9.21 On 30 September, at an Oasis case management meeting, closure actions were agreed. These included contacting Jason to inform him of the closure, unless there was an increased risk, and to remind him of the safety plan. Two attempts were made to speak to him by telephone. On the first occasion, he said he was busy. On the second, he said the same but the IDVA was able to tell him about the case closure and how to seek support if required in future. Oasis closed the case on 30 October.
- 11.9.22 Oasis have identified that they should have told KCCAS, the referring organisation, that they had closed the case. This would have allowed



Oasis to update KCCAS on any actions taken after the MARAC and to check whether KCCAS had had any further contact with Jason. Oasis also recognise that they should have told Town A Borough Council of the closure, as they had offered to provide a venue for a meeting.

- 11.9.23 KDAC must ensure that before closing a case that was initially referred to a member organisation by another agency, the referring organisation should be asked if they have any further relevant information.

**(Recommendation 16)**

- 11.9.24 At the time of finalising this report, KCC Commissioning Services are commissioning domestic abuse services in Kent, which may result in new providers. It is important that recommendations for KDAC are carried over to new providers.

11.10 Victim Support

- 11.10.1 Victim Support (VS) is an eponymous organisation, which has the following mission statement:

*As an independent charity, we work towards a world where people affected by crime or traumatic events get the support they need and the respect they deserve. We help people feel safer and find the strength to move beyond crime. Our support is free, confidential and tailored to your needs.*

- 11.10.2 During the period covered by this DHR, Jason was referred to VS by Kent Police six times. The first three occasions, during 2013 and 2014, followed him being assaulted. None of these referrals were flagged as domestic abuse. Jason was spoken to following the referrals and he did not VS help in either case. On the third occasion, he was contacted but said he could not talk; he was sent an SMS text message with VS contact details. These three referrals were dealt with in accordance with VS policy.

- 11.10.3 Jason was referred to VS on three occasions in 2015. The first was a case of theft in a dwelling, the second of criminal damage and the third was an assault. VS dealt with the first referral by way of a letter containing the contact details and offer of support.

- 11.10.4 The criminal damage referral, in September 2015, resulted in the most engagement VS had with Jason. He said he had gone out, leaving a friend at home. When he returned, his flat had been 'trashed.' He then described the perpetrator as an 'ex-friend whom [he] trusted.' He did not

disclose the perpetrator's name. He discussed feeling anxious and low, saying he was in contact with his GP and the [CMHT](#) as he was suffering from bipolar disorder.

- 11.10.5 VS sent him a personal alarm and a window chime alarm. They contacted him to confirm he had received this and he then agreed to further support. A meeting was arranged with a VS volunteer supporter at VS premises, because Jason said it was not safe to meet at his home. When contacted on the day of the meeting to confirm he would be attending, he said he would not be able to. He added that he could not agree a later date. A letter was sent to Jason giving VS contact details. No further contact was received and the case was closed.
- 11.10.6 The last referral, in November 2015, had a domestic violence (DV) flag. It noted that Jason was a repeat victim and a [DASH](#) risk assessment had been graded Medium. The referral made no mention that Jason had been the subject of a MARAC case. He was contacted by VS within 48 hours and treated in accordance with VS protocols for domestic abuse victims. He said, '*...he [was] fine and [did] not require support.*' The case was closed.
- 11.10.7 Michael was referred to VS on one occasion, in January 2016. This was for a case of harassment; there was no DV flag. He was contacted the day after the referral and said the police were not doing anything about the harassment. He said if he saw the person who was harassing him he did not know what he would do. He added that he suffered from bipolar disorder. VS suggested he should call the police if saw the alleged perpetrator. The VS call handler asked if he had support around him and he replied that he had friends and family. The name of the perpetrator was not provided to VS by the police or Michael. He was sent a text message with VS contact details. VS had no further contact with Michael.
- 11.10.8 Each involvement with Jason and Michael was dealt with in accordance with VS policies, procedures and protocols in place at the time of the referral. The target time each referral was met.
- 11.10.9 VS do not ask for details of alleged perpetrators; this includes cases involving domestic abuse. The relationship between the victim and alleged perpetrator may be obvious or disclosed by the victim. In these circumstances, VS do not ask for the alleged perpetrators name or other details. If the victim discloses these, they are not generally recorded by VS. The name of the alleged perpetrator recorded was not recorded in any of the referrals relating to Jason or Michael.

