Domestic Homicide Review

Angela

2021

Executive Summary

Independent Report Writer:	Elizabeth Hanlon
Commissioned by:	Kent Community Safety Partnership
	Medway Community Safety Partnership
Review completed:	28th June 2023

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Summary of Contents

1 Angela – The Review Process

1.1 Angela is described by her sister and her ex-partner, Joseph, as being a fun person who was very outgoing. She would always make a big joke of things and was someone who did not want any responsibility. They described her as a “female Peter Pan”, someone who never grew up. They will miss her greatly.

1.2 This overview report has been commissioned by the Kent Community Safety Partnership and the Kent and Medway Safeguarding Adults Board (on behalf of the local CSPs including the Medway Community Safety Partnership) concerning the death of Angela which occurred in 2021.

1.3 The panel wish to send their condolences to the family and friends of Angela. Pseudonyms for both Angela and the male she was in a short relationship with, Anthony, have been used throughout this report to maintain anonymity. Angela’s ex-partner has also been given a pseudonym. These pseudonyms were shared with the family who agreed with the names used.

Name	Gender	Relationship	Ethnic Origin
Angela	Female	Deceased	White British
Joseph	Male	Ex-partner/father of baby	White British
‘Baby’	N/A	Baby of Angela and Joseph	White British
‘Sister’	Female	Sister of Angela	White British
Anthony	Male	Short term relationship with Angela	White British

1.4 The deceased in this case was a white female of British nationality. Angela was in her 30s at the time of her death. The male Anthony, who she was in a very short term relationship with, is a white male of British nationality. Anthony was in his late 20s at the time of Angela’s death. Angela left behind one child from a previous relationship. The child was living with their father at the time of Angela’s death.

1.5 In 2021 Angela was found unconscious in her room in Hostel B where she was living. She was taken to hospital and placed on life support. Angela sadly passed away a few days later.

1.6 A Coroner's Inquest was held into the death of Angela in September 2021. The Assistant Coroner recorded the cause of death as a suicide. The allegation of rape reported to the police by Angela was subject to an investigation but no prosecution took place.

1.7 Angela's death was referred to the Kent and Medway Safeguarding Adults Board (KMSAB) for a decision to be made as to whether it fitted the criteria for a Safeguarding Adults Review (SAR). It was identified that the criteria for a SAR was met however, it was considered duplicative to undertake both a SAR and a DHR and therefore it was agreed that a joint review would be undertaken.

1.9 The Domestic Homicide Review (DHR) and Safeguard Adult Review was started in September 2021 following a decision by the Kent and Medway Domestic Homicide Review Panel that Angela's death fitted the criteria for a DHR having paid due regard to the guidance within the 2016 publication which states;

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

2 Contributors to the Review

2.1 Each of the following organisations contributed to the review:

Agency/Contributor	Nature of Contribution
Kent Police	Independent Management Review
Kent County Council Integrated Children's Services	Independent Management Review
Kent County Council Adult Social Care	Independent Management Review
Borough Council A, Housing	Independent Management Review
Look Ahead, Hostel B	Independent Management Review

We Are With You	Independent Management Review
Porchlight	Summary Report
Kent & Medway Clinical Commissioning Group (Integrated Care Board)	Independent Management Review
Maidstone & Tunbridge Wells NHS Trust	Independent Management Review
Kent Community Health NHS Foundation Trust	Independent Management Review
Kent & Medway NHS and Social Care Partnership Trust	Independent Management Review
Medway NHS Foundation Trust	Summary Report

2.2 Independent Management Reviews (IMRs) were written by a member of staff from the organisation to which it relates. Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The IMRs were quality assured by supervisors and were signed off by management prior to being presented to the panel.

3 The Review Panel Members

3.1 The Panel for the review was made up of the following representatives;

Name	Organisation	Job Role
Elizabeth Hanlon		Independent Chair and Report Writer
Kathleen Dardry	Kent County Council, Community Safety	Practice Development Officer
Victoria Widden	Kent & Medway Safeguarding Adults Board	Safeguarding Adults Review Manager
Matthew Basford	Kent Police	Detective Chief Inspector
Sophie Baker	KCC Integrated Children's Services	Practice Development Manager
Catherine Collins	KCC Adult Social Care	Adult Strategic Safeguarding Manager
Tracey Creaton	Kent & Medway CCG	Designate Nurse for Adult Safeguarding
Bridget Fordham	Medway NHS Foundation Trust	Head of Safeguarding
Auxilia Muganiwah	Kent & Medway NHS and Social Care Partnership Trust	Specialist Safeguarding Advisor
Karen Davies	Maidstone & Tunbridge Wells NHS Trust	Named Nurse for Safeguarding Adults

Annie Readshaw	Kent Community Health NHS Foundation Trust	Named Nurse Safeguarding Children
Mike Bansback	Look Ahead, Hostel B	Head of Safeguarding and Quality
Hannah Willis	We Are With You	Head of Mental Health Service Delivery
Claire Keeling	Borough Council A, Housing	Housing Solutions Manager
Yvette Hazelden	Look Ahead *(Domestic Abuse Specialist)*	Strategic and Development Lead
Tim Woodhouse	Kent County Council, Suicide Prevention *(Suicide Expert Opinion)*	Suicide Prevention Project Support Officer
Symon Hewish/Satinder Kang	Change Grow Live *(Substance Misuse Expert Opinion)*	Locality Lead
Charlie Grundon	Porchlight	Safeguarding Lead

3.2 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had any relevant contact with Angela and/or Anthony. It also included a senior member of the Kent Community Safety Unit and an independent advisor from a Kent-based domestic abuse service.

