Safer Bromley Partnership

Domestic Homicide Review (DHR)

Overview Report

Death of Karen

Aged 50 years

Died: May 2022

Independent Panel Chair and Author Theresa Breen MA
Report completed 15.12.2023

Section 1- Introduction

1.1 This report of the death of Karen[1], is examined under the principals of a domestic homicide review (DHR)[2] which examines agency responses and support given to Karen, a resident of Bromley prior to the point of her death in May 2022. At the time of writing, the Home Office were examining the appropriateness of re-naming such reviews as a Domestic Abuse Related Death Reviews (DARDR). In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 In May 2022, an ambulance was initially called by Karen's eldest son David[3], to an address in Bromley after he discovered Karen's lifeless body and could not rouse her. Life was pronounced extinct at the scene and police were called. Karen's second son Mark[4] who had arrived, revealed some deteriorating Mental Health (MH) concerns to police officers present. There was no specific suicide note but two handwritten pages and number of post-it notes were found at the time, which suggested that Karen may have taken her own life by suicide, and this was reported to the Coroner's Office.

1.3 The review will consider agencies contact and involvement with Karen from January 2008 to May 2022. The reason these dates were chosen was because of the extensive history of domestic abuse (DA) that Karen stated she had suffered and, 2008 records the first incidence of an abusive relationship noted by agencies.

1.4 The key purpose for undertaking DHR's is to enable lessons to be learned from the circumstances in which the death of a person has or appears to have resulted from violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The Home Office (HO) directed the Community Safety Partnership (CSP) to complete a DHR, stating that the fact that DA may be historic, does not negate its significance and the impact that abuse was being felt at the point of the fatal incident (see S2.2 below). In this review, the panel focused on identifying whether the impact of the DA was significant at the point of Karen's death.

1.5 At the early stage of this report, the review panel were keen to highlight that they identified evidence which demonstrated that Karen experienced two distinct periods of trauma. Karen reported that she had been significantly impacted by historic DA which occurred between 2008-2013, and which she periodically referenced throughout her life and she stated that she suffered from Post Traumatic Stress Disorder (PTSD). However, at the time of her

[1] A pseudonym used to protect the identity of the witness.
[2] A domestic homicide review (DHR) means a review of the circumstances in which the **death of a person aged 16 or over has**, or appears to have, **resulted from violence, abuse, or neglect** by— **a person** to whom he/she was related or **with whom he/she was or had been in an intimate personal relationship,** or a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
[3] A pseudonym used to protect the identity of the witness.
[4] A pseudonym used to protect the identity of the witness.

death in 2022, a range of other complex issues (highlighted between 2018-2022) impacted her, including poor MH and her economic environment; of which minimum wage, working challenges, unemployment, rent arrears, all featured impacting her ongoing poverty, and she disclosed problematic issues in her relationship with her children, which all increased her despair and hopelessness.

1.6 Through the lens of trauma informed practice, it is possible in this report to identity intervention opportunities which were successful and others which were not.

Section 2- Timescales

2.1 Following the death of Karen, a formal notification was sent by the Metropolitan Police Service (MPS) to the Safer Bromley Partnership (SBP) on 13.05.2022, with an explanation that the case was being examined by police as a non-suspicious death: as a suspected suicide.

2.2 This review initially began as a 'proposed' Safeguarding Adults Review (SAR), on 30.06.2022. A request for information was sent to partners on 06.07.2022. A review panel[5] met on 25.07.2022, to consider the information, and the decision was to refer the matter for a SAR, at which point a further review of facts would be considered prior to adoption by the SAR panel with the Chair of the SBP being informed of their decision on the same day.

2.3 The decision was communicated to the Home Office (HO) on 01.08.2022. Some delays occurred whilst determining with the HO if the case met the criteria for the DHR process. After direction from the HO that the case was to be treated as a DHR, a Chair was appointed on 21.12.2022. The first available date for the panel was identified and the review began with the first panel meeting on 16.02.2023. The panel met on 7 occasions via Teams. It was concluded on 15.12.2023, final sign off by the panel on 21.02.2024.

Section 3- Confidentiality

3.1 During panel, the Chair explained that all information discussed at DHR panel is strictly confidential and must not be disclosed by panel members to third parties without discussion and agreement with the CSP and the DHR Chair. The disclosure of information outside these meetings would be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved. The findings of each review are confidential until publication. Information is available only to participating officers, professionals, and their line manager.

3.2 All agencies were asked to adhere to their own Data Protection procedures which include security of electronic data. All submitted documentation was password protected from the outset and passwords were only issued to those directly involved in the Panel process. The use of pseudonyms is the normal convention to protect the anonymity of individuals and/or families. The family of the victim would normally influence the choice of pseudonym. The victim's family were contacted by letter but did not respond. The chair was unable to discuss

[5] Attendees from NHS, Adult Safeguarding, Children's Safeguarding, Early Intervention, MPS (Police), GP, Bromley DA Services, Bromley Healthcare Services.

the approach to anonymity. The Chair chose pseudonyms used in this report with cultural sensitivity, for all parties referred to in this report. The following pseudonyms have been used to protect the identities of the victim, other parties and family members.

Pseudonyms:	**Relationship to Karen**	Age at time of incident	Source material for this report[6]
Karen	Victim	50 years	Records from agencies
David	1st born Son	30 years	Police notes
Mark	2nd born Son	29 years	Police notes
Robert	3rd born Son (twin)	21 years	Records from agencies
Sarah	1st born Daughter (twin)	21 years	Records from agencies
Lucas	First husband - father of 2 eldest children	U/K	Records from agencies
John	Second husband - father of twins	U/K	Records from agencies
Chris	Partner between 2009-2018	U/K	Records from agencies
Richard	Stepson - son of John	U/K	Records from agencies

3.3 Karen was 50 years old at the time of this fatal incident. She was a black British female, originally from Mauritius.

Section 4- Terms of Reference (TOR) [7]

4.1 The panel discussed the Terms of Reference (TOR) at the first panel meeting, which informed the chronology returns and agreed the TOR at second meeting. The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co - ordinated multi-agency approach to ensure that DA is identified and responded to effectively at the earliest opportunity.

[6] Police notes contained within police officers' statements, including notification to Coroners which had been shared in this review for a statutory purpose.
[7] Listed at Annex 1

- Contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice.

(Multi-Agency Statutory guidance for the conduct of DHR's 2016 section 2 paragraph 7)

4.2 Timeframe under review

The DHR covers the period from January 2008 to May 2022, the date of Karen's death.

4.3 Case specific Terms

Victim: Karen aged 50 years.

Children: Four children (now adults)– they have not been interviewed during this review but reference to their circumstances is relevant to understanding Karen's life.

4.4 Specific terms: key lines of enquiry

The Review Panel and Chair considered the 'generic issues' as set out in statutory guidance and were asked to examine the following case specific issues.

- ***Whether there were any barriers experienced by the victim or her family/ friends/colleagues in reporting any abuse in Bromley or elsewhere, including whether she knew how to report DA should she have wanted to.***

- ***What did services know about the abuse and whether there were opportunities for professionals to 'routinely enquire' as to any DA experienced by the victim that were missed.***

- ***What was or could have been put in place for victims who exited abusive relationships.***

- ***Whether there were opportunities for agency intervention in relation to DA regarding the victim or alleged perpetrator that was missed.***

The Review Panel and Chair discussed additional enquiries that the Chair would pursue with friends and family members should they be identified:

- ***Whether family, friends or colleagues were aware of any abusive behaviour (including Coercive or controlling[8]) from any perpetrator to the victim, prior to the death and,***

- ***To examine patterns of abuse and coercive and controlling behaviours perpetrated by any perpetrator against the victim.***

[8] In March 2013, the Government introduced a cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviours in intimate or familial relationships (section 76).

- ***To consider potential gaps in service provision, alongside potential barriers to accessing services*.**

4.5 Despite attempts, the author was unable to establish contact with and/or interview any family members or friends (listed at section 3) and was therefore unable to secure separate commentary or observations from them, to answer the additional enquiries. The author therefore relied on the content of the police accounts, or agency records to address lines of enquiry.

Section 5- Methodology

5.1 Following Karen's death, a formal notification was sent by the MPS to the Safer Bromley Partnership on 30.06.2022, with an explanation that the case was being examined by police as a non-suspicious death - as a suspected suicide. As a result of this there was no family liaison officer (FLO) appointed. This is normal practise in policing where there are no suspicious circumstances. The Bromley decision making panel sat on 25.07.2022 and the HO were notified on 01.08.2022. This was initially considered as a SAR, not a DHR. The HO directed it be considered for a DHR on 26.10.2022. They reflected,

'***The fact that DA may be historic, does not negate its significance and the impact that abuse was being felt at the point of the fatal incident'***.

5.2 The HO directed that the DHR should aim to understand what services knew of (the) abuse and what was or could have been put in place to recognise the root cause of her trauma and to prevent her from taking her own life. A DHR could enable a review of support for victims who have exited abusive relationships and the efficacy of this support over the longer term.

5.3 Theresa Breen was appointed on 21.12.2022 as the chair of the panel and author, but the Christmas holiday period and annual leave absences prevented the commencement of the review. It was also considered to be inappropriate to contact the family at this period. The first available date for the panel was identified and the review began with the first panel meeting on 16.02.2023.

5.4 A data trawl had been commissioned following Karen's' death which assisted the decision making to conduct a review. The agencies approached during the data trawl were Bromley &Croydon Women's Aid (BCWA), Adult Social Care (ASC), Children Social Care (CSC), Early Intervention, NHS, Oxleas NHS Foundation Trust (Oxleas), Bromley Healthcare and the London Borough of Bromley (LBB) DA strategic lead, requesting information to present to the panel.

5.5 During the review, a mixture of Individual Management Reviews (IMR's)[9] and summary information was received from agencies. IMR's were compiled by an agency representative independent of line management of the case. An agency narrative or summary is completed by an agency rather than an IMR when it has been decided collectively by the DHR panel that not enough involvement has occurred with the victim. However, the panel believes that whilst

[9] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Karen and contain analysis of the engagement.

a full IMR is not warranted, the agency may hold information of relevance to the Review. These were discussed at panel with comments sought from all agencies via a feedback loop to the Chair to inform analysis and the writing of an initial draft of the overview report.

5.6 Due to the lack of family engagement, the author was unable to identify any friends or colleagues of Karen to assist with this review. Therefore, other material that was relied upon in this review were statements made to police at the time of the incident which were submitted as part of inquest file. The police records (interview summaries or statements) were shared by police for a statutory purpose (DHR), so these accounts were viewed as 'statements of truth'. The statements were used for the purpose of giving an account of the circumstances leading up to the suicide to enable the Coroner to decide on the cause of death. At the time of writing an inquest had not been convened.

Section 6. Involvement of family, friends, work colleagues, neighbours and wider community

Family

6.1 Attempts were made to speak to the family members, to brief them, explain the DHR process and share the TOR. The Chair initially wrote separately to three named sons, who she had contact details for, on separate occasions (May, September, October 2023). The relevant Home Office DHR leaflet was included and a description of the specialist and expert advocate services available. The author had no contact details (address, email or phone) for Karen's daughter Sarah and requested contact details for her in letters written to Karen's sons. No responses were received.

6.2 The Chair also requested assistance from the Coroner's Office to facilitate contact, but no response was received from the family. At the point of writing, due to non-contact, neither the TOR nor the final report have been shared with them. The family did not meet the review panel or author.

6.3 It was not possible to identify other witnesses who could assist the panel in this report. No additional witnesses were identified to police and there is no indication from agency records of any friends. No work colleagues were identified to participate in this review as Karen had been unemployed or on sick leave in the two years leading up to her death. The social isolation that Karen experienced was documented in her agency records.

6.4 Neighbours were not approached as the author was unable to obtain the views of Karen's family or next of kin, so considered it inappropriate to do so. The panel considered that her extensive engagement with agencies gave insight into the life that Karen was experiencing.

6.5 Karen's ex-husband John is referenced throughout this report as a convicted perpetrator of DA against Karen. For that reason, he was not approached to participate.