## 12. Multi-Organisation Risk Assessment Conference (MARAC)

- 12.1 Jason was referred to the Town A MARAC by an Independent Domestic Abuse Adviser (IDVA) on 30 June 2015, following a referral to the KDAC duty desk by KCC Adult Services. His case was considered at the MARAC meeting held on 11 August.
- 12.2 The actions of individual agencies following Jason's referral are considered in Section 11 above. This section looks at the MARAC process in Kent and Medway and whether, in the light of this case, the support it provides to high-risk victims of domestic abuse can be improved.
- 12.3 There are 13 MARACs covering Kent and Medway. All of them are coterminous with local authority boundaries; either Medway unitary authority or district and borough councils in Kent. Medway MARAC meets weekly; the others monthly. The coterminosity with local authority boundaries means some organisations might attend more than one meeting.
- 12.4 There are five MARAC coordinators, employed by Kent Police, who are responsible for organising the meetings. Each coordinator covers between two and four MARACs. In common with other police forces, Kent Police receive funding from the Home Office for MARAC coordinator posts.
- 12.5 Kent Police employ a MARAC Central Coordinator, who is not senior to other MARAC coordinators and does not line manage them. The Central Coordinator is responsible for ensuring that the MARACs provide a consistent level of support to high-risk domestic abuse victims. The Central Coordinator deputises for coordinators at MARAC meetings.
- 12.6 The Central Coordinator is also responsible for ensuring the Kent and Medway MARAC Operating Protocol and Guidelines (OPG) are updated and that each MARAC adheres to them. The OPG is a comprehensive document, which at the time of writing was last updated in July 2015. Unlike most documents relating to domestic abuse and safeguarding in Kent and Medway, the current version is not available online. In the spirit of openness, Kent and Medway Domestic Abuse Strategy Group (KMDASG) should consider publishing the OPG online. **(Recommendation 17)**
- 12.7 A further responsibility of the Central Coordinator is to provide training for all MARAC members and chairpersons. This is good practice but at the time this DHR was completed, it was difficult to achieve due to staffing issues.

- 12.8 MARAC meetings are generally chaired by Kent Police. There are exceptions and the Central Coordinator is making efforts to encourage other organisations to take the chair. This is a good aspiration because it would further reinforce the multi-agency approach to supporting high-risk domestic abuse victims. KMDASG should take the lead in encouraging appropriate agencies to become involved in chairing MARAC meetings. **(Recommendation 18)**
- 12.9 In general, there is good attendance at MARACs by member organisations. There are occasionally issues but these are not specific to the Town A MARAC, nor relevant to Jason's referral. It is worth noting how important attendance is because an organisation cannot be assigned an action unless they attend, even if their activity could be key to safeguarding a victim.
- 12.10 Jason's referral was not considered at the first MARAC following it, which was held in July 2015. This was because it was received too late to be included. The coordinator closes the list for the next meeting sufficiently far in advance to allow preparation and circulation of papers. To bring cases before the MARAC more quickly, it would be necessary to hold meetings more frequently, but this would have an impact on organisations' resources. In Medway, where meetings have been held weekly since July 2015, the annual caseload is about 5120 referrals, whereas in Town A it is under 200. The current caseload outside of Medway means that on balance, monthly meetings are appropriate.
- 12.11 The specific issues relevant to Jason's referral, considered in this DHR, are that no minutes were taken at the Town A MARAC on 12 August 2015 and the agreed action arising from his case was not implemented.
- 12.12 The responsibility for taking minutes at MARAC meetings falls to the relevant coordinator. It is inevitable there will be occasions when that coordinator is absent, for example due to leave or sickness. This was the case in the meeting at which Jason's case was considered. When the local coordinator is unable to attend, the Central Coordinator will normally attend and take minutes.
- 12.13 On this occasion the Central Coordinator could not attend because she was chairing another MARAC meeting that day. The meeting at which Jason's referral was considered was the first in Kent or Medway for four years at which minutes were not taken. An action list was prepared by the police representative and this included one action relating to Jason. Both the KCCAS representative and the IDVA present at the meeting recorded that other actions were agreed, although each recorded different actions.

- 12.14 The reason why this action was not implemented has been considered in Sections 11.2 (Kent Police) and 11.9 (Oasis) above, and recommendations have been made. This section considers whether there is an effective process for ensuring MARAC actions are completed or if not, the reasons why are recorded.
- 12.15 When formal meetings are held within agencies, they will normally be chaired, minutes taken and actions allocated. At the following meeting, one of the first items on the agenda will be to review each action and confirm that it has been completed. If it has not, the person to whom it was allocated will be expected to provide reasons why. The chairperson of the meeting will then decide whether the explanation is reasonable and if not, they will reallocate the action. In short, the completion of actions is enforceable.
- 12.16 It is usual for multi-agency meetings to consider actions from previous meetings and for the organisation accepting the action to report back in the same way as in internal meetings. However, there is an implicit understanding in multi-agency meetings that actions cannot be enforced by one or more organisation on another. The effectiveness of the meeting, in terms of the actions arising from it, is dependent on two things. First, an understanding by each organisation that agreed actions will be implemented. Second, each representative must have the authority within their organisation to agree actions and commit resources to implement them.
- 12.17 MARAC meetings rely on these multi-agency meeting principles. Minutes are important because they should set out the actions and the reasoning behind them. They should also act as a historical record of what was agreed and done, which can be considered in the event of a re-referral. Since Jason's case, if the coordinator is absent, minutes will either be taken by the Central Coordinator or another agency representative. This is a good example of action being taken to address an issue and it should be formalised. KMDASG should agree a process that ensures minutes are taken at all MARAC meetings and include this in the OPG. **(Recommendation 19)**
- 12.18 It is also important that following the absence of a coordinator or the Central Coordinator at a MARAC meeting, the process ensures the appropriate administrative actions are taken. It is not clear that the action list was circulated following this meeting. Representatives of at least two organisations present at the meeting (KCCAS and Rising Sun) thought there were additional actions relating to Jason's case.
- 12.19 At MARAC meetings held in Kent and Medway, outstanding actions from the previous meeting are raised near the start of the agenda. It has been suggested the action relating to Jason was not outstanding