3.3 The panel met on five occasions, where they identified the key learnings, set the terms of reference, examined Independent Management Reviews (IMRs) and agency information, and scrutinised the overview report and its recommendations. The review process was paused for a month due to the pandemic and the additional pressures placed upon agencies. At the first panel meeting in September a decision was made that due to the additional pressures agencies would be given additional time to complete their IMRs. Upon completion of the overview report an action plan was developed and fully populated by panel members prior to Home Office submission.

4 DHR Panel Chair and Author of the Overview Report

4.1 The Independent Chair and report writer for this review is Elizabeth Hanlon, who is independent of the Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective from Hertfordshire Constabulary, having retired seven years ago,

who has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership Reviews and Serious Case Reviews. She has written several Domestic Homicide Reviews for Hertfordshire, Cambridgeshire, and Essex County Council.

4.2 The Chair has received training in the writing of DHRs and has completed the Home Office online training and online seminars. She also has an enhanced knowledge of Domestic Abuse. She also attends the yearly Domestic Abuse conferences held in Hertfordshire and holds regular meetings with the Chair of the Domestic Abuse Partnership Board in Hertfordshire to share learnings across boards. She is also the current Independent Chair for the Hertfordshire Safeguarding Adults Board.

5 Terms of Reference for the Review

5.1 In conducting the Domestic Homicide Review into the death of Angela, the Panel had regard to:

5.2 Establishing whether any agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Angela.

5.3 If such abuse took place and was not identified, considering why not, and how such abuse can be identified in future cases.

5.4 If domestic abuse was identified, were the agency responses in accordance with their own and multi-agency policies, protocols, and procedures in existence at the time.

5.5 If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

5.6 This review will also consider current legislation and good practice.

5.7 Specific issues to be addressed.

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

5.9 Were practitioners' sensitive to the needs of Angela, 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?

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

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

5.12 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?

5.13 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?

5.14 When, and in way, were Angela's wishes, and feelings ascertained and considered? Is it reasonable to assume that the wishes of the Angela should have been known? Was Angela informed of options/choices to make informed decisions? Were they signposted to other agencies?

5.15 Was anything known about Anthony? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place? Were there previous incidences of DA with other partners that should have been considered?

5.16 Had Angela disclosed to any practitioners or professionals and, if so, was the response appropriate?

5.17 Was this information recorded and shared, where appropriate? Was there an emphasis on self-reporting or was information shared appropriately between agencies?

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

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

5.20 Are there other questions that may be appropriate and could add to the content of the case? Was there a history of self-harming or suicidal ideation linked to Angela?

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

5.22 Are there lessons to be learned from this case relating to the way in which agencies worked to safeguard Angela and her child, and promote their welfare, or the way it identifies, assesses and manages the risks posed by Anthony? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

5.23 Did any staff make use of available training?

5.24 Did any restructuring take place during the period under review which had an impact on the quality of the service delivered?

5.25 How accessible were services to Angela?

5.26 Angela recently gave birth to a baby who was born prematurely. The baby was living with their birth father and Angela was only allowed supervised access. The baby was under a Child Protection Plan. What impact did this have on Angela? Was a whole family approach considered?

5.27 What impact did Angela's alcohol dependency have upon her relationship with professionals and was this dealt with in a consistent manner?

5.28 Were there any identified mental health considerations surrounding Angela and any previous incidents of self-harm or suicide attempts/ideation? Was the Mental Capacity Act (MCA) considered and applied to Angela and Anthony?

5.29 What considerations did agencies make regarding Angela being homeless and the placing of her in a hostel with identified health and support issues? Were any issues of vulnerability identified regarding Angela and Anthony in relation to placing them into a mixed hostel? Were the appropriate risk assessments completed regarding Angela and Anthony when placing them into the hostel?

5.30 Were agencies aware of any care and support needs surrounding Angela and Anthony as individuals, and if so was the appropriate level of support in place? Were the appropriate referrals made? Was there a good understanding of the thresholds for professionals in relation to referring Angela and Anthony for any safeguarding concerns?

5.31 Was the Violence Against Women and Girls agenda identified and were agencies open regarding the relationship that Angela and Anthony formed?

5.32 Did practitioners understand how and when domestic abuse aligns with statutory adult safeguarding?

5.33 Did practitioners understand alcohol misuse and self-neglect and how these fit with adult safeguarding?

5.34 Do practitioners understand how care and support needs form vulnerability?

5.35 Were there clear lines of accountability in terms of support needs – did everyone know what each other was doing? (Multi-agency working)

5.36 Had the perpetrator abused partner/s or a family member before?

5.37 Was the perpetrator known to agencies as an abuser?

5.38 Has the perpetrator any previous relevant offending history?

5.39 Was the perpetrator being managed or supervised by, or attending any of the following; MAPPA, Probation, Mental Health Services, Drug and Alcohol Services, attending or had attended a perpetrator programme?

5.40 Was any good practice identified within agencies to help develop future practice?

6 Summary Chronology

6.1 Angela was the mother of one child who lives with the biological father. Angela was in her 30s at the time of her death. She had spent most of her adult life in Spain, where she moved after the death of her mother. Angela started a relationship with her ex-partner Joseph in November 2019 where shortly afterwards she fell pregnant. Her baby was born 16 weeks premature. There were a number of health complications with the baby which meant that they spent a considerable amount of time in different hospitals. During the time in hospital Angela would visit and spend time most days with her baby.