6.6 Karen's ex-partner Chris is also referenced as a suspected perpetrator[10] of DA against Karen. For that reason, he was not approached to participate.

[10] Karen was not ready to engage with a prosecution at that time.

Section 7- Contributors to the Review / Agencies submitting IMR.

7.1 The HO Guidelines make it clear that IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the subjects of the review; and any other action taken.

7.2 Each IMR author had no previous knowledge of the subjects of the review nor had any involvement in the provision of services to them. They were selected as people independent from any clinical or line management supervision for any of the practitioners who provided care for them and could provide an analysis of events that occurred; the decisions made; and the actions taken or not taken.

7.3 Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why. As well as the IMRs, each agency provided a chronology of interaction with the subjects of the review, including what decisions were made and what actions were taken.

7.4 The IMRs considered the TOR and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion on their own agency's involvement and to make recommendations where appropriate.

7.5 Each submission was quality assured by the author and panel Chair, who carried out a quality audit of all IMRs and summary reports.

Agency	**Contribution**
Bromley Healthcare Community Interest Company (CIC)	IMR and Chronology
Metropolitan Police Service (MPS)	IMR / police statements
Bromley Lewisham & Greenwich (BLG) Mind[11]	IMR and Chronology
London Borough of Bromley (LBB)[12] Children's Social Care (CSC)	Chronology
LBB Adult Social Care (ASC)	IMR and Chronology
Primary Care- GP	IMR and Chronology
Oxleas NHS Foundation Trust	IMR and Chronology
Housing Services (Clarion)	IMR and Chronology
London Ambulance Service (LAS)	IMR and Chronology

7.6 Agency background

7.6.1 Bromley Healthcare Community Interest Company (CIC): Bromley Healthcare CIC is a social enterprise that provides a wide range of community health care services to people

[11] Bromley Lewisham & Greenwich (BLG) Mind
[12] London Borough of Bromley

of all ages in Bromley, Bexley, Greenwich and Lewisham. For this report, it focusses on the Talk together Bromley (TtB) service.

7.6.2 MPS: The Metropolitan Police Service (MPS) is the capitals' police service. The MPS has more than 44,000 officers and staff, the MPS is the UK's largest police service, with 25% of the total police budget for England and Wales. The organisation is structured into business groups including front line services, specialist detective services and public protection staff who all contribute to dealing with DA, Violence Against Women and Girls (VAWG) and homicide investigation.

7.6.3 BLG Mind: Bromley Lewisham & Greenwich (**BLG) Mind** are a third sector organisation who provide a range of MH services in the borough of Bromley[13]. Between 2019 and 2022, Karen accessed two BLG Mind services:

- Recovery Works- contracted through the ICB, this service provides longer term support (six-twelve months) to people in the borough with severe and enduring MH needs.
- Bromley Well- BLG Mind are a partner in the Bromley Third Sector Enterprise (BTSE) consortium who are commissioned through LBB to deliver the Bromley Well early intervention service. Karen accessed the Bromley Well MH and Wellbeing Pathway (delivered through BLG Mind).

7.6.4 LBB CSC- Looked After Children: Provide help and support to children and young people whenever it is decided that they need to be looked after by Children's Social Care. Children and families in various situations may benefit from social services support (broad examples are listed):

- Children who the court deem should no longer live within their own family. This could lead to a plan for permanence outside of the extended family. However, rehabilitation to their parents or a member of the extended family will be actively considered.
- Children whose home situations have broken down and have no alternative carers available within the extended family. This may be, for example, when a parent has died or gone into hospital or prison.
- Children whose behaviour at home has become unmanageable for their parents and this is causing risk to themselves and others.
- Children who have committed a serious offence and the court decides that the child should be looked after by Children's Social Care rather than at home until the court process is concluded.

7.6.5 LBB ASC: Bromley Adult Social Care aims to help people stay independent, safe and well so they can live the lives they want to. This includes people who are frail, have physical disabilities or neurodiversity, learning disabilities or MH issues as well as the people who care for them.

Section 9 of the Care Act 2014 requires local authorities to carry out an assessment of anyone who appears to have needs for care and support, regardless of whether those needs are likely

[13] Karen accessed the Bromley Well MH and Wellbeing Pathway (delivered through BLG Mind) and Recovery Works.

to be eligible. The assessment should focus on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve. ASC provide information and advice about care and support to all residents and offer short term help and options for longer term support if people have more complex needs.

Section 42 of the Care Act 2014 requires that each local authority must make enquiries (or cause others to do so) if it believes an adult is experiencing, or is at risk of, abuse or neglect. When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. The findings from the enquiry are used to decide whether abuse has taken place and whether the adult at risk needs a protection plan. A protection plan is a list of arrangements that are required to keep the person safe.

7.6.6 Primary Care GP: Under the NHS, Primary Care GP services provide local medical care for Karens. Karen was registered with a GP Surgery and local Medical Centre for the time-period that is specified by the review. The analysis focusses on significant chronological entries within her records from Dulwich and her full Medical Record following registration at the Links Medical Practice which was from Jan/ Feb 2012 onwards.

7.6.7 Oxleas NHS Foundation Trust (Oxleas): Oxleas provides a wide range of NHS healthcare services to people in community and secure environment settings. The services include community health, care for people with learning disabilities and MH care. The multidisciplinary teams look after people of all ages and we work in close partnership with other parts of the NHS, local councils, and the voluntary sector and through their new provider collaboratives. Their community MH services are provided across the boroughs of Bromley, Greenwich, and Bexley.

7.6.8 Housing Services (Clarion): Clarion Housing is the UK's largest housing association, owning and managing 125,000 homes: 360,000 people live in a Clarion home. Karen was resident in a Clarion property at the time of her death.

7.6.9 London Ambulance Service (LAS): The main role is to respond to emergency 999 calls, providing medical care to Karens across the capital, 24-hours a day, 365 days a year. Other services offered include providing pre-arranged Karen transport and finding hospital beds. Working with the police and the fire service, LAS are prepared for dealing with large-scale or major incidents in the capital. The 24-hour 111 Integrated Urgent Care (IUC) services in North East and South East London answer more than 1.2million calls a year. By integrating the 999 and 111 services they are able to treat more Karens over the phone; in their home; or refer them to appropriate care in their own community. This is key in achieving their strategic ambition of reducing the number of unnecessary trips to hospital; and should mean 122,000 fewer Karens a year being taken to emergency departments.

Section 8 - The review panel members.

8.1 The following individuals have also been nominated by their organisations to sit on the panel:

Name	Role and Organisation
Theresa Breen (TB)	**Chair and Author**
Rob Vale (RV)	Head of Safer Communities – Public Protection Division, Bromley
Jamie O'Malley (JOM)	DA Strategic Lead- Public Protection Division, Bromley
Aneesa Kaprie (AK)	Head of Service C&F Hub, Referral and Assessment, Staying Together, ATLAS & EDT
Rachel Dunley (RD)	Head of Early Intervention and Family Support, Children's Services
Heather Payne (HP)	Associate Director of Safeguarding- Bromley Healthcare Trust (BHC)
Constanze Sen (CS)	Bromley and Croydon Women's Aid
Claire Lewin-Farrell (CLF)	Head of Safeguarding, South East London Integrated Care System - Bromley
Emily Duignan (ED)	Change Grow Live
Susan Clinton	Head of Operations, Clarion Housing Association
David Glover (DG)	Head of Social Work and Safeguarding Kings College Hospital NHS Foundation Trust
Tessa Leake (TL)	Named GP for Adult Safeguarding, South East London Integrated Care System - Bromley
Lynda Bartlett (LB)	Designated Nurse Safeguarding - South East London (Bromley) Integrated Care System
Karen Laffar (KL)	Trust Wide Domestic Abuse Lead, Oxleas
Viran Wiltshire (VW)	Detective Sergeant MPS
Helen Fraser (HF)	Education
Cathy Lloyd-Williams (CLW)	Head of Service Children Looked After and Care Leavers - Bromley Children's Services
Daniel Comach (DC)	Principal Social Worker- Children and Adults Services - Southwark.
Jade Speed (JS)	London Ambulance Service
Laura Saksena (LS)	Head of Services- Bromley, Lewisham & Greenwich Mind (BLG Mind) Mind

Section 9- Author and Chair of the overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors. In this case, the Chair and Author was the same person.

9.2 Theresa Breen was selected as the Chair of the Review Panel and Author of the report. She retired from British Policing (Metropolitan police) in November 2018, after 30 years. As a former senior police officer, she worked across a range of policing disciplines, including Serious Organised Crime, Counter Terrorism and Safeguarding in management positions. She gained experience of reviews working extensively in partnership with other agencies and

had experience of working with diverse communities. She was a trained Senior Investigating Officer (SIO).

9.3 She worked across a number of Public Protection and Safeguarding portfolios in London and Surrey, managing and overseeing MAPPA[14] and MARAC[15] processes. As the police Public Protection lead in Westminster, she managed and oversaw DA services, to diverse communities. As a Borough Commander in a West London Borough, she was the core police member of the Safer and Stronger Strategy Group. Operating as 'Gold London[16],' Theresa had overall strategic command of multiple incidents including those involving DA and homicide.

9.4 Working in partnership, Theresa additionally led the national police implementation of the cross-agency Operational Improvement Review (OIR) recommendations following the terrorist activities across the UK in 2017/18. Theresa has not worked in the borough of Bromley and has no connection with any of the agencies involved in this review. She has completed the relevant Home Officer DHR Chair training.

9.5 Theresa has been the Chair and Author for 10 DHR's and is a current Chair and Author for the new OWHR[17] pilot process. She is a trainer for Sancus Solutions, delivering safeguarding and equality training, and delivered the OWHR training to over 90 delegates, including safeguarding and, equality and diversity input.

Section 10- Parallel Reviews

10.1 Post-mortem: A Forensic post-mortem (FPM) examination was conducted by a Home Office Pathologist. Whilst there is no reference to the suspected consumption of bleach being a contributory factor to her death, the cause of death was recorded as:

- 1a. Upper Gastrointestinal Haemorrhage
- 1b. Duodenal Ulcer

10.2 There is no ongoing police investigation. The investigation into the circumstances of Karen's death was completed by the police South Area Basic Command Unit (SN BCU). It was completed swiftly and a report was submitted to HM Coroner, presenting the information as a suspected suicide.

[14] MAPPA stands for Multi-Agency Public Protection Arrangements, and it is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.
[15] MARAC is a multi-agency meeting which facilitates the risk assessment process for individuals and their families who are at risk of domestic violence and abuse. Organisations are invited to share information with a view to identifying those at "very high" risk of domestic violence and abuse. Where very high risk has been identified, a multi-agency action plan is developed to support all those at risk.
[16] The generic command structure, nationally recognised, accepted and used by the police, other emergency services and partner agencies, is based on the gold, silver, bronze (GSB) hierarchy of command and can be applied to the resolution of both spontaneous incidents and planned operations.
[17] OWHR is Offensive Weapons Homicide Review is a HO pilot to deal with the under researched and reviewed area of homicides involving offensive weapons in 4 pilot sites across the UK.

10.3 Due to the wording of the cause of death from the FPM and the absence of specific reference to the bleach, it is *inferred* as opposed to being an explicit statement, that Karen had consumed bleach. The fact that the death certificate does not refer to bleach also raises the possibility that it could have been a duodenal bleed meaning natural causes. At the time of writing, an inquest has not been started or concluded. The panel were unable to state with any certainty what the Coronial conclusions would be, and this challenged the review panel to interpret the assumption that Karen has taken her life by suicide, when considering whether the historic DA was significant or whether the impact that abuse was being felt at the point of Karen's death.

Section 11 - Equality and Diversity

11.1 The Review Panel considered the nine Protected Characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation) during the DHR process in evaluating the services provided and have been regularly revisited throughout the Review. The Author also considered the information from the Crime Survey for England and Wales (CSEW) data for the year ending March 2022.

11.2 Age: Karen was a 50-year-old woman at the time of her death. Research shows[18] in the UK in 2021, the age group with the highest rate of suicide was for those aged 50 to 54 years at 14.9 deaths per 100,000. This shows that coupled with her other complex needs, Karen was statistically vulnerable due to her age, to committing suicide. Whilst age can play a significant impact on the likelihood of DA occurring, at the time of her death, Karen was not in a relationship or subject to DA.