because a decision had been taken not to implement it. It would not therefore be mentioned at the next meeting. This potentially means every action from a MARAC meeting might never be implemented and only the agency subject to the action would know that.

- 12.20 The process of capturing actions is complicated by the fact an organisation might not attend the next meeting to report on their action. An example would be a school that sends a representative to a meeting where the parent of a pupil was subject of a MARAC referral. However, the purpose of MARAC is to safeguard those domestic abuse victims most at risk. Administrative difficulties should not stand in the way of the primary purpose. KMDASG must establish a process that ensures all MARAC actions from the previous meeting have either been implemented or if not, the reasons why. A record must be kept of the results. **(Recommendation 20)**
- 12.21 It is acknowledged that the number of referrals to MARACs in Kent and Medway has increased over the past few years, without an increase in the resources to administer the meetings. For this reason, careful consideration has been given to ensuring that the recommendations made do not increase bureaucracy, which would adversely impact on the support MARACs give to domestic abuse victims who are at the greatest risk of serious harm.

### **13. How Organisations Worked Together**

- 13.1 If organisations who have contact with domestic abuse victims work well together, the risk of harm is reduced by sharing information and ensuring support is provided by the most appropriate organisation(s). It also ensures best use is made of limited resources. The success of inter-agency working relies on effective communication to ensure each organisation knows when its services are required and has the information on which to base decisions about action it might take.
- 13.2 Jason disclosed his intimate encounter with Michael to Kent Police about six months after it happened and it was recognised that this meant the incident they were dealing with was domestic abuse. No other organisation seems to have known about this intimate encounter until the last year of Jason's life. Regardless of this, his vulnerability was evident because he was being subjected to abuse by a friend and he was too frightened of reprisals to report assaults to the police.
- 13.3 SECAmb staff demonstrated a good understanding of the importance of information sharing. They used the safeguarding alert process on three occasions. Following the second of these, KCCAS made enquiries with Kent Police and identified Jason was suffering from

domestic abuse. KCCAS recognised that the criteria for a [Section 42](#) enquiry were met and managed this appropriately. They referred Jason's case to the IDVA service, which in turn resulted in the MARAC referral. This was an excellent example of frontline staff identifying safeguarding concerns, which were shared. This resulted in Jason's case being considered in the appropriate multi-agency forum.

- 13.4 There were no safeguarding alerts raised by Kent Police and KCCAS. A GP and Kent Police failed to make repeat referrals to the MARAC, which would have provided a further opportunity to review the case. This shows there was still work to be done to ensure staff from all agencies understand when information should be shared with others. Recommendations have been made covering these areas.

## 14. Conclusions

- 14.1 Jason suffered harassment, control and coercion, and physical assaults by Michael for about two and a half years. The domestic abuse he suffered led to his death.
- 14.2 In 2010, when attending an incident in which Jason was the victim and Michael the perpetrator, Kent Police classified it as domestic abuse because Jason told them he had a one-night stand with Michael six months previously. They did this because the definition of domestic abuse in place at that time referred to 'intimate partners' and they decided this applied to Jason and Michael. On that basis, it is appropriate to consider any subsequent abuse against Jason by Michael as domestic abuse, even though other organisations may not have been aware of it fitting the definition.
- 14.3 Although Kent Police correctly identified Jason as a victim of domestic abuse in 2010, between then and his death, there were occasions when he was not dealt with as such.
- 14.4 The term 'intimate partners' is used in the cross-government, non-statutory definition of domestic abuse – the term is not defined. The term 'personally connected' is used in the offence of controlling or coercive behaviour (Section 76 of the Serious Crime Act 2015) and is defined. The offence and the definition of 'personally connected' are set out in [Appendix D](#).
- 14.5 The relationship Jason and Michael had does not meet the definition of 'personally connected'. Thus, Michael did not commit the S.76 offence, even though the abuse he was inflicting on Jason met the definition of domestic abuse, and his behaviour met the definition of 'controlling or coercive'. The Home Office must ensure that the definition of 'personally

connected' in the Statutory Guidance for Section 76 of the Serious Crime Act 2015 is changed to ensure that all victims of domestic abuse are protected. **(Recommendation 21)**