6.2 Angela was alcohol dependent and sadly her alcohol problems did not cease during or after her pregnancy. When discharged from hospital Angela and the baby both went to live with Joseph and his family. A Child Protection Plan was put in place in March 2021 by Social Services due to concerns surrounding Angela's ability to care for the baby. Joseph was working nights at this point

and concerns were raised regarding Angela abusing alcohol and the impact that this had on the care she was providing. Due to the concerns, Angela left the family address and contact was minimised to four hours supervised a day. The baby was left in the care of Joseph and his family. The loss of her baby had a significant impact on Angela's drink problems and subsequently her mental health.

6.3 Shortly after leaving the family home Angela made an attempt on her life by taking an overdose of tablets and alcohol. She received hospital treatment before being discharged under the care of the crisis team. Angela went to stay with her sister however, this was always identified as a short-term solution due to the lack of room. Although identified as short-term Angela stayed with her sister for several months before becoming homeless. Due to Angela's alcohol abuse and mental health problems, she was placed in temporary accommodation in a hostel.

6.4 Whilst living in the hostel Angela started a relationship with a male, Anthony. This relationship appeared to take place over a two-week period and during that time Angela made a report to the police that she had been raped by Anthony whilst at the hostel. Anthony was arrested for the offence of rape and bailed to live at a different accommodation.

6.5 In 2021 Angela was found unconscious in her room. She was taken to hospital where she later sadly died. Joseph and the baby were due to visit the hostel to see Angela at the same time as she was found. Joseph stated that he had had text conversations about seeing her minutes before she was found by staff members. Joseph stated that the text messages were upbeat and stating that she was looking forward to spending time with Joseph and their baby.

7 Conclusions

7.1 A study completed by the American Journal of Epidemiology 'Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling 2018'[1], examines whether mothers who had a child taken into care by child protection services have higher mortality rates

[1] https://academic.oup.com/aje/article/187/6/1182/4956003

compared with rates seen in their biological sisters who did not have a child taken into care. The research identified that there were an additional 24 deaths per 10,000 person-years among mothers who had had a child taken into care. The higher mortality rates, particularly avoidable mortality, among mothers who had a child taken into care indicate a need for more specific interventions for these mothers.

7.2 When children are taken into care by child protection services, the safety and well-being of the child are the highest priority. This process often overlooks the health and well-being of the mother. Previous studies have found that mothers who had a child taken into care often have more health issues and social instability than mothers in the general population; these challenges worsen after their child is taken[2]. The distress that a mother faces after a different type of loss, the death of a child, is publicly acknowledged and has been linked with many health consequences, such as increased mental illness and heightened mortality[3]. Recent findings indicate that mothers who had lost custody of a child through child protection services have higher rates of mental illness following separation from their child than mothers who experienced the death of a child[4]. While mothers who had a child taken into care have higher rates of suicide attempts and completions, it is not known whether there is a higher rate of mortality among mothers from other causes after losing custody of a child[5].

7.3 Mothers involved with child protection services often face stigma; many have been accused of abuse or neglect and have not met society's ideal of what constitutes good parenting[6]. Public health interventions that provide

[2] Wall-Wieler E, Roos LL, Bolton J, et al. Maternal health and social outcomes after having a child taken into care: population-based longitudinal cohort study using linkable administrative data. J Epidemiol Community Health. 2017

[3] Li J, Laursen TM, Precht DH, et al. Hospitalization for mental illness among parents after the death of a child. N Engl J Med. 2005

[4] Wall-Wieler E, Roos LL, Bolton J, et al. Maternal mental health after custody loss and death of child: a retrospective cohort study using linkable administrative data
(published online ahead of print October 29, 2017)

[5] Wall-Wieler, E Roos LL, Brownell M, et al. Suicide attempts and completions among mothers whose children were taken into care by child protection services: a cohort study using linkable administrative data Can J Psychiatry 2018

[6] McKegney Si*lenced Suffering: the Disenfranchised Grief of Birthmothers Compulsorily Separated From Their Children* 2003

more stability and address the unique health-care challenges of individuals (both mothers and children) involved with the child protection services could reduce rates of premature mortality.

7.4 Although Angela's baby was not taken into care, the fact that Angela and the family were advised that Angela could not remain at home with her baby, would appear to have had the same impact upon Angela's mental health. Angela did receive mental health support, but this was at the time of a crisis and there was limited long term support. Although support was put in place for Angela, including an additional Early Help Worker from ICS, it was identified that professionals did not fully understand the impact on Angela of being separated from her baby, especially as she had identified additional care and support needs. The level of risk to Angela following her suicide attempt did not seem to have an impact upon the support that agencies gave to her. There appeared to be an emphasis on Angela accessing support services with limited knowledge of the impact her alcohol addiction had upon her. There also seems to have been limited identification of the link between the impact of trauma on Angela and her mental health.

7.5 Angela was initially assessed by We Are With You, including a clinical interview and completing a clinical questionnaire. The assessment was based on mental health issues and past history. Risks were indicated and Angela stated during the assessment that she thought that she would be 'better off dead', and those thoughts would occur once or twice a month. This assessment took place following Angela's initial attempt to take her own life.