11.3.1 Disability: The Equality Act 2010 defines **disability** as: 'A physical or mental impairment that has a 'substantial' and 'long-term' negative effect on a person's ability to do normal daily activities.' Whilst Karen was not registered disabled, her complex MH issues would indicate that she may have had a long-term disability.

11.3.2 There is no information within agency reports to suggest either Karen fell into this definition relating to physical disability or learning difficulties. However, there is significant information[19] that Karen was exhibiting MH issues including stress, anxiety and long-term depression prior to her death. As recently, as 06.05.2022, she had referred herself for counselling and talking therapy for low mood and anxiety although she had denied any thoughts of suicide or self-harm. Karen had attended her GP for routine medical treatment but had also, over many years presented with depression and MH deterioration, which were referred to MH services, who provided support, assessment, and treatment. Karen had been stated that she had PTSD which would have additionally suggested an undiagnosed disability. Of note, there is no formal diagnosis of PTSD coded in her GP records, so the review commentary about PTSD may be her personally referring to the condition informally rather than a formal diagnosis. It appears that Karen herself informed other agencies that she had PTSD, so this became an unchecked 'fact' in their records. PTSD is mentioned in the chronology on 22.11.2021.

[18] Statista Research Department, Sep 28, 2023
[19] Contained throughout the chronology.

11.3.3 On 12.09.2012, Karen disclosed to ASC worker that she suffered from dyslexia and was always forgetful, but again she stated she had no formal diagnosis of this**.** It is unclear that if this had been formally diagnosed, what further support she would have received. This could have been a contributory factor in her communication issues, but there was no evidence found in this review to support that. However, in examining the information held by agencies, Karen appeared to be confident in self-referring, asking for support and articulating her needs.

11.4 Sex: Sex always requires special consideration. Karen was female. CSEW[20] data showed that 1.7 million women experienced DA in the reporting period, which equates to 7 in 100 women. DA is a hidden crime that is often not reported to police. Her sex made Karen more vulnerable to abuse. As women statistically are more likely to be abused, sex is considered a vulnerability. There was a number of agency records of historic physical assault during this review and specific information and intelligence held by agencies that Karen had been subject to DA by at least two partners. As a woman, the likelihood that she could have been a victim is high.

11.5 Sexual orientation: The sexual orientation for Karen is believed to have been heterosexual.

11.6 Marriage and civil partnership: Although at the time of her death, she was single, Karen had previously been married twice. There is no family information supplied about the context to those marriages, however agency information which Karen disclosed to agencies gives an insight into her marriages and the challenges she faced in her relationships, which both contained DA.

11.7 Pregnancy and maternity: Karen was the mother of four adult children at the time of the death. Due to the age of her children, this characteristic was not considered a relevant factor in her death.

11.8.1 Race: The 2021 census informs that the population in Bromley is predominantly white (76%), with non-white minorities representing the remaining 24% of the population. Karen was of black British (formerly Mauritian) nationality so would have been counted in the 7% for her ethnicity in Bromley. Whilst there is no specific information in this report to suggest that her race played any part in her death, it is important to note there is a huge body of evidence that black African and African Caribbean women are more likely to have a common MH disorder than their white counterparts (DHSC, 2018).

11.8.2 The panel did consider Karen's experiences as a black woman and the barriers she may have experienced in disclosing domestic abuse. The dominant research on DA and race, appears to focus on the US[21]. In the UK, there is a body of research which specifically examines how ethnic minority victims are affected in reporting and how they are supported as

[20] Crime in England and Wales : year ending September 2024. Crime against households and people aged 16 years and over, using data from police recorded crime and the Crime Survey for England and Wales (CSEW).
[21] Domestic Violence: A Scourge on the African-American and Caribbean-American Communities

victims, by police and other agencies. Recent research by Victim Support[22] suggests that where police had failed to act on DA reports, ethnic minority victims were the worst affected and were 'disproportionately dismissed and side-lined'. And research by Bristol University[23] highlighted 'structural factors such as socio-economic disadvantages (for example, poverty, deskilling and class dislocation upon migration), racism, the role of state policies, including service responses, immigration and welfare policies, funding regimes and transnational legal regimes form a crucial 'conducive context, that can facilitate or sustain the violence that takes place in private spheres'. However, in this particular review the panel found that Karen was able and confident in making reports to the police and she was given significant support by multi agency partners when she did so (Section 15.2 below covers this in more detail). Her race and DA is also explored below at Section 11.11.9. The panel also considered race against the complex nature of the historic DA that Karen experienced and concluded not her personal circumstances were related to whole mental health, her economic situation and her complex relationship with her children and Section 17.4 addresses this. A recent report, 'Life or Death'[24] examining 44 cases, reveals systematic failures in protecting Black and minority ethnic women from domestic homicide and suicide. They included, 'Pressures within some minority communities not to report abuse outside the family, High levels of police racism deterring reporting. Fear of losing children preventing reporting due to social services involvement, Immigration concerns preventing undocumented women from reporting, Language barriers disadvantaging minority women, Stereotyping and assumptions affecting credibility assessments, Lack of understanding of 'honour'-based abuse missing severe risk, Criminalization of victims through counter-allegations, Healthcare failures in identifying abuse The report shows how cuts to specialist support services, designed for and by minority women, have cost lives. It highlights inadequacies in post-death investigations, including inappropriate use of 'cultural expertise' and weaknesses in examining police conduct.

11.8.3 Karen had been in the UK for over 30 years at the time of her death. She spoke English and did not use interpreters to communicate.

11.9 Religion and belief: On 10.08.2021, Karen revealed to her GP that she 'used to practice Buddhism', indicating a past involvement. There are no further agency records on that subject, so Karen's religious beliefs are unknown, and the panel were unable to obtain this information from family members but is not believed to have had a bearing on the events being reviewed.

11.10 Gender reassignment -Not Applicable to this Review.

11.11.1 Intersectionality was discussed at length during the panel. In simple terms, intersectionality describes the ways in which systems of inequality based on any of the protected characteristics, and/or class and other forms of discrimination "intersect" to create

[22] Victim Support New research shows police failing to act on domestic ... https://www.victimsupport.org.uk › *News*

[23] Aisha K. Gill, Sundari Anitha (2022): The nature of domestic violence experienced by Black and minoritised women and specialist service provision during the COVID-19 pandemic: practitioner perspectives in England and Wales.

[24] https://raceequalityfoundation.org.uk/news/new-report-highlights-failures-in-protecting-black-and-minority-ethnic-women-from-domestic-violence/

unique dynamics and effects. It is a concept for understanding how aspects of a person's identities combine to create different and multiple discrimination and privilege. Examples of these aspects are those escribed in protected characteristics such as gender, race, sexuality, religion, disability or age.

11.11.2 The Cabinet Office Race Audit summary (2018)[25] identified that Asian and Black households and those in the Other ethnic groups were more likely to be poor and were the most likely to be in persistent poverty.

11.11.3 Findings from the by Race Equality Foundation in the Collaboratives MH Briefing (2022)[26] which highlights:

11.11.4 'The greatest impact caused by COVID-19 is the economic and financial instability felt by many. Particularly Black and minority ethnic people who are often in precarious jobs or exposed to working conditions that heighten chances of contracting the virus, are especially vulnerable due to living in areas of England where the unemployment rates are highest. Unemployment has well-established negative health impacts in terms of morbidity and mortality and, is disproportionately experienced by those with lower skills or who experience precarious work conditions.'[27]

11.11.5 This account is particularly pertinent to Karen's experiences within employment.

11.11.6 Karen was especially vulnerable with overlapping MH and social care needs, including poverty, unemployment, housing challenges and the breakdown of her familial relationships, alongside an apparent level of social isolation, all of which are identified social determinants for significantly poorer MH outcomes.

11.11.7 It is proposed that victims and survivors from Black, Asian or racially minoritised women call often poorly represented by official datasets. According to a survey of Black, Asian and racially minoritised survivors, using specialist domestic abuse services, 96 percent reported experiencing psychological, emotional and verbal abuse. 72 per cent had experienced physical abuse, while 30 per cent had experienced attempted or threats of murder from the perpetrator. 18 per cent of respondents had been in a violent relationship for between five and ten years, and 26 per cent of respondents had been in a violent relationship for ten years or more.36 This duration is significantly longer than the national average, suggesting that women in racially minoritised groups are finding it harder either to find support at all, or to find support which is suitable for their needs[28]. In this review, the panel considered this data and recognised the vulnerability that Karen was experiencing since 2008.

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[25] Race Disparity Audit Summary Findings from the Ethnicity Facts and Figures (2018)
Microsoft Word - Revised RDA report March 2018.docx (publishing.service.gov.uk)

[26] Race Equality Foundation in the Collaboratives MH Briefing (2022)
Layout 1 (raceequalityfoundation.org.uk)

[27] Racial disparities in MH: Literature and evidence review (2022) Bignall etal
Layout 1 (raceequalityfoundation.org.uk)

[28] SafeLives' response to the Violence Against Women and Girls Strategy call for evidence 2021

11.11.8 The safeLives research and report identified that, **'**Despite being just as likely to experience abuse as any other ethnic group, research shows that the level of disclosure for these (Black, Asian and racially minoritised) victims of domestic abuse is far lower than that of the general population'. In this review, the panel considered the information provided which indicated that Karen did appropriately make disclosures and seek support in a timely way.

11.11.9 Conflicting data is unhelpful, and safeLives identify, 'Part of the problem with these datasets is that they have to be considered, to some extent, to be unreliable. Frontline agencies, including some domestic abuse services, are poor at asking about recording the racial (and religious) identity of people with whom they come into contact. Not only does this make the dataset unsatisfactory, but it also inevitably means that this aspect of someone's identity is being either overlooked or inappropriately responded to by the practitioner with whom they are connected'. Recent government data[29] indicates almost twice as many women in the White ethnic group experienced domestic abuse in 2023 (6.0%) compared with Black or Black British women (3.1%) and Asian or Asian British women (3.0%). The safeLives research tends to support this data, but in a contradictory way, instead suggesting that, 'From our Insights datasets, we know that victims from Black, Asian and racially minoritised communities typically suffer abuse for 1.5 times longer before getting help than those who identify as White, British or Irish'.

Section 12- Dissemination

12.1

- Bromley Safety Partnership (CSP members).
- All agencies contributing to the review.
- Mayor of London- Policing and Crime
- DA Commissioner.

Section 13 - Background, Overview and Chronology

13.1.1 This following part of the report combines elements of the background, overview and chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The narrative is told chronologically to give background history of Karen prior to and including the timescales under review stated in the terms of reference to give context to their story. It is built on the lives of Karen, her children, and the reported relationships she had been in. It is punctuated by subheadings to aid understanding.

13.1.2 There was significant interaction with agencies over the scoping period, specifically those dealing with Karen's MH. The following information is drawn from documents provided by agencies and from the police investigation following Karen's suspected suicide. The information in this section is factual. Where there are 'unremarkable or routine' medical entries, they are summarised. The analysis appears at section 14 of the report.

[29] Domestic Abuse victim characteristic's, England and Wales: year ending March 2023; characteristics of victims of domestic abuse based on findings from the Crime Survey for England and Wales and police recorded crime.

13.2 Backgrounds Information (the Facts)

13.2.1 At the time of her death, Karen lived in a two storey, three-bedroom flat in the Bromley area. She mainly lived at the premises alone, but in the months before her death, one of her adult sons, David[30], was temporarily staying with her due to personal circumstances. Karen was at that time, single and no one else was permanently resident at the property. She had not been working at the time of her death, having been medically signed off work (period circa 2 years). She had previously worked as a security officer but described to professionals' difficulty with the length of shifts (11 hours) and the impact on caring for her family. She had also described (to her GP) some workplace challenges regarding reported bullying.