- 14.6 In June 2015, following the second safeguarding alert by SECamb, KCCAS asked Kent Police for any information they had about Jason. When KCCAS contacted Jason, he gave information that signalled he might be a victim of domestic abuse. Both the referral by SECamb to KCCAS and the subsequent referral by the latter to the Independent Domestic Violence Adviser (IDVA) service were examples of good practice.
- 14.7 When Jason spoke to the IDVA dealing with his case in June 2015, he described Michael as his ex-boyfriend and referred to their previous relationship. The IDVA assessed Jason as being a high-risk domestic abuse victim. This was an appropriate grading based on a DASH risk assessment, which included the IDVA's professional judgement. The IDVA correctly referred Jason to the MARAC.
- 14.8 There was a single action relating to Jason's case recorded on the MARAC action list. This action was assigned to Kent Police. The decision by them not to implement it, or to at least explore ways of giving Jason the confidence to report criminal offences to the police, was significant. It meant that he received no support resulting from his referral to the MARAC. Although the decision not to implement the action was discussed with the IDVA, it was not shared with other members of the MARAC.
- 14.9 Following the MARAC meeting, Jason was the victim of domestic abuse that met the criteria for a repeat referral. Recommendations have been made for the organisations that failed to recognise this.
- 14.10 Even had Jason not had the intimate encounter with Michael, which meant he was the victim of domestic abuse, he was an adult who needed care and support. Following his death, it seems likely his case meets the criteria set out in S.44 of the Care Act 2014 for conducting a Safeguarding Adults Review. For this reason, the chair of the Kent and Medway Community Safety Partnership should share this report with the chair of the Kent and Medway Safeguarding Adults Board. **(Recommendation 22)**
- 14.11 A significant factor in Jason's death was that he and Michael had alcohol problems. During Michael's daily visit to Jason's flat they would both drink heavily. Michael had relatively little involvement with organisations during the period covered by this DHR and his problem drinking was not identified. Jason had a lot of contact with



organisations and while all identified his problem drinking, very little was done to help him in this regard.

- 14.12 The only efforts made were by KMPT, who repeatedly made attempts to encourage Jason to engage with Turning Point, all of which were unsuccessful. Alcohol Concern, the national charity established to help reduce the problems caused by alcohol, identified in their [Blue Light project](#) that about 85% of problem drinkers are not attempting to change their drinking habits. As well as the harm they suffer, this can put a significant drain on the resources of the police, the NHS and social services.
- 14.13 Charities such as Turning Point have limited funding and work hard to cope with providing support to those willing to engage with their treatment service. It is unrealistic to expect them to be able to put significant resource into encouraging those who are not.
- 14.14 For statutory organisations there will be an initial additional cost in working to change the attitude of treatment resistant drinkers to the extent that they engage with treatment services. However, success will see savings in the future and more importantly might reduce the likelihood of tragic outcomes such as Jason's case. Statutory organisations would do well to consider whether the approach set out in the Blue Light project manual might bring benefits that make the initial investment worthwhile.
- 14.15 Careful consideration has been given during this DHR to whether the care and support given to Jason as a domestic abuse victim were influenced by his gender and/or because the abuse he suffered followed an intimate same-sex relationship.
- 14.16 The [Kent and Medway Domestic Abuse Strategy 2013-2016](#) recognises that research suggests domestic violence occurs in all sections of society irrespective including of, among other factors, gender and sexual orientation. When discussing underreporting of domestic abuse, the strategy quotes Home Office figures, which estimate the number of likely female victims of domestic abuse. However, the strategy acknowledges about 18% of domestic incidents reported to Kent Police have a male victim. There are no figures for domestic abuse incidents in same-sex relationships.
- 14.17 There is no evidence the care and support given to Jason, or in some cases the lack of it, was due either to his gender or sexual orientation. During the research for this DHR, the support provided to male domestic abuse victims and those in same sex relationships was discussed with the Chief Executive of Oasis Domestic Abuse Service. About 5% of the domestic abuse victims the organisation deals with are

men. Much work has been done to encourage men who have been victims of domestic abuse to report it.

14.18 Efforts have also been made to encourage gay men to report domestic abuse. Oasis have also attended the Thanet Pride event and the feedback they received was that gay men need to feel they have a safe space where people understand their specific issues - they look for the rainbow flag.

14.19 One of the largest and best-known support agencies for victims of domestic abuse in same-sex relationships, Broken Rainbow, closed in June 2016. Galop is a London-based helpline that provides nationwide support for LGBT victims of domestic abuse but it is disappointing, given the feedback provided to Oasis, that there are no Kent-based organisations offering this specific support. Jason did engage with Oasis initially, as he did to an extent with KCCAS, but he may have been prepared to receive advice and support more readily from an organisation that understood his personal situation better.