7.6 Recent news reports[7] have highlighted the risks associated with professionals completing risk assessments. According to the latest official data, 6,211 people in the UK killed themselves in 2020. It is the most common cause of death in 20-34 year olds. It has highlighted that of the 17 people each day, on average, who kill themselves, five are in touch with mental health services and four of those five are assessed as "low" or "no risk". Philip Pirie, who sadly lost his son Tom in July 2020, identified that Tom had been seen by a counsellor, for mental health concerns, and he had been assessed as low risk of suicide the day before he took his own life. Mr Pirie is campaigning to

[7] https://www.bbc.co.uk/news/health-61154248

overhaul the system for assessing suicide risk. In July 2020, a Royal College of Psychiatrists report concluded the approach to suicide risk assessment was "fundamentally flawed" and the use of terms such as "low risk... unreliable, open to misinterpretation and potentially unsafe". Using scales or ratings could provide false reassurance, it said, especially when suicidal thoughts could vary significantly across a short time period. In Angela's case she did receive a clinical assessment as well as an online assessment which supports the risk assessments.

7.7 NICE (National Institute for Health and Care Excellence) guidelines[8] advise staff not to use risk-assessment tools to predict suicide, though identify that they can be helpful in developing a safety plan.

7.8 The Borough Council Housing missed an opportunity of reviewing and updating the suitability and vulnerability assessment, especially due to Angela's attempt to take her own life. It has been identified that sometimes clients are too worried to tell the Housing Team everything in fear of being turned away. However, this would not be the case, instead they would become more of a priority. Angela was specifically asked about domestic abuse (which she did not disclose) which is good practice.

7.9 The 2021-2025 Suicide Prevention Strategy in Kent and Medway[9] identifies that in order to reduce suicide and self-harm in Kent and Medway as much as possible they have adopted the six priorities from the national suicide prevention strategy and adapted them for local circumstances. Their priority one is to reduce the risk of suicide in high priority groups. The strategy identifies "We will also work with all relevant partners on specific projects to reduce the risk of suicide and self-harm in high-risk groups including but not limited to:

- Middle aged men
- People with previous suicide attempts/self-harm
- People known to secondary mental health services

[8] https://www.nice.org.uk/donotdo/do-not-use-risk-assessment-tools-and-scales-to-predict-future-suicide-or-repetition-of-selfharm
[9] https://www.kent.gov.uk/__data/assets/pdf_file/0010/130969/Kent-and-Medway-Suicide-and-Self-harm-Prevention-Strategy-2021-25.pdf

- People who misuse drugs and alcohol
- People who are impacted by domestic abuse
- Children and young people
- New high-risk groups as identified by real time suicide surveillance"

7.10 Consideration is to be given to including mothers who have had their children removed from their care either by ICS or on a voluntary basis and to include being placed with other family members.

7.11 The recent Health and Social Care Secretary Sajid Javid recently spoke regarding suicide prevention and identified that "As well as looking at those communities at greatest risk, we must also look at the risk factors that lead to suicides across all communities. We know that the causes of suicide are complex and intertwined but the data does show that there are some areas where we can have a big impact. For example, there is a project in Kent that found that 30% of all suspected suicides in a 2-year period was linked to domestic abuse. Our new plan will look at risks like domestic abuse and gambling, as these weren't looked at in the previous strategy"[10]. This identified the good work that is currently taking place in relation to suicide prevention in Kent.

7.12 Due to the amount of time that Angela and Anthony were in a relationship there was no information received by professionals surrounding domestic abuse between them. Following the rape allegation Angela also identified instances where Anthony had been controlling toward her. These included following her to the toilet and not letting her out of his sight. Upon making the rape allegation professionals acted well in supporting Angela and the appropriate referrals for support were made.

7.13 Agencies have identified within their IMRs that they did not feel on any occasion that Angela was lacking the capacity to make decisions and as such Mental Capacity Act Assessments were not considered necessary. Having mental capacity means that a person is able to make their own decisions. An assessment is designed to empower and protect an individual who may be

[10] https://www.gov.uk/government/speeches/health-and-social-care-secretary-of-state-speech-on-suicide-prevention - :~:text=As well as, the previous strategy

unable to make a decision because the way their mind or brain works is affected, for example, by illness or disability, or the effects of drugs or alcohol[11]. Agencies did not feel that Angela's use of alcohol impacted so greatly on her that it impeded her capacity to make her own decisions.

7.14 All agencies that took part in the review process have up to date policies and procedures in place for Domestic Abuse, Stalking and Harassment and current risk assessments. The risk assessments were used by agencies however, as already stated the impact of the risk was not always identified. Within Hostel B's IMR the writer highlighted that although training surrounding safeguarding was mandatory for their staff this was not the case for training on domestic abuse. They did identify that training was available for their staff and that many had completed the training despite it not being mandatory.

7.15 The impact of COVID-19 was discussed within the panel and although professionals stated that it did change the way their staff worked, they did not feel that it impacted on the level of support that was made available to Angela.

7.16 Anthony's vulnerability was also discussed at the panel meeting and concerns were raised regarding his care and support needs. A decision was made that a multi-agency meeting would be held to discuss Anthony and to look at any additional support required.

8 Key Issues Arising from the Review

8.1 Key Events Analysis

The analysis is divided into three separated time frames:

1) The birth of the baby and Angela's recognised mental health concerns including alcohol dependency.

2) Angela moving out of the family home and leaving the baby with the biological father and his family, and her initial suicide attempt.