13.2.2 From the police investigation, it was revealed that Karen had been alone in her flat on the day before she died as her son David had gone away for a few days. On his return, he had found the front door locked and he used his key to gain entry. He noticed his mother, on a mattress on the floor in her bedroom and believing her to be asleep, he did not try to wake her at that point. The following morning, he went to rouse her and discovered her rigid to touch. He called 999 and a LAS paramedic and the police attended. He also called his brother Mark[31] who attended. Karen was declared deceased at 08.52 hours by the paramedic.

13.2.3 The scene was described by police[32]. Karen was found deceased, lying on the mattress on the floor of her bedroom. Outside of Karen's bedroom was a pile of boxes, on top of which were 2 pages written by the deceased[33]. The first page was a note addressed 'to whom it may concern', which detailed that she did not have a current passport as it has expired. The letter was not completed. Next to the first page, lay a separate page with the words. 'HELP' and 'MIRACLE' written multiple times. The handwriting was confirmed by both sons, as Karen's. Both pages were seized for comparison with other notes found. In the bedroom, police discovered three small post it notes with writing interpreted as a 'statement of intent'. The officers described this as a suicide note. At the time of writing this report, the exhibit post it notes cannot be found, but were seen by a number of people including Karen's sons who can testify as to the content of them.

13.2.4 In the bathroom, two empty bottles of bleach were found in the bath beside a glass containing a straw and 'yellow liquid'. This is believed to have also been bleach. The officers described that although there were no signs of injury, when Karen was moved for examination, a smell of disinfectant came from her mouth area, suggesting that she had taken her life by suicide by consuming the bleach (whilst the later post-mortem described the cause of death, it did not explicitly refer to the bleach).

13.2.5 Initial inquiries at the scene indicated that Karen had a long history of MH issues including depression and she had reported being a victim of DA over many years, although she was not believed to be a victim of abuse at the time of her death. Her son David[34] disclosed to police that she had deteriorating MH at the time of her death (this is explored in agency

[30] A pseudonym given by the Chair.
[31] A pseudonym given by the Chair.
[32] Police Coroners notification and statements.
[33] Handwriting was confirmed by her sons.
[34] Police records

information). There is no record on the police investigation notes that David had either noticed the written pages or notes previously mentioned.

13.3 Chronology- period 01.01.2008 to May 2022.

13.3.1 The chronology details agency interaction with Karen between **January 2008** to **May 2022**. Where information is of a routine nature it is described as so. Where the interaction is deemed to give specific information about DA and the impact on her, it is more detailed. The information is presented to demonstrate what was known by different agencies about the same information and any action taken. It also references if referral is made to other agencies or if any action took place. The structure of the information is presented as:

'Date: / Agency providing information: / Contact recorded: / Any comment or notes.'

13.3.2 Whilst outside of the agreed scope of the review, the following relevant information, provided by the MPS deals with Karen's DA relationship history with John prior to the review period.

13.3.3 Karen came to notice of police for domestic incidents with John and Karen was known to police on 16 occasions. Police recorded these within the Crime Reporting Information System (CRIS), and the police merlin [35] system, as an 'Adult Coming to Notice' (ACN). There are 10 reports in 2005 to 2007 which are not listed in IMR but are referenced (all between John and Karen as the victim).

Five (5) incidents were reported as 'non-crimes'.

Five (5) additional incidents were reported as 'crimes', of which:

- Three reports were about harassment and the reports were closed.
- One report was about harassment – John was charged.
- One report about burglary – John was the suspect and Karen the victim. John was charged with violence to secure entry (smashed window and picked up bat).

Two (2) further incidents include:

- May 2007 where John bit Karen on nose – CRIS is on for Common Assault.
- June 2007 where John assaulted her in street – CRIS is on for ABH.

A number of other relevant entries outside the scoping period, were recorded by agencies which indicate the DA that Karen suffered.

Hereafter, all entries are referenced by date.

[35] The 'Merlin' IT application is used to record the details of those vulnerable people aged 17 and under via a Pre-Assessment Check (PAC) and for details of vulnerable adults aged 18 or over via an Adult Come to Notice (ACN). MERLIN is also used for the recording and investigation of Sudden Deaths, Unidentified Persons/bodies and other found persons.

29.09.2005: Agency- GP. Recorded contact in DMC Records: 'Unable to sleep due to problems with partner'. No further information listed.

Between 2005 to 2007: Agency - MPS. Recorded contact: MPS CRIS[36] created regarding DA incidents with ex-partner John. Outcome: John was previously the partner of Karen and has two children with her, Sarah and Robert. In 2007, Karen took out a court order against John due to the various assaults and threats made against her.

23.03.2007: Agency- GP. Recorded contact in DMC Records: Bullied by husband under severe stress, unable to sleep. No further information listed.

March 2007: Agency- CSC LAC. Recorded contact: Referral received to Southwark social care reporting Sarah had seen her father John with a gun. Karen admits she has seen John with firearms and that he has left a threatening note due to learning about the referral. Karen's mood/presentation is described as of concern due to mood swings. Police checks revealed John has 21 previous (Common assault-1976, possession of a firearm- 1976, possession of cannabis-1981, ABH x 2 - 1989, Assault on police- 1991). Unsubstantiated information held in 2005 saying John was a crack addict. Outcome: Between 2005- 2007 numerous DV incidents reported, and John was investigated for harassment, but no charges were brought against him.

08.05.2007: Agency- GP. Recorded contact in DMC Records: Bullying by husband, social services involved. Partner hit her and dragged her across the carpet last week. No outcome listed. No further information listed.

21.06.2007: Agency- GP. Recorded contact in DMC Records: Assault by partner- tried to grab her and kiss her but she fought him off. No physical injuries recorded. Response/Outcome: GP provided supporting letter to apply for housing as Karen felt she was no longer safe.

24.7.2007: Agency- CSC LAC. Recorded contact: John is heard at MARAC panel. John was considered to be a high risk, very dangerous individual and breached a non-molestation order x 2 in June 2007. Police consider the injunction as insufficient. There are 35 offences against his name, including 20 convictions, prolonged periods in prison with conviction for robbery (aggravated by having a shotgun with intent). 5 convictions involving violence, including common assault ABH and wounding to use violence under premises. Possession of controlled drug (1981). Since March 2005,15 DV incidents reported to police majority non-crime. No outcome was listed. No further information was listed.

22.8.2007: Agency- CSC LAC. Recorded contact: Karen was in court for an injunction against John on DA charges. Karen reveals a long standing DA and feels she is struggling to cope with the children. No outcome is listed. No further information is listed.

16.10.2007: Agency CSC LAC. Recorded contact: the family moved to temporary housing in Crystal Palace due to concerns about dangers regarding John. Response/Outcome: Family moved to Temporary Housing due to concerns as John presents as a high risk.

[36] CRIS- CRIME REPORT INFORMATION SYSTEM – method used by MPS to record Incidents.

Chronology

In the review period, between **01.01.2008 to May 2022,** Karen is mentioned in 11 separate MPS reports which is contained in the combined chronology.

06.10.08: Agency - MPS. Recorded contact: MPS CRIS recorded listing DA, Actual Bodily Harm (ABH) against Karen by John. Karen attended a police station shaking and crying, her hand was bleeding. Karen had been assaulted by her ex-partner John. She claimed that she was taking her friends child to primary school when she bumped into her ex-partner. Karen had care over both their children, but he was able to see them on certain days. He began arguing with her regarding the children, but she stated that she did not want to talk to him about it in person and if he was unhappy with the circumstances that he should go through the appropriate channels. John had with him a large Rottweiler dog and also a black umbrella, he quickly became more aggressive. He began to attack Karen. He used the umbrella to strike her where he could. Karen put her hands up to try and protect her face but had cut her hand quite badly. Karen stated that he was antagonising the dog to attack her, but she had not suffered injuries from the dog. John was charged with common assault, convicted, and sentenced to 88 days imprisonment[37].

22.10.2008: Agency – GP providing Primary Care. Recorded contact: Karen was attacked by ex (John), two weeks ago, and he was still calling her a lot on the phone. No outcome listed. No further information listed.

14.01.2009: Agency- GP providing Primary Care. Recorded contact in DMC Records: the records mention that a court restraining order walls issued, and Karen had high anxiety levels. No outcome listed. No further information listed.

18.02.2009: Agency-MPS. Recorded contact - MPS CRIS created - DA incident, Breach of non-molestation order. (In 11.02.2009, Karen took taken out a Non-Molestation Order (NMO) against John. The order was obtained at the Family Proceedings Court High Holborn, due to the various assaults and threats he made against Karen. During this time Karen was a resident within London Borough of Southwark. The NMO stated that John was prevented from attending Karen's house, or making contact via phone, text or in person). The order also covered the children. Karen stated that since the order was granted, she has received numerous calls from John and on 18.02.2009, he attended her home address. It was stated that John was knocking at the door and shouting through the letter box. Karen's children were present but knew not to answer the door and eventually John went away. Karen stated that she is fearful of John who she has reported incidents on numerous occasions. John had statedly recently come out of prison where he served eighty (80) days after being found guilty of battery against Karen. Response/Outcome: An assessment was conducted and the outcome recorded as medium risk. John was arrested and charged with breach of NMO upon Crown Prosecution Service (CPS) advice.

30.09.2009: Agency- MPS. Recorded contact: Police merlin's[38] created. Karen reported Robert as a missing person. Karen awoke to find the front door open and Robert not in his

[37] Karen variously described this as a conviction for Grievous Bodily Harm.

bedroom. His bike was missing, and he did not have his school uniform. Karen stated they had an argument the night before over him not concentrating on his homework, so she sent him to his room. When she said good night he said he missed his father and asked when he could see him next. Robert's fathers (John) address was checked, and Robert was found there, he had cycled there, asking for directions on route. There was a court order in place relating to John not having contact with Karen or children due to previous domestic violence. Robert was safe and well and stated he missed his dad and wanted to see him. Robert had not been reported missing before, the report was graded as low**.** The MASH[39] model was not in operation in 2009 and so the practice at the time was NOT for all police merlin's to be shared with CSC. The decision to report Robert missing to CSC would have sat with MPS colleagues. There report evaluated the risk as low, and it is assumed this is why it was not referred into CSC. With the introduction of the MASH model the Police were co-located with CSC (now locally called Children and Families' Hub since March 2023), and from that time, the MPS started to share all police merlin with CSC MASH. The family did not come to the attention of CSC until 2012, some three years on.

10.06.2011: Agency- GP. Recorded contact in DMC records: the files note that Karen has a history of depression with Domestic Violence and went into a refuge. No Outcome was listed and there was no entry beside this information.

20.10.2011: Agency- GP. Recorded contact in DMC records: Karen tells the GP she has been in a refuge and passed a man on the street who reminded her of her ex-partner and of the past. She is mistrustful of men and feels anxious.

27.02.2012: Agency- GP. Recorded contact in DMC records: Karen described that she was in substandard accommodation since 2009 (urgent placement due to Children[40]). One child aged 10, had sore throat in January and was now better. That was a water leakage in house in February and after that (Karen) developed spasm in upper abdomen, problems swallowing food, and during this week, can't keep food down. Karen described vomiting in the context of 'feeling that going to choke'. She was reviewed for MH concerns, and medication walls issued to aid sleep. Response/Outcome: Interaction with GP- to consider referral to DA services.

28.03.12: Agency- GP. Recorded contact in DMC records: Routine medical review.

02.03.2012 and 08.03.2012: GP records normal results.

13.03.2012: Agency- GP. Sleep concerns were raised by Karen who said the 'children 'just do their own thing for meals, the house is in a tip, but I can't function. The lady from primary school has been contact with teacher, and she had been to CAB, but it's a contract problem'. Response/Outcome: The referral actioned to the short-term Intervention team at Stepping Stones.

19.03.2012: Agency Oxleas. Recorded contact: The GP made a referral to the liaison and intake team (LIT- later in chronology name of triage service PCP). The GP was concerned regarding Karen's memory and inability to retain and process information. Karen reported to

[39] Multi Agency Safeguarding Hub
[40] Information identifying children removed.

LIT practitioner that she was feeling anxious and depressed. Karen's GP requested a psychiatrist assessment.