## 15. Lessons To Be Learned

### 15.1 Domestic abuse victims may need care and support, and may meet the criteria set out in Section 42 of the Care Act 2014.

15.1.1 Understanding of the relevant sections of the Care Act 2014 can be important in domestic abuse cases. Dependent on the circumstances, it may be more appropriate to hold a multi-agency safeguarding planning meeting involving the appropriate agencies than to use the MARAC process. Alternatively, an action from the MARAC meeting might be to suggest such a planning meeting is the best way forward.

15.1.2 The need to safeguard domestic abuse victims is paramount and a flexible approach to the best means to achieve this is important.

### 15.2 The administrative processes supporting MARAC meetings are important in ensuring that high-risk domestic abuse victims receive the service and support they need.

15.2.1 This case highlights how important accurate minute taking and recording of actions is as part of the MARAC process. It is not about bureaucracy; it ensures all agencies are clear about what has been agreed and what is required of them. It also provides a clear record of previous considerations and actions in the event of a repeat referral.

### 15.3 There needs to be an emphasis placed on ensuring an understanding of the criterion for repeat referrals to MARACs in Kent and Medway.

15.3.1 The criterion is clear and appropriate but there is evidence that it is not being applied.

### 15.4 Organisations should not rely on email as the sole means of communication when referring safeguarding issues between internal departments or to other organisations.

15.4.1 An email provides a written record of a referral but there is no guarantee it will reach the right destination, or that the email address it is sent to is regularly monitored. Consideration should always be given to making the first referral verbally, to ensure the person receiving is someone who can ensure that it is actioned in a timely manner. Confirmation of the right email address for a follow up confirmation can then be made.

**15.5 There is a currently a lack of support specific to LGBT victims of domestic abuse across Kent and Medway.**

15.5.1 It is not clear whether Jason would have engaged more willingly with an organisation that could empathise with his personal situation but there is a service gap in this area.

## OFFICIAL SENSITIVE

### 16. Recommendations

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

	<b>Paragraph</b>	<b>Recommendation</b>	<b>Organisation</b>
1.	11.2.21	In cases that have been referred to MARAC, where there is information that the victim is too frightened to report domestic abuse to them, Kent Police must actively seek to engage with the victim.	Kent Police
2.	11.2.23	Kent Police must ensure that Public Protection Unit supervisors have considered all the available information before making decisions about MARAC actions and that they record their rationale.	Kent Police
3.	11.2.37	Kent Police must ensure that officers working in Public Protection Units have an in depth understanding of how best to provide support to victims of domestic abuse.	Kent Police
4.	11.2.43	Kent Police must ensure that an understanding of the MARAC repeat referral criterion forms part of their domestic abuse training programme.	Kent Police
5.	11.2.46	In its domestic abuse training programme, Kent Police must highlight that once two people have had an intimate relationship, it will be domestic abuse if one inflicts upon the other, behaviour that is mentioned in the definition of domestic abuse, regardless of the passage of time.	Kent Police

## OFFICIAL SENSITIVE

6.	11.2.47	Kent Police must ensure that police officers and police staff who may have contact with vulnerable people understand when safeguarding alerts should be made to Kent County Council Adult Services (KCCAS).	Kent Police
7.	11.3.32	KCCAS must ensure that staff who might work on cases involving domestic abuse are aware of the criterion for the repeat referral of a case to the MARAC.	KCCAS
8.	11.3.34	KCCAS must ensure that they have a robust system for communicating safeguarding information within their organisation and to other organisations.	KCCAS
9.	11.4.19	Clinical Commissioning Groups (CCG) should ensure that GPs are aware of the MARAC process, including the criterion for referring repeat cases.	CCGs in Kent and Medway
10.	11.4.24	NHS England should ensure that the contractor responsible for storing archived GP records is aware of the requirement to provide the records in a timely manner when requested for a DHR.	NHS England
11.	11.4.25	CCGs in Kent and Medway should provide guidance to GPs about providing records when requested as part of a DHR, taking account of Section 10 of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.	CCGs in Kent and Medway
12.	11.8.10	Town A Borough Council must ensure that their Housing Area Managers are understand the provisions of the Kent and Medway MARAC Operating Protocol and Guidelines and how to make MARAC referrals.	Town A Borough Council
13.	11.8.11	ABC should consider nominating an officer who will attend the MARAC in the absence of the Housing Options Officer.	Town A Borough Council