3) Angela moving into Hotel B and her relationship with Anthony.

[11] https://www.scie.org.uk/mca/practice/assessing-capacity

8.2 The Birth of the Baby and Angela's Recognised Mental Health Concerns Including Alcohol Dependency.

8.3 Angela and Joseph's baby was born prematurely in hospital aged 24+4 weeks' gestation. Giving birth to such a premature baby would have been a very stressful and frightening experience for Angela. It was known to professionals that Angela had previously diagnosed mental health issues including suffering from anxiety and an eating disorder, Bulimia. Angela's medical records also recorded that she had a history of drug and alcohol dependency. The additional stress upon Angela following the birth of her baby was not recognised by all professionals. During the time that the baby was in neonatal care, Angela's mental health was observed to be very fragile. She was often observed to be anxious, upset, and tearful and acknowledged that she might have been suffering from post-natal depression. Suspicions were raised by staff on several occasions that Angela may have been drinking alcohol excessively. When they asked Angela she denied that she had been drinking alcohol. Angela was signposted to services that could offer her support for alcohol dependency problems however, these were not followed up by staff.

8.4 On several occasions Angela was observed to fall asleep at her baby's cot side by hospital staff. Angela was offered two weeks' hospital accommodation whilst the baby was there which appeared to help Angela but it has been identified that this could have been considered at an earlier stage to take the mental, physical and financial strain off of Angela.

8.5 A referral was made to ICS regarding concerns that hospital staff had surrounding Angela and possible alcohol problems. This included receiving a call to the hospital when the baby was born stating that Angela drank excessively during her pregnancy and concerns that she was drinking during her visits to see her baby. There is no reference to any family member being spoken to regarding the phone call made to the hospital. These conversations might have opened the door to having a frank conversation with Angela and the family unit regarding her alcohol intake both during and after the birth of her baby. A referral was made to ICS regarding concerns of Angela's ability to care for the baby. The referral was of an appropriate nature and was followed up by

ICS. Upon being spoken to, Angela informed ICS that she had drunk alcohol during her pregnancy but that she had ceased drinking three months ago. The information provided by Angela is contrary to her liver function test as well as observations from staff whilst she was visiting the baby in hospital.

8.6 Throughout the review period it is identified that several agencies had conversations with Angela regarding her alcohol dependency and the referral process to gain help and support. On nearly all the occasions, including conversations with her family, Angela reported that she was engaging with CGL and that she had a support worker. This has been identified as not being the case and the two referrals received by CGL were not acted upon following conversations with Angela who informed them that she had stopped drinking and therefore did not need any additional support. Professionals were very quick to accept the information given to them by Angela without any follow up. It appears that during the ICPCs, follow up meetings and Core Group meetings it was identified that Angela was receiving support from CGL. If this had been followed up or CGL invited to attend the meetings, then it would have shown that in fact Angela was not accessing support.

8.7 Good support was given to Angela in relation to concerns expressed surrounding her mental health and post-natal depression. Angela was discussed at a multidisciplinary team meeting where a decision to make a referral to Adult Social Care was made, and also for support to be offered to Angela. It is unsure as to whether this referral was a safeguarding referral or a referral for assessment of care and support needs under the Care Act 2014. There is no documented outcome regarding this referral. Angela was seen by the Specialist Mental Health Midwife who discussed her level of stress and anxiety. Support for housing, and mental and emotional wellbeing was discussed. A referral was made to the Neonatal Outreach Admission to Home (NOAH) team for home support. It was also identified that Angela had been accessing counselling support from her GP. Although it has been identified that a high level of mental health support was offered to Angela it was also identified that this must have, at times, been confusing for her and would have added to the pressure that she was feeling. There does not appear to be any joined-up approach discussed or consideration to gaining information from those services who were talking to Angela to see if they were appropriate. Agencies, although working hard to support Angela were often doing so in silos.

8.8 The support provided to Angela, Joseph and the baby by the Kent Community Health NHS Foundation Trust, predominantly through the HV and Children's Therapy team, was of a particularly high standard. There is significant evidence within their IMR that both Angela and Joseph had a good relationship with the HV and that they utilised her for her professional support. The HV went over and beyond her role to support Angela and the family with the many challenges and vulnerabilities over the period of the review. However, it is acknowledged by the KCHFT IMR writer that some of the work carried out by the HV should have been communicated with the Social Worker and the boundaries of support may have been blurred. Both Angela and Joseph and ultimately Angela's family, would contact the HV in the first instance and there were times where the HV should have contacted the SW for support.

8.9 During the ICPC and Core group meetings consideration does not appear to have been given as to whether a Mother and Baby unit[12] could have been an option for Angela and the baby. This could have enabled an assessment and treatment of her mental health as well as subsequent parenting assessments. There is no evidence of any parenting support for her or any assessments that determine her ability. The focus was very much upon her alcohol and mental health which could have been address alongside her parenting capacity. Having discussed the MBUs within the panel meeting it was considered that Angela's mental health problems would not meet the threshold for a placement.