10.04.2012: Agency- CSC LAC. Recorded contact (Bromley chronology- staff nurse from Barts). Robert was on his scooter and was hit by a car. He was in hospital for 1 week. No outcome or further information walls listed.

13.04.2012. Agency: GP records. Recorded contact – The Dr at Stepping Stones was unable to contact with the Karen. The GP will chase up.

26.04.12: Agency- Oxleas. Recorded contact- A Psychiatry appointment was made for 26.04.12. The appointment was cancelled by Karen.

06.08.12: Agency- Oxleas. Recorded contact - Karen failed to attend the Psychiatry appointment scheduled on 06.08.2012. The team followed up twice. The team kept this referral open as they were concerned that Karen had not been seen by anyone including the GP.

14.08.2012: Agency- GP records. Recorded contact – They phoned Karen to chase up and there was no answer on her mobile. Oxleas contacted and asked the GP to follow up. GP noted they would visit.

07.09.12: Agency- CSC LAC. Recorded contact from CSC Bromley files- Karen contacted the children's school to report abuse by a former partner that had recently restarted. Karen was referred to CSC for advice and guidance.

16.08.2012: Agency – GP. Recorded contact from records- The GP made an opportunistic visit and recorded, 'Spoke to family member who stated she is away at present and should be back next week. They promised they would let her know that the GP called.

31.08.2012: Agency – GP. Recorded contact from records- The GP spoke to Karen, who was very tired and thought going away was supposed to be helping her. Karen said she kept forgetting Stepping Stones, and did not want to see a MH doctor. She disclosed she did not normally answer a private unknown number. Karen agreed to phone Stepping Stones to rearrange appointment on 06.09.2012.

06.09.2012: Agency – GP. Recorded contact from records- Karen described that she was weighed down with a legal battle with an ex-partner and her 2 youngest children. She said she had moved house 5 times before this house. She described that she could not get nothing done, and reported that her children describes her as forgetful and living in the past. She reported her son having a road traffic accident, and describes being distressed by scars on her skin caused by the scar of cigarette burns from her previous partner. Count described a happy first marriage and a second marriage to a man who she described as 'a conman' not able to keep up with job seekers appointments. Karen was tearful in the consultation, struggled to follow the instructions of the GP. The GP was concerned that Karen did not follow her instructions. Karen was advised to restart her medication and consider a referral DA support services.

07.09.2012: Agency- ASC: Recorded contact from records- The Deputy Head of Primary School raised concerns regarding Karen. She was asked to attend to speak to a care manager face to face. Karen was noted as very nervous and guarded over the telephone. (This practice was compliant with ASC policy at the time – face to face interview / assessment is offered). Karen was advised not to open door and dial 999 if the abuser turns up at home. The ASC records noted that she had four children in the home. The SW spoke to Karen who stated she has been a victim of abuse by her youngest children's father in past. He is now back, and the abuse has started over again. LBB ASC LAS record indicates that ASC's involvement with MS lasted for 10 years. (Sept 2012 – March 2022). There are 65 case notes, ASC 29 contacts with Karen.

10.09.2012: Agency- ASC. Recorded contact from records – The SW called Karen to remind her of the appointment. The reminder call is considered a welfare check call, and it is compliant with good practice.

12.09.2012: Agency- ASC. Recorded contact from records- Karen had a face to face interview and assessment at the Civic Office. Karen appeared very withdrawn and tearful as she explained her current situation. The record listed that Karen was a black female, who was originally from Mauritius. Karen has two adult sons David and Mark and two children (twins); they all lived with her. Karen was married before but became widowed. She went into a relationship with her deceased husband best friend, who she says physically and financial abused her. As a result of this relationship, she lost her house and everything valuable that she owns. Her partner left her and went on to marry another woman.

Karen stated that she suffers from dyslexia and is always forgetful but has no formal diagnosis of this. She did not sleep in her house but in a shed built by her sons. She reports that in light of her difficulties she wanted to give her son (Robert) to his father to care for, but he is not agreeing to this happening. Karen stated that she is known to Dulwich Social Services, she has been placed in various shelters for women who have experienced domestic violence all around the country. At one stage, her two older sons were living with friends in order for this not to affect their schooling. She states that her ex-partner was charged with grievous bodily harm (this is incorrect information and was clarified by police records) and imprisoned, when he came out and could not find her, he decided to go to the children's school and was following them home from school threatening to harm them if they do not give him the location of her whereabouts. Karen stated that in light of this she decided to come out of hiding and befriend her partner because she does not want her children harmed. The SW had serious concerns in relation to Karen's MH and the welfare of her children, especially the two younger ones (who they believed) whose development may be affected if Karen did not receive help. A referral was made to GP. A case discussion was held with a Senior who advised to send a fax to the doctor informing that ASC are concerned about the client's MH and request that he make contact. A fax sent to the Links Medical Practice. The SW made a call to the children and family's team and a referral was subsequently made.

13.09.2012: Agency- GP. Recorded contact from records- The notes record that Karen was in tears and needed to needs to see the Dr. ASC updated that Karen had been referred to the MH Team and says she 'can't stay closed in, wants to be out in cold and she has a few problems high blood pressure'. She was listed for the on-call Doctor. The Dr had a long discussion with Karen (and the Dr noted this was mainly confused ramblings about her past, her parents not understanding her and misleading her, and how she ran away. Also mentioned

problems with her house and went to see social services about it and they made fun of her). Karen reported she had no money as her benefits were stopped. Karen described somatic symptoms: headaches, trembling, back, abdomen and leg pains. The Dr recorded that Karen's thoughts were clearly disjointed, she was agitated, crying throughout, wearing dark sunglasses indoors, loud music playing from headphones throughout her consultation. The Dr commented this was agitated depression. The Dr contacted LAIT and requested an urgent review of Karen, who was advised of the referral and was told to contact thesurgery, if she had no contact made in one week. A referral to MH team made.

13.09.2012: Agency- ASC. Recorded contact from records- Dr from the Medical Practice called to confirm that they had referred Karen to CMHT[41] in March and Karen did not attend.

13.09.2012: Agency- Oxleas. Recorded contact from records- Received referral from GP with concerns about Karen's deteriorating MH. They arranged for an assessment the following day. An immediate appointment was offered.

14.09.2012: Agency- ASC. Recorded contact from records - The Children & Families team acknowledged receipt of Karen's referral.

14.09.2012: Agency: Oxleas. Recorded contact from records- An assessment was conducted by the liaison and intake team. Karen said she suffered back pain which kept her in bed at times. She said that she experienced a difficult court case regarding custody with her two youngest children's father. He stated he was abusive towards her and has hit her and burned her with cigarettes. He had access to the children several times a year. She reported she had lived in lots of different addresses to get away from him. She previously lived in Southwark; she had lived in Bromley since 2009. There had been a court case regarding custody of the children, and she was shocked that the Judge granted her ex-partner access to see the children. She reported 'tyranny' for the last year from her ex-partner John. She shared her background (documented in section 11 and 13) and revealed prior abuse by John. A plan was made liaison with CSC (confirmed SW Bromley social care) and for Karens review regarding starting antidepressant or antipsychotic medication. There was liaison with her eldest son David regarding his mother's presentation. Oxleas noted that the court experience seemed to be traumatic for Karen, and the impact on children and frequent moves led to potential lack of community support. Oxleas questioned whether dyslexia was a barrier for Karen engaging with services and noted that English was a second language. (Karen had disclosed in a GP appointment that she spoke French. The panel could not ascertain if this was her primary language). They noted a lack of financial support and the impact of drug use on the family. Oxleas assessed she was a high risk of significant harm. Good practice was identified in this meeting, including liaison with CSC and family engagement.

18.09.2012: Agency- GP x 3 entries. Recorded contact from records- 1. Karen called, and was very upset and said she has severe backpain and was out of painkillers. This was passed to on call Dr. 2. Karen returned the Dr's call and she was seen by duty Dr on 14.09.12 and was given appointment for 22.10.12. the Dr noted the Karen 'remains agitated, highly strung, and emotionally labile during consultation for back pain' Karen said she has not had appointment

[41] Community MH Team

from the psychiatrist yet. The Dr contacted LAIT to request appointment date for her and talked to duty worker who would find out if appointment made and call back.

20.09.2012: Agency- MPS. Recorded contact from records- MPS police merlin created. There was a DA incident between Karen and Mark who had an argument over Karen requesting money from her older son David, for housekeeping. Karen reported to be suffering from depression and anxiety and stated to Police that she was struggling financially and was unable to work. The twins were upstairs in bed and apparently did not wake up during the incident so were not aware Karen and Mark were arguing. There were no offences stated on this occasion in relation to Karen and Mark. A non-crime book domestic was recorded (police merlin), the DASH[42] was graded as standard risk.

27.09.2012: Agency - GP. Recorded contact from records x 4 Incident 1. Oxleas DNA[43] letter, 2. Social Services contact GP raising concerns and requesting a call back. 3. History was recorded that Karen seemed more coherent, and less thought-disturbed than previously. They noted a clean appearance. Karen was talking on a mobile phone in French when called in. Karen stated she had received letter from CMHT. 4. (GP) called Social Services as requested and was told the Dr was busy. She will call back later.

08.10.2012: Agency- GP. Recorded contact from records- Letter to Stepping Stones.

22.10.2012: Agency- Oxleas. Recorded contact from records- LIT team (face to face), Karen was seen and a care plan agreed for brief psychoeducation and medication.

07.11.2012: Agency- Oxleas. Recorded contact from records- Liaison with Children's Social care (Bromley liaison and intake team). Third party information from SW that 'Karen contacted social services today stating that she cannot cope with the children and had nearly burned down the kitchen.' A note was added that it was unclear is this was an attempt to take her own life, however Karen denied this[44]. A plan was agreed to call Karen that day following CSC liaison.

07.11.2012: Agency: Oxleas. Recorded contact from records- LIT Team recorded a telephone call – Karen stated that she was in a domestic violent relationship over ten years ago. Since the end of the relationship her ex-partner had found her in her different properties and has visited the children at school. This makes Karen very anxious and uncomfortable. The last time Karen had contact with her ex-partner was two months ago, when they went to court regarding access to the children. Karen stated that she had been anxious over the last few days, due to hearing someone knocking at her door when she is trying to sleep. This has made it difficult for Karen to sleep, she was anxious that her partner will turn up at night. Karen stated that she has difficultly with her housing, with her finance's, with her living situation and with her lack of support. Karen felt that she is battling with her current situation, and she needed help. Oxleas made a call to children's social care who then booked a home visit for that day

[42] The DASH tool (DA, Stalking, Harassment and Honour Based Violence Assessment) is part of the Multi Agency Risk Assessment Co-ordinator (MARAC) referral. It's a risk assessment form to help you work out the risk level for the victim.
[43] DNA- Did Not Attend
[44] No other information is provided to support the theory that this was an attempt to take her own life.

(evidence of working together). The SW agreed to call ambulance at home visit, should urgent MH intervention be required.

07.11.2012: Agency CSC LAC. Recorded contact from CSC Bromley file- Karen contacted the school, saying she was low in mood and had nearly caused an accidental fire in the kitchen after falling asleep with a kettle on the hob. She said she wanted the children to go into care as she couldn't cope. The SW contacted the liaison intake team regarding Karen's MH. She appeared to be suffering insomnia and anxiety, erratic thoughts and volatile mood. The SW team completed a same day duty visit and Karen was given details of Bromley Women's Aid and Stepping Stones MH service. Robert told the SW that he didn't see his dad anymore even though it was evident John had collected the children from school. David was in the home and able to support Karen to avoid the children going into care. SW was advised that Karen was seen by Dr for a medication review.

08.11.2012: Agency LAC. Recorded contact from CSC file- A telephone call to Bromley Women's Aid confirmed that Karen had not self-referred as suggested, but they agreed to allocate staff and contact her. Karen confirmed she has an appointment with a worker from the project.

12.11.2012: Agency- GP. Recorded contact from records- Routine medical care.

20.11.2012: Agency-GP. Recorded contact from records- Letter sent to outside agency- Protection Initial assessment report ONLY.

22.11.2012: Agency-GP. Recorded contact from records-Housing Referral Letter was issued stating that Karen was not fit for work. A Fit Note documented the diagnosis as 'depression; Karens history was recorded and the fact that she needed support.