## OFFICIAL SENSITIVE

14.	11.9.12	Kent Domestic Abuse Consortium (KDAC) should remind IDVAs when attempts to contact victims, whether successful or not, cannot be recorded contemporaneously on the database, full and accurate records of the time and content of calls should be made and added to the database at the earliest opportunity.	KDAC
15.	11.9.19	KDAC members must agree a process that ensures the IDVA who has the greatest knowledge of a case attends the MARAC meeting when it is discussed.	KDAC
16.	11.9.23	KDAC must ensure that before closing a case that was initially referred to a member organisation by another agency, the referring organisation should be asked if they have any further relevant information.	KDAC
17.	12.6	Kent and Medway Domestic Abuse Strategy Group (KMDASG) should consider publishing the Kent and Medway MARAC Operating Protocol and Guidelines online.	KMDASG
18.	12.8	KMDASG should take the lead in encouraging appropriate agencies to become involved in chairing MARAC meetings.	KMDASG
19.	12.17	KMDASG should agree a process that ensures minutes are taken at all MARAC meetings and include this in the Kent and Medway MARAC Operating Protocol and Guidelines.	KMDASG
20.	12.19	KMDASG must establish a process that ensures all MARAC actions from the previous meeting have either been implemented or if not, the reasons why. A record must be kept of the results.	KMDASG

**OFFICIAL SENSITIVE**

21.	14.5	The Home Office should ensure that the definition of 'personally connected' in the Statutory Guidance for Section 76 of the Serious Crime Act 2015 is changed to ensure that all victims of domestic abuse are protected.	The Home Office
22.	14.10	The chair of the Kent Community Safety Partnership (CSP) should share this report with the chair of the Kent and Medway Safeguarding Adults Board.	Kent CSP



# Kent & Medway Domestic Homicide Review

## Victim – Jason Davis

### Terms of Reference

*These terms of reference were agreed by the DHR Panel following their meeting on 29 July 2016.*

## INTRODUCTION

### Reasons for Review

The criteria for a DHR is met because it is believed that Jason and Michael had been intimate partners and Michael continued to visit Jason on a regular basis up until the event that led to Jason's death.

In addition, in 2015 a MARAC referral was made because it Jason was believed to be the victim of domestic violence at the hands of Michael. Jason was assessed as being a high-risk victim.

### Terms of Reference

#### Background

On 17 May 2016, an ambulance crew went to a flat in Town A, Kent, which was the home address of the victim, Jason Davis, who lived there alone. They found that Jason was dead and that he had suffered head injuries. Police were called and a murder investigation began.

Michael Lyons, who also lived in Town A was arrested on suspicion of Jason's murder. Michael was charged subsequently with this and remanded in custody.

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 27 June 2016. It agreed that the criteria for a DHR had been met. On 7 July, the Chair of the Kent Community Safety Partnership confirmed that a DHR would be conducted and the Home Office has been informed.

#### The Purpose of a DHR

The purpose of this review is to:

- i. Establish what lessons are to be learned from the death of Jason Davis in terms of the way in which professionals and organisations work individually and together to safeguard victims.

- ii. Identify what those lessons are both within and between organisations, how and within what timescales that they will be acted on, and what is expected to change as a result.
- iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-organisation working.
- iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-organisation working.

### The Focus of the DHR

This review will establish whether any organisation or organisations identified possible and/or actual domestic abuse that may have been relevant to the death of Jason Davis.

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

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

The subjects of this review will be the victim, Jason Davis, and the alleged perpetrator, Michael Lyons.

### DHR Methodology

The DHR will be based on information gathered from IMRs, chronologies and reports submitted by, and interviews with, organisations identified as having had contact with Jason and/or Michael in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The DHR Panel will decide the most appropriate method for gathering information from each organisation.

Independent Management Reports (IMRs) and chronologies must be submitted using the templates current at the time of completion. Reports will be submitted as free text documents. Interviews will be conducted by the Independent Chairman.

IMRs and reports will be prepared by an appropriately skilled person who has not had any direct involvement with Jason or Michael, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

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

Each organisation required to complete an IMR must include all information held about Jason or Michael from 1 January 2012 to 17 May 2016. If any information relating to Jason being a victim, or Michael being a perpetrator, of domestic abuse before 1 January 2016 comes to light, that should also be included in the IMR.

Information held by an organisation 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 Jason and/or Michael. 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 2012, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, sexual orientation, cultural and/or faith should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

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

### Specific Issues to be Addressed

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

- i. Were practitioners sensitive to the needs of Jason and Michael, 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 organisation have policies and procedures for the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Jason and/or Michael (as applicable)? Did the organisation 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?
- iii. Did the organisation comply with 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. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious, sexual orientation and gender identity of Jason or Michael (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
- vii. Were senior managers or other organisations and professionals involved at the appropriate points?
- viii. Are there ways of working effectively that could be passed on to other organisations or individuals?
- ix. Are there lessons to be learned from this case relating to the way in which an organisation or organisations worked to safeguard Jason and promote his welfare, or the way it identified, assessed and managed the risks posed by Michael Lyons? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other organisations and resources?
- x. How accessible were the services to Jason and Michael (as applicable)?
- xi. Was the referral of Jason to the Multi-Organisation Risk Assessment Conference (MARAC) managed effectively?

To what degree could the death of Jason have been accurately predicted and prevented?