8.10 During the time that the baby was being identified as a Child In Need the emphasis was placed upon Angela's alcohol dependency and concerns as to her ability to look after her baby. Following the ICPC in March 2021 a decision was made for the baby to be made a subject of a Child Protection Plan under the category of Neglect. Professionals continued to work closely with Angela, Joseph and the baby. However, three months after the plan was initiated Angela moved out of the family home leaving the baby in the care of Joseph and his family. Several agencies, including Joseph, reported that Angela had

[12] A Mother and Baby Unit (MBU) is specialist inpatient treatment unit where mothers with mental illness are admitted with their babies. In MBUs, mothers experiencing postpartum psychosis can be supported to care for their babies whilst having the specialist care and treatment they need.

been told by the ICS SW that she needed to move out of the home. There is a suggestion from the family, that Angela was also told that unless she moved out the baby would be taken into care. The ICS SW states that it was a family decision following advice from them regarding the level of risk posed to the baby. The main issue is to look at the level of support offered to Angela as a result of moving out of the home. ICS's main role is to protect children and as such their main responsibility was towards the baby however, as professionals they still have a responsibility to make sure that Angela is safe and well.

8.11 ICS did in fact bring another Early Help Worker on board to work with Angela to ensure that she accessed the appropriate counselling services, provided support in relation to housing and also made a referral to CGL for support for her alcohol dependency. This is good practice and demonstrates that Angela's needs were considered. The ICS report identified the need for a lead person for Angela, as there was a heavy reliance in Angela self-reporting to different professionals.

8.12 During ICS's work with Angela it was felt that she had a real desire to be a good mother but that her addictions and behaviours due to her lived experiences were overwhelming. The impact of all of Angela's vulnerabilities, health matters and addictions are identified within the ICS's IMR as an area that needed more understanding. No referrals were made to Adult Social Care, not even after Angela's suicide attempt which was a missed opportunity. The SW did not fully appreciate the consequential impact leaving the family home and the baby had on Angela. There was a great deal of good practice such as joined up working between agencies in relation to the baby. However, this level of joined up support was not in place for Angela. In Kent and Medway all the NHS organisations and the Kent and Medway councils have been working together as a sustainability and transformation partnership (STP) since 2016.

8.13 There is no evidence that the multi-agency professionals considered Angela's past experiences and traumas which could have formed a trauma informed approach. There was a missed opportunity for Angela to be assessed under the Care Act 2014 in her own right. Supporting People with Adverse Childhood

Experiences (SPACE) matters is a collaborative project across Kent and Medway to prevent and reduce the impact of ACEs. Kent County Council's vision is to support trauma informed working across a wide range of professional settings and services.

8.14 Following Angela's suicide attempt another assessment was undertaken by ICS. The Child and Family Assessment and conference report was updated and rightly the focus was the risk to the baby however, the impact of Angela being separated from her baby was underestimated especially given her level of vulnerability. KSCMP have recently published a report which highlights the impact of parental mental health on children and highlights the point that 'Children should never be considered as a protective factor for parents who feel suicidal or have mental health issues'. What professionals should have considered was the risk factor to Angela of not being with her baby.

8.15 Angela had limited involvement with Adult Social Care. The initial referral send by the HV was received into ASC in March 2021 at the time that Angela left her family home. The referral stated that Angela had left her baby with her partner and his family after being advised to do so by ICS. The level of the impact of Angela leaving her baby does not appear to have been identified as an area of concern and was therefore not treated with sufficient urgency. The issue of Angela's vulnerabilities was highlighted, she had Stevens-Johnson Syndrome, her mother had died at an early age, she was homeless, had recorded alcohol dependency issues and multiple agency involvement. However, the seriousness of concerns identified by the HV was not sufficiently reflected within the referral and there was no indication of what the HV expected to happen as a result of the referral. The referral mainly touched on Angela's housing needs and therefore the level of Angela's vulnerabilities was lost.

8.16 The initial referral into ASC from the HV was updated following the incident at the train station where Angela, having been found intoxicated, was taken to hospital and the subsequent suicide attempt. A referral to the Kent Enablement and Recovery Service (KERS) was made and Angela was offered a duty screening appointment. She spoke to the Duty Social Worker following this telephone contact. However, the information on Angela's records do not contain sufficient evidence of her needs, and the rationale for

follow up action was not included. The referral to KERS took 12 days and as such this was a missed opportunity to engage with Angela and provide the necessary support. Angela was not screened for MH Social Care until 22 days from the date of the referral. There were identified missed opportunities to engage Angela and to assess initial risks towards her and for agencies to have worked more closely together to provide support. A multi-agency meeting could have been called by any of the involved agencies at an earlier point in Angela's journey. This would have given her the opportunity to engage in the support that she needed.

8.17 It must be reflected that this was during the pandemic and as such there was a delay in KER's service involvement. ASC have identified new daily triage processes that have been put in place to capture referrals within a 24/48hr timeframe.

8.18 There are published reports[13] relating to alcohol use and safeguarding which identify methods of improving care as; better multiagency working, stronger risk assessments and improved understanding and training for practitioners. This would help them better identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm. This is an area that could benefit from improved multi-agency procedures.