28.11.2012: Agency- ASC. Recorded contact from records- The SW worker called Karen and gave the details regarding the Child In Need (CIN) meeting to be held on 04.12.2012 at school at. Worker from Women's Aid had referred Karen to a solicitor regarding her housing situation.

28.11.2012: Agency- Oxleas. Recorded contact from records- SW called LIT team, informed there was a CIN Meeting planned for 04.12.2012. No evidence of later attendance by LIT team.

5.12.2012: Agency- CSC LAC. Recorded contact from records- A CIN Meeting held at school. Karen's children became subject to a CIN plan with a view to offering multi agency support for Karen regarding her ongoing MH.

07.12..2012: Agency-GP. Recorded contact from records- Routine medical care.

18.12.2012: Agency- CSC LAC. Recorded contact from CSC Files- Robert was arrested for taking an offensive weapon to school. Robert was subsequently subject to permanent exclusion.

07.01.2012: Agency - GP. Recorded contact from records- Karen had spoken to Stepping Stone Bromley; last record was in October and plan was to have repeat bloods and to be referred to short term intention team.

07.01.2013: Agency-GP. Recorded contact from records- Karen attended for a repeat prescription of medication and reported she 'has up and down days', has stress factors in her life, and finds it hard to sleep at night but can sleep better in the day. Karen feels lack of motivation and concentration but was very keen to get better. She reports no great improvement , had been on medication since she started in February 2012, with a difficulty in concentration, and feeling lightheaded. The Dr diagnosed depression and increased Karens medication.

12.01.2013: Agency- CSC LAC. Recorded contact from records: Robert changed primary school and was transferred to a PRU[45].

23.1.2013: Agency CSC LAC. Recorded contact from records- Mark leaves the family home as Karen feels his behaviour is abusive. Karen attributes the weapon Robert found to Mark. The Social worker supports this decision to stabilise the situation at home.

24.01.2013: Agency- Oxleas. Recorded contact- Karen has made comments of wanting to get away from everything[46]. Oxleas record the risk to self and others as low.

25.01.2013: Agency CSC LAC. Recorded contact from records- Karen says she will prohibit the children from seeing John.

30.01.2013: Agency CSC LAC. Recorded contact from records- Karen reports that John intercepted the children returning home from school.

12.02.2013: Agency- Oxleas. Recorded contact from records- A joint home visit took place- the LIT team with SW. They note that Karen presents of symptoms of depression and struggling to cope with daily life tasks. They agreed a plan to advise on access to 'one stop shop'. This was good evidence of teams working together.

14.02.2013: Agency- Oxleas. Recorded contact: Karen's information was assed internally to Oxleas Psychological Therapies short term intervention team (SIT). The GP was informed of closure from LIT team.

11.03.2013: Agency- GP. Recorded contact: Medical treatment for routine issue.

11.03.2013: Agency- GP. Recorded contact: The SIT team were unable to contact Karen to make appointment for intervention.

12.03.2013: Agency- Oxleas. Recorded contact: SIT team telephone call and Karen said she was OK, taking prescribed anti-depressant medication. She reported she did not currently have a partner and was living with twin 11-year-olds and a 20-year-old son. Her second son,

[45] Pupil Referral Unit
[46] This is not assessed as a risk to self-harm.

aged 19 at time was living with a friend. Karen reported that she felt able to make contact if she was in a MH crisis.

19.03.2013: Agency- Oxleas. Recorded contact: The SIT team held a face to face appointment. Karen presented with low mood, saying she was unmotivated and lethargic. She was diagnosed with depression and anxiety. Karen reported her medication was increased but not effective. Oxleas noted trauma from past prolonged physical and emotional abuse.

22.03.2013: Agency- Oxleas. Recorded contact: SIT attempted telephone contact with the SW but were unable to contact SW for an update.

23.04.2013: Agency- Oxleas. Recorded contact: SIT had telephone contact with Karen as she had missed an appointment previous day. Karen described she had a problematic relationship with her second son who has now moved out of family home. SIT had a telephone call with SW and the was update shared.

07 and 09.04.2013: Agency- Oxleas. Recorded contact: A telephone call was reported from Karen from SIT team; Karen cancelled 2 appointments and reported her son was unwell.

16.06.2013: Agency- GP. Recorded contact: Letter from MH Stepping Stones.

06.06.2113: Agency- Oxleas. Recorded contact: SIT telephone call with SW. This was liaison to support Karen's attendance at appointments.

07.06.2013: Agency CSC LAC. Recorded contact: The CIN plan was closed down due to the family making good progress and engagement with Women's Aid and Stepping Stones. It was agreed that a team around the family (TAF) approach would be managed by Welcare.

26.06.2013: Agency- Oxleas. Recorded contact: SIT team made a home visit and reported that Karen stated that she had attended college. Karen had stopped taking medication a couple of months ago without medical advice. Karen found the professional support of social services useful. Karen was privately renting but has attempted to apply to housing. This was refused but she was in the process of appealing. She was also liaising with the landlord to carry out necessary repairs to her property.

01.07.2013: Agency- Oxleas. Recorded contact: The SIT team home visit and the time was a limited appointment as Karen said she needed to go to the child's school.

05.07.2013: Agency- Oxleas. Recorded contact: The CIN meeting took place. The care coordinator unable to attend due to unexpected staffing issues. A report was sent and the SW contacted.

09.07.2013: Agency CSC LAC: Recorded contact: Robert was referred to Bromley Youth Service.

29.07.2013: Agency- Oxleas. Recorded contact: SIT team appointment at clinic. Karen believed she would benefit from therapy for the past trauma of DA she had experienced. Karen

talked about negative feelings toward her mum who she felt was critical and these experiences knocked her confidence. The care coordinator contacted the Bromley Freedom project who signposted Karen to Bromley Women's Aid, and Women and Girls Network for 1:1 counselling. Karen said she was happy to self-refer. Karen was given a DA leaflet with necessary numbers. She was also provided with and discussed Gingerbread (Single Parents Equal families) leaflet for advice around money, relationships, benefits, and employment. Karen reported that her children's case was closed by social service. A holistic approach to need and DA services considered.

09.09.2013: Agency- Oxleas. Recorded contact: SIT team appointment at clinic. Karen reported housing issues, and her landlord was seeking eviction via court. Karen was struggling with bills but paying gradually. She said that she was due to start group counselling around DA with Women's Aid on the 13.09.2013.

23.09.2013: Agency- Oxleas. Recorded contact: SIT team. Karen did not attend her appointment. Karen called and mentioned there was no urgent need for a support letter to housing but she would discuss this at her next appointment. Karen remained medication free.

24.09.2013: Agency CSC- LAC. Recorded contact: Karen was served with a possession notice due to rent arrears. The family were given until 02.10.2013 to move out.

07.10.2013: Agency- Oxleas. Recorded contact: SIT team- Karen called to cancel her appointment. Karen expressed that she had been given a repossession order for her accommodation and was actively looking for a private rented accommodation. Her son was supporting her. Karen requested appointment 4 weeks later to allow her to concentrate on house search. Housing issues were prioritised over health needs at this time.

8.11.2013: Agency- Oxleas. Recorded contact: SIT team. Her appointment was cancelled, so contact was made with Karen by telephone and she stated that she was well.

21.11.2013: Agency- Oxleas. Recorded contact: SIT team appointment at clinic- social issues around housing were noted as Karen had been served with eviction for the 04.12.2013. Karen said she had discontinued counselling and courses via Women's Aid as she felt they reminded her of being ill and she wanted to move forward.

05.12.2013: Agency- Oxleas. Recorded contact: Karen attended a SIT outpatient's appointment with psychologist. Karen remained medication free and stated she was better off without it. Karen's stressors around housing were temporarily resolved as the court agreed she could remain in her house till February 2014. Karen was building good support network of friends from college and was in contact with her family in Mauritius. Karen was discharged back to her GP. Oxleas advised the GP to refer Karen to CBT through IAPT (talking therapy) or Karen to self-refer to CBT (Cognitive Behaviour Therapy) through IAPT if needed. Oxleas noted that the long gap until next involvement by MH services may indicate she felt well during this period.

13.06.2014: Agency MPS. Recorded contact: Karen moved to what would be her last flat within Bromley. Police were contacted by Karen, as an unknown male had assaulted Robert. This had occurred on a bus from Bromley to Eltham at approximately 1900 hours. Robert sat

down at the back of the bus on the bottom deck. He stated that he was looking at a large black man and the suspect male said, ‘don't act bad’ and assaulted Robert. Robert stated he was slapped which left him with a scratch to the face. The report was closed by police as all investigative opportunities were exhausted.

21.03.2015: Agency-GP. Routine medical care.

30.04.2014: Agency- CSC LAC. Recorded contact: Robert was excluded from school due to a violent attack on another student.

03.08.2015: Agency GP records. Recorded contact: Karen had medication initiated for her blood pressure.

05.03.2015: Agency- CSC LAC. Recorded contact: Robert presented to Youth Justice Office saying he had been kicked out of home by his mother. In a telephone call with CSC, Karen was adamant that she will not have him back in the house. Robert was accommodated under the Children’s Act 1989 in an emergency foster placement and CSC opened a social work assessment.

11.03.2015: Agency- CSC LAC. Recorded contact: During a social work visit, Sarah reported that Robert has been sleeping in a cupboard and that her older brother had moved back in. A social work assessment was completed by the Teenage and Parent Support Service (TAPSS) which concluded that Robert would be at risk of physical chastisement if he returned home to Karen. They noted that Karen seems to blame Robert for her physical health issues, and it is agreed that reunification is not appropriate. Sarah was assessed as being happy and thriving at home in her mother’s care and her case was subsequently closed.

30.03.2015: Agency- CSC LAC. Recorded contact: John was contacted regarding assuming care of Robert. He declined on the basis that his accommodation is too small, and he would rather support Robert once he is older and more settled.

13.07.2015: Agency- CSC LAC. Recorded contact: A social work assessment of John and his wife was carried out to potentially care for Robert. John insists that Karen has lied about the DA history.

26.07.2015: Agency- CSC LAC. Recorded contact: Robert was placed in the full time in the care of John. Robert moves to a further address.

13.08.2015: Agency- CSC LAC. Recorded contact: Karen reported that John returned Robert to her care and ‘dumped’ all of his belongings on the doorstep. John said Robert had been looking at his wife in the bathroom and this prompted the placement breakdown. Karen was described as being emotionally stressed at her interview with the SW and appeared to have been back in direct contact with John.

14.8.2015: Agency- CSC LAC. Recorded contact: Robert was presented at hospital by Karen, stating that John had punched him in the chest and slapped his face with the back of his hand on 02.08.2015. A strategy meeting was held, and a joint police section 47 investigation was

undertaken. Robert confirmed the allegations but says he did not want anything to happen to his dad.

15.10.2015: Agency- GP. Recorded contact: Routine medical care.

23.10.2015: Agency CSC LAC. Recorded contact: The family were referred to Bromley children's project for stepdown support and Robert was referred for mentoring. Robert remained in his mother's care.

17.11.2015: Agency CSC LAC. Recorded contact: The case was closed to Children's Social care. Case was referred to Bromley Children's Project as a stepdown from statutory involvement for ongoing family support.

15.12.2015: Agency-GP. Recorded contact: Routine medical care.

15.12.2015: Agency - Bromley Healthcare CIC. Recorded contact: Routine medical care.

15.12.2015: Agency- Bromley Healthcare CIC. Recorded contact: Routine medical care.

16.12.2015: Agency- Bromley Healthcare CIC. Recorded contact: Routine medical care.

18.12.2015: Agency-GP. Recorded contact: Routine medical care.