## DOMESTIC ABUSE – DEFINITIONS

The cross-Government definition of domestic violence current from the start of the period covered by this DHR until 2013 was:

*Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality.*

This definition changed in 2013 to:

*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional.*

xii.

## GLOSSARY

Abbreviation/Acronym	Expansion
A&E	Accident & Emergency
ACT	Adult Community Team
ADT	Automatic Data Transfer
AO	KCCAS Assessment Officer
CCCCG	NHS Canterbury and Coastal Clinical Commissioning Group
CDT	(KCCAS) Central Duty Team
CMHT	Community Mental Health Team
CMS	(Victim Support) Case Management System
CNT	(KCHFT) Community Nursing Team
CRHTT	Crisis Resolution and Home Treatment Team
CSP	Community Safety Partnership
DA	Domestic Abuse
DAC	Domestic Abuse Coordinator
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DASPOC	(Kent Police) Domestic Abuse Single Point of Contact
DHR	Domestic Homicide Review
DSO	(Safeguarding Adults) Designated Senior Officer
DV	Domestic Violence
EKHUFT	East Kent Hospitals University NHS Foundation Trust
GP	General Practitioner
HAM	(Town A Borough Council) Housing Area Manager
HDC	Home Detention Curfew
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Report

IO	(Safeguarding Adults) Inquiries Officer
IPCC	Independent Police Complaints Commission
IRO	(Victim Support) Initial Response Officer
KDAC	Kent Domestic Abuse Consortium
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KCCAS	Kent County Council Adult Services
KMDASG	Kent and Medway Domestic Abuse Steering Group
LGBT	Lesbian, Gay, Bisexual and Transgender
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service
NPS	National Probation Service
OOH	(GP) Out of Hours
OPG	(MARAC) Operating Protocol and Guidelines
PCC	Police & Crime Commissioner
SECAmb	South East Coast Ambulance Service NHS Foundation Trust
TPO	Tenant Participation Officer
VS	Victim Support

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

### **MARAC**

A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist (IDVA), police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential.

Further information about MARACs can be found at:

<http://www.safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf>

### **STORM**

STORM is the proprietary name for the IT system used by Kent Police to manage incidents.

When a telephone call from a member of the public requesting police assistance is received, a STORM incident log will be created by the call handler. That log is used to record all information received and actions taken in response to the call. STORM automatically records the time an entry is made and the identity of the person making it.

STORM is a networked computer system and can be viewed by most Kent Police officers and staff. The ability to make entries on the system is dependent on a person's role within Kent Police.

### **Genesis**

This is the proprietary name for the computer system that Kent Police use to create and store crime reports, [secondary incident reports](#) and criminal intelligence. There is a comprehensive search facility on Genesis. For example, entering a person's name will retrieve all the information held about them. In the case of domestic abuse, it will show the whole history of police involvement including attendance, safety plans and arrests. Genesis also has the facility to store documents such as non-molestation and restraining orders, which will also be retrieved when a person's name is entered. Using a name is only one way to search Genesis; many other search parameters can be entered.

### **Central Referral Unit (CRU)**

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



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

### **Crime Report**

This is the report that must be completed when an officer attends an incident where there is evidence that a crime has been committed. It is recorded electronically on Genesis (see below) and contains details of the crime, including the victim(s) and suspect(s)/offender(s).

### **Combined Safeguarding Team (CST)**

CSTs are teams of Kent Police officers who have received enhanced training in dealing with all aspects of safeguarding. This includes child, vulnerable adult and domestic abuse. Kent Police previously had separate teams dealing with each of those three disciplines. The specialists in those areas now deal with all three and there are no teams in Kent Police who specialise in, or deal only with, domestic abuse cases.

There is an officer in each CST who is designated as the domestic abuse single point of contact (DASPOC). This officer is the person to whom those who have not received the enhanced training can refer to for advice about cases of domestic abuse.

### **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.

## Secondary Incident Report

A secondary incident report is completed by a police officer following attendance at a domestic abuse incident in addition to the DASH risk assessment, when there is no evidence that a criminal offence had been committed.

## (KCCAS) Area Referral Management Services

This team provides a range of services, the key ones being:

- an initial point of contact for members of the public enquiring about services and assessment of need;
- a range of information, advice and signposting in cases where eligibility for local authority social care is not met;
- signposting to local authority internal services when appropriate;
- signposting to other community based services when appropriate; and
- referral to Adult Community Teams for assessment of social care needs.

The team is aligned to Clinical Commissioning Groups areas and GP cluster services to ensure wider multi-disciplinary and partnership working with health colleagues.

## Mental Capacity Assessment

A mental capacity assessment can be carried out by a qualified person to establish whether another person is able to make decisions for himself about his health and welfare. A person's lack of mental capacity to do this may result from an impairment of, or a disturbance in the functioning of, the mind or brain. A person should be assumed to be capable of making such decisions unless it is proved otherwise by a mental capacity assessment.