8.19 A major point of concern and frustration identified by the family was the impact of housing when Angela moved out of the family home. As a result of her suicide attempt Angela's sister was contacted by ICS as to ask whether Angela could stay with her for a while whilst suitable accommodation was found. This unfortunately led to Angela living with her sister and her family for several months. Following a homeless application Angela was again hospitalised which resulted in another stay with her sister. Angela approached the Borough Council Housing department in March 2021 at the point of being made homeless. She advised that she had been asked to leave the family home by Social Services, due to her drinking and not being able to care for her baby. The Borough Council made contact with ICS who confirmed the circumstances of why Angela left the home. A vulnerability

[13] https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

assessment was undertaken with Angela where it was identified that she did not meet the criteria for a priority need for housing. Angela's assessment was reviewed following notification of her suicide attempt where a referral was made on her behalf to Porchlight and supported housing. The assessment identified that Angela had substance misuse issues and a history of mental health illness. Following her assessment, she was assessed as not facing any more harm than the ordinary person faced with the same situation, which is the homeless test that would have given the Borough Council a reason to believe that she had a priority need. It was identified that appropriate services were offered to Angela including referrals for supported housing and support for debt and budgeting. It has been acknowledged throughout the review and is also being highlighted within the media the lack of suitable housing within Councils. There is a significant gap of suitable housing for those adults with complex needs and as such an inordinate amount of pressure is being placed on Councils to place adults in accommodation which is often unavailable and unsuitable.

8.20 Angela Moving into Hostel B and her Relationship with Anthony

8.21 Hostel B identified that the referral and assessment process that takes place with a new client, in the case of a self-referral, can lack key information and solely relies on information presented by the client themselves which may not always be forthcoming. It was known that a number of professionals were involved in Angela's care however, these were not contacted as a part of the assessment process which could have been the beginning of a joint working partnership between health care professionals and the service. Risk assessments are completed every three months as a minimum, although some will be completed more frequently depending upon the individual, and if any incidents trigger a need for a review.

8.22 During Anthony's time living at the hostel three separate incidents of a sexual nature were identified by staff. It appears that risk assessments surrounding Anthony were updated following receipt of this information however, there does not appear to have been any impact on him continuing to live there. This information was also not shared with Anthony's Probation Officer who used to have meetings with staff from the hostel. It is felt that when the relationship between Angela and Anthony started, the level of risk Anthony potentially

posed should have been assessed and actions taken to try and mitigate those risks. Staff on site were aware of Angela and Anthony forming a relationship. This was discussed with them both individually by the therapist in regard to unhealthy attachments.

8.23 The police have common law powers to disclose information about a person's known history of violence or abuse, normally relating to previous convictions or charges, to the public where there is a pressing need for disclosure of the information in order to prevent further crime.

8.24 Upon making the rape allegation Angela was dealt with in an appropriate manner. A DARA Risk Assessment was undertaken which was graded as high. A Safeguarding referral was made. A Multi-Agency Risk Assessment Conference (MARAC) referral was made however, it has been identified by the police's IMR writer that this was not until six days later which has been identified as an individual lapse. Angela attended the Sexual Assault Referral Centre (SARC) where a referral was made for support from an Independent Sexual Violence Advisor (ISVA). There does not appear to have been a referral to an Independent Domestic Violence Advisor (IDVA) by either the police or workers within Hostel B even though Angela had reported instances where Anthony was displaying coercive and controlling behaviour towards her. There appears to be some confusion between the two services. Hostel B have a DA Champion within their service who would be responsible for completing a referral however, at the time there was not one available to the service.

9 Learning Points and Recommendations

9.1 Agencies within this review have identified their own individual recommendations. This will be monitored by the individual agency and signed off when completed.

9.2 Support Around People Who Are Alcohol Dependant.

9.3 It was highlighted throughout the review that Angela identified to several agencies and family members that she was working with CGL in relation to her alcohol dependency issues. Two referrals were made to CGL by agencies, following consent from Angela. However, when contacted by CGL Angela

stated that she had been alcohol free for several months and therefore did not need support from their service. Angela was signposted to different support services within the community and was told to contact CGL again if she felt she needed any support. Angela was then closed to CGL. Agencies appeared to be happy to accept that Angela was receiving help for her alcohol addiction without any follow-up or clarification. The impact of the work between Angela and CGL would have been significant in relation to the ICPC and Core Group meetings surrounding the baby and ultimately to the decision made for Angela to leave the family home due to her alcohol dependency. Neither attendance or reports were requested from CGL for the Child Protection meetings and agencies were happy to accept the account given by Angela.

9.4 Other agencies involved with Angela also believed that she was accessing support from CGL but no contact was made with the service. The Early Help Worker from ICS who had been allocated to support Angela at the time she left her baby and moved out of the family home, made no contact with other services. Mental health services did not speak to Angela regarding the support she was receiving and whether the support was of an appropriate nature. Professionals did not use sufficient professional curiosity regarding the support Angela was receiving and appeared to accept the facts given to them. Again, it was identified that perhaps agencies had not received sufficient training surrounding adults who are substance dependent and the impact this substance abuse might have upon them and the lengths some alcohol dependent people will go to, to divert the attention away from their alcohol usage.

9.5 Rates of hospital admissions related to alcohol have been increasing in recent years in Kent – from 320 per 100,000 population in 2008/09, to 444 per 100,000 in 2019/20 (an increase of 39%). A Kent initiative urged residents to try the 'Know Your Score' online tool at www.kent.gov.uk/knowyourscore which asks 10 questions about drinking habits before giving users a score and information of where they can get support in Kent to help if they are consuming too much.

9.6 There is limited guidance and information on the treatment of co-occurring conditions. The NICE guidance[14] is clear that both mental health and substance use treatment services should support individuals' needs simultaneously, with mental health services taking the lead responsibility for assessment and care planning. Individuals should not be excluded from mental health, physical health, social care, housing or other support services because of co-occurring conditions. Commissioning advice published by Public Health England, sets out that commissioners and providers of mental health and drug and alcohol services have a joint responsibility to meet the needs of individuals with co-occurring conditions. This piece of work is already under way within Kent and Medway and the findings of this review should be used to support it.