01.01.2016: Agency - MPS. Recorded contact: MPS CRIS created. This was an allegation of historic Actual Bodily Harm (ABH). Robert was in the care of Local Authority at time of the allegation of assault by Karen. Police spoke with Robert in the presence of a foster carer, regarding the disclosure that Karen had hit him with a chain in November 2015. Karen was interviewed by Police; she detailed the assault on Robert with a weapon. Robert had been at a bus stop with his sister Sarah, and he got into an argument with a man. Sarah phoned Karen in distress because Robert was getting into a fight. When Robert got home, Karen was very angry because he put Sarah at risk. There was a chain by the door, and she grabbed the chain and accepts that she hit Robert with it. Karen apologised to Robert afterwards. Karen confirmed that it occurred before Robert went into care. Robert stated he does not get on with Karen but says they are family so will not substantiate the allegation. The police noted that there were no witnesses and no forensic evidence or CCTV. Without the assistance of Robert, in an Achieving Best Evidence (ABE) interview, Police could not progress this matter due to insufficient evidence. Robert was safeguarded for the foreseeable future at his foster placement.

20.01.2016: Agency GP. Recorded contact: Routine medical.

03.02.2016: Agency- GP. Recorded contact: Routine medical care.

10.02.2016: Agency- Bromley Healthcare CIC. Routine medical review.

14.3.2016: Agency CSC LAC. Recorded contact: Robert presented at the civic centre reception, saying he has left home following an argument with his mother. Robert went to stay with a friend nearby but returned home the next day. A social work assessment is re-opened.

17.05.2016: Agency- GP. Recorded contact: Routine medical review and Karen describes stress.

23.05.2016. Agency- GP. Recorded contact: Routine medical review.

24.05.2016: Agency- GP. Recorded contact: the GP rang Karen and had no answer.

13.06.2016: Agency- GP. Recorded contact: Routine medication review.

06.07.2016: Agency CSC LAC. Recorded contact: Robert is seen at home by a SW. Karen reported that she feels his behaviour is disruptive due to a lack of positive male role models and suggests he is involved in a gang. Robert remains in his mother's care. A referral is made for a mentor and Karen says she is seeking a tutor for Robert.

05.08.2016: Agency- GP. Recorded contact: Child Protection assessment form saved.

23.8.2016: Agency- CSC LAC. Recorded contact: Robert is reported missing by Karen but he arrives at civic centre the same day and asks to be re-accommodated. Robert stays with a friend for two nights as the Local authority work to support him returning home to Karen.

24.8.2016: Agency CSC LAC. Recorded contact: Robert discloses that he had been physically abused by Karen in the November 2015 and gave details of the incident where Karen assaulted him with a long thick chain several times. He also stated she had punched him in the eye. The LA initiated a section 47 child protection investigation. Authorisation was not given to re-accommodate Robert.

25.08.2016: Agency Police: Recorded contact: Robert reported to a social worker an historic allegation of assault by Karen. Robert had been open to Children's Social Care (CSC) since the 18.06.2016, after a referral was received from emergency services that he had been stabbed. Karen is stated to have assaulted Robert in November 2015; Robert did not want to return home, which he stated was highly stressful and he could not cope in that environment. The investigation into the assault was closed due to it being assessed that there was insufficient evidence to proceed.

25.8.2016: Agency CSC LAC. Recorded contact: Robert goes missing and refuses to return to Karen's home. Police state they will take him into police protection as soon as he is found.

30.8.2016: Agency CSC LAC. Recorded contact: Robert presents at Bromley police station. Karen agrees for Robert to be re-accommodated under section 20 Children's Act 1989 in a foster placement.

07.09.2016: Agency GP. Recorded contact: Routine appointment.

05.11.2016: Agency- GP. Recorded contact: Karen's history is recorded and she said she had recent stress at work, home and with the benefits department, resulting in her feeling low in mood and getting anxiety symptoms. Karen disclosed, her housing benefit had been cut due to her not providing information needed, so she was appealing the decision. Karen stated she

works 11hr shifts as a security guard but as a consequence of long hours, she was not able to supervise her teen kids who she says are running wild, with violence and missing episodes. Karen had asked for her work hours to be reduced but she says her requests are ignored. Karen had raised blood pressure. Karen was put on medication for her MH.

20.09.2016: Agency CSC LAC. Recorded contact: Sarah was referred to MASH[47] due to the safeguarding concerns raised by Robert. CSC opened a social work assessment in relation to Sarah. Karen raises concerns about her ability to cope with Sarah and asked if she could be accommodated to allow her to travel to Mauritius. Sarah is 100% attendance in school and presenting well, so Karen's request was declined, and the social work assessment is positive for Sarah to remain at home.

09.11.2016: Agency- GP. Recorded contact: Routine medical appointment.

15.03.2017: Agency GP. Recorded contact: Review of physical health was requested by GP.

17.03.2017: Agency GP. Recorded contact: Karen's history was taken. She reported being stressed, overworked in financial debt with the threat of eviction. Count also reported some food poverty. GP noted that she needed urgent debt advice and provided Karen with two numbers.

14.06.2017: Agency GP. Recorded contact: Routine medical review.

19.06.2017: Agency GP. Recorded contact: Karen has been in contact with the debt advisor and has court papers regarding eviction.

22.06.2017: Agency GP. Recorded contact: Routine medical review.

04.07.2017: Agency GP. Recorded contact: Karen was very tearful, agitated, and described again that she was having housing problems, was about to be evicted, had challenges with relationships with a child in care which traumatised her. Karen said she was having thoughts that she cannot cope with things. When questioned, the doctor was satisfied that Karen had no active plans of self harm or suicide. Karen requested something stronger to help sleep, and the GP advised that she resume taking her anti-depressants. The GP advised that if Karen had any thoughts of self-harm (TOSH) or suicide, an urgent review would be needed.

10.11.2017, 17.01.2018, 02.05.2018- GP Routine medical reviews.

13.6.2018: Agency CSC LAC. Recorded contact: Sarah was seen at school with bite marks to her shoulder. She said she was involved in a fight with two boys in North London. She also said she had not been home in several days and was sleeping at her brother's home. Karen denied Sarah's account and said Sarah got the bite marks play fighting at a barbecue. Social care complete an assessment. Sarah is NETE[48] and is referred for targeted youth support.

[47] Multi Agency Safeguarding Hub (MASH) is a central point where agencies, like Children's Social Care, Police, and Health, collaborate to share information and make joint decisions about safeguarding concerns regarding children and young people, aiming to ensure timely and effective interventions
[48] Not in Education, Employment or Training

18.06.2018: Agency GP. Recorded contact: Routine medical appointment.

23.08.2018: Agency: MPS. Recorded contact: An MPS CRIS was created with Karen as the victim of DA and Threats to Kill. Karen contacted Police to report threats from Chris. Karen stated she met Chris in 2009 and their friendship developed into a relationship in August 2010. During their relationship they never lived together as they both had their own homes. Karen and Chris had children from previous relationships but none together. They split up in January 2016. Their relationship ended on good terms, and they stayed friends in regular contact with each other.

Karen reported to police that in late 2017, Chris moved in with Karen as he was due to be evicted from his address in January 2018 and would have been homeless. Karen stated this was only meant to be a temporary thing. Karen stated during the time Chris lived with her she had to change her way of living. Chris did not show her respect or tidy up after himself which would cause arguments between them. Karen stated she had enough, Karen asked Chris to move out which caused them to have a verbal argument. During the argument Chris punched the kitchen window and kicked the front door. No damage was caused. During completion of DA Stalking and Harassment (DASH) questions Karen disclosed about three (3) months previous (sometime in May 2018) during a verbal argument about Chris's daughter, he 'flipped out and started to threaten her with kitchen knives waving them around in the air'. Chris then got his samurai sword and threatened her with it saying he was going to murder her and chop her up. Karen stated she did not report this at the time as she felt she may have overstepped the mark about his daughter. They continued to live together after this incident. Karen handed over the samurai sword to Police.

26.08.2018: Agency: MPS. Recorded contact: Chris attended Bromley Police Station to be interviewed under caution on 26.08.2018. Chris explained that when he returned to the address after he finished work, he found that he had been locked out. He admitted that he became angry and kicked the door, but he then left then property. The risk was recorded as standard using DASH, and Chris was arrested and interviewed. On 10.09.2018, Karen stated that she just wanted to draw a line under what had happened and move on with her life positively. The Officer in Case (OIC) advised Karen on molestation orders and to go through third parties with police assistance to arrange the collection of the remainder of Chris's belongings. On 04.10.2018, the matter was reviewed by Evidential Review Officer (ERO) and Karen did not wish to pursue the allegations and the case was then closed (No Further Action), citing insufficient evidence for the realistic prospect of conviction at court.

29.08.2018: Agency- Bromley Healthcare CIC. Recorded contact: A child safeguarding entry was on record. A MASH referral was received from the Police (as described above) due to reports of DA between parents of Karens children. The father was described as controlling, displaying intimidating behaviour which contributed to the mother's deteriorating MH issues. The father was reported to be living at the family home despite previous history of DA since November 2017. In view of the information gathered, together with historical information on records, the thresholds for level 3 specialist children's social care intervention was met and child and family assessment was recommended.

29.08.2018: Agency- MPS. Recorded contact: MPS Crimint created with a DA incident. Police completed a police merlin on 23.08.2019, regarding domestic incident between Sarah, Karen

and Chris. Sarah (aged 16 years) had witnessed Karen and Chris have a verbal argument, and Karen had asked Chris to leave the property as she no longer wanted him to reside there. Upon leaving the property he has begun punching the window to the kitchen and was kicking the front door. This is linked to the incident on 23.08.2018.

14.09.2018: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM) System noted that Karen's partner Chris, was looking for his property.

21.09.2018: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM) System noted that; Karen was having problems with work and debts and struggling to stay in line and wanted help to manage her tenancy and arrears.

08.10.2018: Agency GP. Recorded contact: A Fit Note Document was issued to Karen (Diagnosis: Stress related problem). Karen reported stress, including work, home life, rent arrears and significant financial stresses.

09.10.2018: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM) Stem noted that: they had called Karen to discuss what advice and support was needed. There was no answer and no voicemail service available.

15.10.2018: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM) system noted: they spoke to Karen who said she was struggling and unable to work due to ill-health and her 17-year-old daughter was living with her and in full time education (college). Karen was worried about her rent arrears and being affected by the bedroom tax. Karen was in debt with housing but also water rates. Karen had the forms for housing benefit which she was struggling to fill in due to her mental state. The deadline to get the forms back was 18.10.2018. The CRM advised that they could book a visit to get assistance with forms and suggested a referral to Guideline for finances/debt advice and WBT (financial management service) for a financial health check to make sure she is getting all she is entitled too. The CRM agreed to call Karen back with a date and time for a visit.

06.11.2018: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM)- A referral was made to the tenancy sustainment team as Karen was unable to pay the rent, stating she has been unable to go to work due to asthma attacks because of pollution. Karen disclosed she was not claiming any benefits or eating, as when she left the house she has an asthma attack. Karen said she also did not have any money to pay for the electric. Her father has advised her that she should not apply for benefits but find work. Karen stated she has not been able to complete the benefits form as she is missing some information. She was given a food voucher but was unable to go out to collect it. Karen said she does not want her 17-year-old daughter to be involved.

06.11.2018: Agency- GP. Recorded contact: A new Fit Note document was issued with a diagnosis of stress related disorder. Her history was taken during a long consultation relating to work stress, Karen disclosed she felt she was being harassed by a colleague and also felt discrimination by her employer as the only female worker in the place. Karen said she felt under pressure at work and home and was unhappy but had no thoughts of self-harm.

19.11.2018: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM). Karen called requesting to speak to someone regarding her tenancy as she has been ill and off work for 6 weeks and had been signed off another 4 weeks. Her arrears were building but she has a cousin who can stay with her to support her with her health. Karen was unsure how long they would need to stay but was asking for a call from housing regarding this.

19.11.2018: Agency- ASC. Recorded contact: SW worker took a call from Karen, who phoned to find out about how she could become a foster carer for Bromley. Karen explained that her own 3 children had 'divorced her' and they were no longer in touch and her 17-year-old son was in care with a foster carer. Karen went on to say that she has bad asthma, so she struggles to use public transport and was off of work currently due to the pollution there. Karen was told that she would not be able to apply to become a foster carer. The file was closed.