## Section 42, Care Act 2014

Section 42 sets out the criteria for a statutory safeguarding enquiry:

- (1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) -
  - (a) has needs for care and support (whether or not the authority is meeting any of those needs),
  - (b) is experiencing, or is at risk of, abuse or neglect, and
  - (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

- (2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.
- (3) "Abuse" includes financial abuse; and for that purpose, "financial abuse" includes—
  - (a) having money or other property stolen,
  - (b) being defrauded,
  - (c) being put under pressure in relation to money or other property, and
  - (d) having money or other property misused.

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

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

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

<http://www.liveitwell.org.uk/support-help/community-mental-health-teams-cmhts/#Referral>

### **Crisis Resolution and Home Treatment Team (CRHTT)**

The CHRTT is a service set up to respond to and support adults who are experiencing a severe mental health problem which could otherwise lead to an inpatient admission to a psychiatric hospital.

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

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

<http://www.liveitwell.org.uk/support-help/community-mental-health-teams-cmhts/help-in-a-crisis/>

### **Criteria for a Safeguarding Adults Review**

The criteria for conducting a Safeguarding Adults Review are set out in Section 44 of Care Act 2014:

- (1) A Safeguarding Adults Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if -

- (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
  - (b) condition 1 or 2 is met.
- (2) Condition 1 is met if -
- (a) the adult has died, and
  - (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
- (3) Condition 2 is met if -
- (a) the adult is still alive, and
  - (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

## CONTROLLING OR COERCIVE BEHAVIOUR

### The Offence

Section 76 of the Serious Crime Act 2015

- (1) A person (A) commits an offence if -
- (a) A repeatedly or continuously engages in behaviour towards another person (B) that is controlling or coercive,
  - (b) at the time of the behaviour, A and B are personally connected,
  - (c) the behaviour has a serious effect on B, and
  - (d) A knows or ought to know that the behaviour will have a serious effect on B.
- (2) A and B are “personally connected” if -
- (a) A is in an intimate personal relationship with B, or
  - (b) A and B live together and -
    - (i) they are members of the same family, or
    - (ii) they have previously been in an intimate personal relationship with each other.

Section 76 has further sub-sections that can be viewed at:

<http://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted>

### Personally Connected

The Statutory Guidance for Section 76 sets out what ‘personally connected’ means:

The perpetrator and victim have to be personally connected when the incidents took place - meaning that at the time the incidents took place they were in an intimate personal relationship (whether they lived together or not) or they lived together and were family members, or they lived together and had previously been in an intimate personal relationship.

It is not necessary for the perpetrator and victim to still be cohabiting or in a relationship when the offence is reported as long as the incidents took place when they were “personally connected”, and after the offence came into force. If they were not personally connected, or the incidents took place after a relationship/cohabitation, the stalking and harassment legislation may apply.

The statutory guidance can be read in full at:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/482528/Controlling\\_or\\_coercive\\_behaviour\\_-\\_statutory\\_guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf)



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Cllr Michael Hill OBE,  
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ME14 1XQ

27 October 2017

Dear Councillor Hill,

Thank you for submitting the Domestic Homicide Review (DHR) report for Kent (DHR18) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20 September 2017. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a well written report which constructively challenges agency practice as well as highlighting good practice. Despite the lack of involvement by family and friends, the author has done well to see events through the victim's eyes in a sensitive way. The Panel particularly commended evidence of wider research of other related reviews in the area i.e. an Adult Safeguarding Review.

There were, however, some other aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The 278 page combined chronology submitted with the report should not be published. However, the Panel concluded it contained information that could help inform the background on the victim and perpetrator in the main report. For example, both had mothers who had mental health and alcohol misuse problems which could be relevant in terms of the impact this may have had on their upbringing;

## Appendix E

- The discussion under equality and diversity could examine in more detail the sexuality of the victim and consider whether this impacted on the response of agencies and whether there were any barriers to the victim accessing services;
- The Panel felt it would be helpful if the executive summary included narrative on the perpetrator's criminal history about his previous violence to give context;
- Given the analysis around housing, consideration could be given to making the recommendation to address these findings more robust;
- Linked to the above, you may wish to consider including a recommendation to have a deputy housing manager who can attend MARAC in the absence of the regular attendee;
- A mental health and substance misuse specialist on the review panel may have been beneficial;
- The Panel suggested it might be helpful if the relationship between the victim and perpetrator could be discussed earlier in the report to help a reader understand the dynamics of the relationship;
- A glossary spelling out the acronyms in the executive summary would be helpful;
- Please proof read the full report as there are typing and grammatical errors. For example, GALOP runs a helpline and not a hotline. Please also check whether the annual MARAC caseload set out in paragraph 12.10 is correct.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at [DHREnquiries@homeoffice.gsi.gov.uk](mailto:DHREnquiries@homeoffice.gsi.gov.uk) and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

**Christian Papaleontiou**  
Chair of the Home Office DHR Quality Assurance Panel