9.7 The published briefing paper[15] on multiple disadvantage and co-occurring substance use and mental health conditions identifies a series of recommendations including those relating to accountability, local partnerships and commissioning. It is highly recommended that these are considered by agencies within Kent and Medway.

9.8 The issue of people with co-occurring conditions was also highlighted within a recent Kent and Medway DHR "Louise" where a recommendation was identified as - A good way forward will be a multi-agency seminar with key partners to discuss and explore alternative strategies and best practice to tackle this relatively small cohort of hard-to- reach people. These findings are also reflective of findings within similar SAR's The findings within this review should also be reflected within that identified piece of work.

	Recommendation	Organisation
1	KCC Integrated Children's Services are to remind their staff involved in CP Case Conferences and Core Group meetings to request attendance and reports from all agencies involved in the support planning process surrounding the child and significant family members, including GP and charities supporting the person i.e. substance misuse services.	KCC Integrated Children's Services

[14] https://www.nice.org.uk/guidance/ng58
[15] http://meam.org.uk/wp-content/uploads/2022/06/Co-occurring-conditions-briefing-FINAL-June-2022.pdf

2a	Better multiagency working, stronger risk assessments and improved understanding and training for practitioners is required to help them better identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm. This is an area that could benefit from improved multi-agency procedures. Consideration to be given to the recommendations identified in the above briefing paper referenced at 18.1.5 and also work taking place supporting people with co-occurring conditions.	Public Health
2b	A multi-agency seminar with key partners is to be developed to discuss and explore alternative strategies and best practice to tackle this relatively small cohort of hard-to-reach people. The findings within this review should also be reflected within that identified piece of work. (as 18.1.6 above)	Public Health

9.9 The Family Environment and the impact of Angela moving out of the family home.

9.10 Few assessments were completed regarding the suitability of Joseph's family home either prior to the baby moving home with Angela or when Angela left. The home was reported as being overcrowded, smoky and with a family member managing terminal illness. Family members were relied upon to support Angela to care for her baby when services raised concerns around Angela's ability to keep her baby safe. ICS were aware that at this time Joseph was working nights and so Joseph's mother was identified as the support mechanism for Angela. This took place without any consideration regarding the relationship between Angela and Joseph's family and what impact this would have upon Angela. Angela would report to professionals that she was feeling isolated from the family, and then later on she would say she felt supported. ICS did not consider whether Angela was being subjected to domestic abuse or coercive or controlling behaviour from family members which would impact on the level of access she would have had to her baby and also the support she received.

9.11 The impact of Angela moving out of the family home was underestimated and although support was offered, this was not joined up. Angela was not identified as a person with care and support needs in her own right and the support provided to her mainly related to her baby. There was a heavy reliance upon

Angela to self-refer to support agencies and there was no identified lead person. Angela had a long history of trauma in her personal life which was known to agencies but which was not considered.

	Recommendation	Organisation
3	Kent Integrated Children's Services to develop a 'spotlight on domestic abuse' series, a programme to develop knowledge in many aspects of domestic abuse, including coercive and controlling behaviour. It is recommended that this training programme be extended to include the link between domestic abuse and suicide and links in with the work already being undertaken by Public Health. Programme materials to be shared with other agencies. This piece of work is to link in with the Kent and Medway suicide prevention strategy which highlights the linkage between domestic abuse and suicide.	KCC Integrated Children's Services and KCHFT
4	Awareness raising forums to take place with professionals to highlight the heightened risk of suicide of a parent when children and parents are separated. To understand and support the parent including the management of risk and to identify suitable signposting, especially when a parent has other risks and has increased care and support needs.	KCC Integrated Children's Services and Adult Social Care, CCGs including Primary Care and KCHFT
5a	Each agency needs to ensure that their front line staff understands the difference between a safeguarding concern referral and a referral for care and support needs and also highlighting the importance of recording the rational of their decision making. The KMSAB to assure itself regarding the knowledge of agencies relating to the above referral process.	All agencies and KMSAB
5b	Joint training to take place between ICS and ASC to highlight the crossover in services and the need to work more closely together. This training is to include ACEs and the Trauma Care approach.	ICS and ASCH

9.12 The Hostel

9.13 An information sharing agreement is in place between the police and Hostel B and evidence was received that this process was working well. The hostel was made aware of incidents surrounding Anthony when he was living at the hostel. It was however, identified that the information was not always passed to other agencies. Anthony was under the Probation Service during his time at the hostel however, the relevant information surrounding his sexualised

behaviour was not shared with them by Anthony's hostel worker. Risk assessments can be an important part of assessing a person, however, can also become counterproductive if not used properly and the impact of the risk not appropriately considered.

	Recommendation	Organisation
6	Hostel B staff are to receive training in relation to completing dynamic Risk Assessments on residents to include viewing the individual from both a victim and a perpetrator perspective. Risk Assessments are to be updated on a three monthly basis and the impact of the risk identified to be carefully considered and what impact the risk has on the resident themselves and other people including staff and other residents. Risk assessments are to be shared with professionals supporting residents at the hostels.	Hostel B
7	All staff within Hostel B are to receive mandatory training in domestic abuse and coercive and controlling behaviour. To ensure that each hostel manager has the responsibility to access local available specialist support, including perpetrator programmes, with links locally for each of their services.	Hostel B