01.12.2018: Agency: ASC. Recorded contact: EDT[49] contact received from Children's services social worker reporting concerns about Karen, appearing vulnerable appeared vulnerable. Sarah had reported observing her mother attempting to start a fire in the bath. Also, Sarah had been fed a packet of noodles due to Karen's lack of funds to purchase food. The C&F[50] worker asked to alert adult services with this highlighted concern. The information was passed to ASC for required follow up and assessment, as the adult was likely to be known to MH service. Karen appeared to have care and support needs. A follow-up Care Act assessment should have been offered and carried out to identify the potential risks (ie. fire).

02.12.2018: Agency ASC. Recorded contact: EMAIL- Team senior emailed MH team to give detail of EDT alert and asked if Karen was known to MH services.

03.12.2018: Agency- ASC. Recorded contact: A case discussion took place by email with the Senior Care Manager, Initial Response Team and the SW as a record of case discussion.

08.12.2018: Agency- GP. Recorded contact: Karen reported her history, including that her daughter left home recently following a lot of discord between them, and had cut ties. Karen was tearful when thought about her life, describing her kids were against her, she described being tormented by their father, experiencing sexism at work and financial worries. Karen denied thoughts of self-harm. The Dr diagnosed anxiety disorder.

17.12.2018: Agency- GP. Recorded contact: Following e-consulation requesting extension of her note for work, a Fit Note document with a diagnosis of stress disorder was issued.

21.12.2018: Agency- GP. Recorded contact: GP spoke with the CSW to share information about Karen and her daughter's concerns.

27.12.2018: Agency- GP. Recorded contact: The GP had a long discussion with Karen regarding her MH, and concerns raised by daughter with Social Services. Karen's medication was reviewed and altered.

28.12.2018: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM) called Karen to book new appointment for the new year.

[49] Emergency Duty Team
[50] Children and Families

30.12.2018: Agency CSC LAC. Recorded contact: Email from the parent of Sarah's boyfriend, who said Sarah has been unofficially living with them for two months. Sarah reported that she had a significant disagreement with her mother when she made a personal disclosure to her. Sarah reported her mother's MH was declining and said Karen had tried to set a fire in the bath in their home. The Social worker met with Sarah and her boyfriend's mum.

02.01.2019: Agency CSC LAC. Recorded contact: Sarah contacts the LA and requests to be accommodated under section 20 Children's Act 1989. A SW completes a home visit with Karen to discuss a referral to the Staying Together team but Karen refuses to allow Sarah to return home.

09.01.2019: Agency- ASC. Recorded contact: Email. The case was allocated to carry out a needs assessment.

17.01.2019: Agency- GP. Recorded contact: A new Fit Note with a diagnosis of stress related disorder is issued. Karen continues to stress that she finds it difficult to travel in public, was struggling with finances, and was in conflict with DWP.

22.01.2019: Agency: ASC. Recorded contact: Email. Karen was not known to Oxleas MH Services. Phone calls were made to Karen and her son Mark, who confirmed that Karen did not have a current working mobile phone. Mark stated that Karen was able to independently manage most of her care and support needs as far as he was aware and was uncertain as to whether she would be receptive to having a Care Needs Assessment (CNA). Mark stated that he would give Karen the message and let her decide if she would like this and was provided with the telephone number for the Initial Response team.

22.01.2019: Agency- ASC. Recorded contact: Internal liaison between social care teams. It Karen's case was to be transferred to the Duty Team for a further face to face care needs assessment and welfare check to gauge whether Karen had the mental capacity to understand the risks around fires, and health and safety awareness. It was concluded that Karen was below the threshold for care and support under the Care Act 2014. A follow-up face to face assessment was in line with suggestion regarding her mental capacity of understanding risks.

23.01.2019: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM)- Karen called to discuss her rent arrears. Transferred to Customer Accounts Team

24.01.2019: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM)- Karen called, stating she was in her property and heard a knock. She thought her gas check was the 28.01.2019.

29.01.2019: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM)- Gas safety check completed and certified 'Safe to Use' on 28.01.2019.

30.01.2019: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM)- Karen called to say that she has received a letter from Housing Benefit to confirm her award is suspended since 25.01.2019 pending certain documents which Karen would provide them on Friday.

01.02.2019: Agency CSC ASC. Recorded contact: Sarah was received into a foster placement. (Sarah later moved on into her own accommodation in October 2021).

01.01.2019: See chronology entry dated 19.05.2021, regarding an assault that happened on this date.

07.02.2019: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM)- Karen was now being dealt with by Citizens Advice Bureau (CAB) and Welfare Benefits (WBA).

05.03.2019: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM) - Karen called and was transferred to accounts to discuss her debts and account. Due to significant debts, an eviction warrant was to be applied to her account and they confirmed she could apply for a stay once an eviction date had been arranged.

07.03.2019: Agency Clarion Housing. Recorded contact: Customer Relationship Management (CRM)- Internal discussions regarding the potential eviction. They noted that Karen had not made payment so the eviction was authorised.

12.03.2019: Agency Clarion Housing. Recorded contact: Karen called to discuss her arrears and eviction proceedings and on 18.03.2019, they were awaiting a name change before applying for warrant.

18.03.2019: Agency- GP. Incident- A Fit Note was issued with a diagnosis of stress related disorder, and ongoing MH issues.

21.03.19: Agency Clarion Housing. Recorded contact: Outright Possession Order (OPO) was issued and they noted Karen was also liaising with the charity Pennysmart. Karen informed them that Bromley Homeless Persons Unit (HPU) were trying to assist her. The arrears were £3907.81 plus £325 court costs.

16.04.2019: Agency- GP. Recorded contact: Routine Appointment- Karen was given information for local counselling services.

09.05.2019: Agency Clarion Housing. Recorded contact: Name change was accepted and the warrant was applied for, for breach of the OPO.

14.05.2019: Agency Clarion Housing. Recorded contact: Karen called to say she is working with Pennysmart. She was advised a warrant has been applied for. Bromley HPU contacted her to see if they can help her. Karen informed them she was off sick (off work) and had been since late last year.. She has asked Bromley to downsize as she was struggling to pay the bedroom tax.

19.05.2021: Agency: MPS. Recorded contact: CRIS and police merlin created. Incident: Sexual assault allegation. Karen attended the Police Station, after receiving a call from her daughter who made an allegation against Karen’s stepson. Whilst reporting the incident, Karen

was unable to provide any detail, as she stated she had been drunk and couldn't remember anything. No Further Action (NFA) was taken as Karen did not wish to pursue allegation.

29.05.2019: Agency Clarion Housing. Recorded contact: A Stay Hearing was on 31.05.2019. they noted Karen had only made £65 of personal payments in the whole of 2019 and the rent had not been covered for the whole of 2019. The eviction was cancelled on 31.05.2019.

20.06.2019: Agency Clarion Housing. Recorded contact: A court hearing took place and Karen was represented by a solicitor. The judge suspended the warrant of payment.

05.11.2019: Agency GP. Recorded contact: Routine medical review.

07.11.2019: Agency GP. Recorded contact: Routine medical care.

11.11.2019: Agency GP. Recorded contact: Routine medical care.

12.11.2019: Agency GP. Recorded contact: Routine medical care.

14.11.2019: Agency- Bromley Healthcare CIC. Recorded contact: An inbound referral to community diabetes service was received from GP surgery. The assessment was completed on the same day and a referral to 'walking away from diabetes' programme made.

30.03.2020: Agency CSC LAC. Recorded contact: Sarah reports in her review that she doesn't have regular contact with her mother. She has spent time with Robert but they don't get on well. She was recorded as an independent 17-year-old. Sarah and Robert manage their own contact with immediate family.

10.01.2020: Agency - Bromley Healthcare CIC. Recorded contact: Karen was offered a diabetes structured education programme.

14.04.2020: Agency Clarion Housing. Recorded contact: Housing received a call from Karen wanting to know when rent payment details had changed.

28.05.2020: Agency Clarion Housing. Recorded contact: Karen called, and she said that discretionary housing payments (DHP) had ceased, as it paid for a year. Karen wanted to check what she should pay. She was advised accordingly and advised to re-apply for DHP and get help from Citizens Advice Bureau (CAB).

07.08.2020: Agency GP. Recorded contact: Routine medical care.

03.09.2020: Agency Clarion Housing. Recorded contact: An ASB case was raised regarding a disturbing letter sent by Karen to her neighbour containing several things including threats of violence. The contact noted that neighbour believed that Karen was currently mentally unstable and was having a mental breakdown. She has been reportedly screaming and crying and crashing things around the property. She has been saying 'I can't go, I have to do God's work', 'I can't go on, people are wicked', 'This is a one-woman army'. The neighbour was advised on the importance of calling the police but does not want to as she is putting her children at risk. ASB was investigated by Tenancy Specialist team

03.09.2020: Agency MPS. Recorded contact: MPS police merlin created- Concerns for Karen's MH. Police were called by a concerned neighbour due to screaming, shouting, and banging coming from Karen's flat. Karen had been seen carrying a stick/piece of wood in the communal areas. The concerned neighbour also called Karen's son Mark. Officers spoke with Mark and he stated he had only just arrived himself. He had received a call from the neighbour. He told officers that Karen possibly had PTSD due to abusive relationships in the past. Karen told officers that she had been struggling recently due to a build-up of stress and emotions. Karen was crying and stated she had not been diagnosed with any MH conditions (no agency information was found to establish that she had been diagnosed). She told officers that at the start of the year, she was looking to get help for her MH through the job centre and they referred her. Karen did not engage with MH services at the time and didn't speak to them much due to lockdown happening. She stated that she would get some help and would contact the job centre referral or go through her GP. Karen told officers that she had no thoughts of harming herself or harming anyone else while she was going through an episode. She stated her family needs her too much. Mark remained with Karen waiting for LAS and officers left. A report was completed for Adult Welfare Concerns, noting this case is predominantly regarding concerns of a neighbour's behaviour and their decline in health.

04.09.2020: Agency ASC. Recorded contact: A police merlin report received: Senior SW advised administration to forward the referral to the CMHT. No details were recorded about this police merlin and not clear whether there was any safeguarding concern. No clear rationale was recorded for the above decision made by the senior. This practice is not compliant with the ASC's safeguarding policy and procedures. Based on the content of the police merlin, a safeguarding concern or referral should be raised for Karen and her two adult children, as it is apparent that Section 42 threshold for an enquiry was met at the time. Merlin reports at the time were forwarded to colleagues in Oxleas.

07.09.2020: Agency Oxleas. Recorded contact: PCP police merlin report. Police called by a neighbour due to screaming, shouting and banging coming from her flat. There was no indicated input by secondary MH services.

10.09.2020: Agency GP. Recorded contact: Karen's telephone number was not accepting calls.

10.09.2020: Agency Clarion Housing. Recorded contact: Recorded offline files- Report received from neighbour stating that Karen had been found sleeping outside property partially naked, and neighbours have provided blankets. He described that she suffers MH issues. He said (in his opinion) she is not in immediate danger and just needs to get inside her home. Karen had got upset and left her flat leaving keys and her phone inside and did not know contact details or addresses for her children. She went to a neighbours' flat but did not want police in attendance, although the neighbour felt that police should be involved for MH concerns.

12.09.2020: Agency- Oxleas. Recorded contact: Crisis line. Telephone call from Mark who was concerned about his mother. He said she was not engaging with others and was withdrawn and not making sense when talking. Mark said he would encourage his mother to contact the crisis line service. He would encourage and facilitate a GP appointment and would

contact emergency services as necessary. There was no further input from the crisis line service at his stage. A Neighbourhood Response Officer investigated and sent notes back stating, 'I've spoken to Karen who confirmed that she now has access to property and there was a family disagreement that caused the issue and 'person X' is no longer at the property. Person X is a friend of Karen's daughter. Karen said she does get stressed and sees her GP if needed and would like help to get employment and is being helped by the job centre who have also referred her for money advice. I agreed to refer tenant to guideline for employment support. I've also advised tenant to contact us if any further advice and support is needed.'

13.09.2020: Agency- Oxleas. Recorded contact: Crisis line. Telephone contact from Karen for advice. She reported that she had problems with budgeting and with paying bills. Karen felt that she needed CBT[51] or counselling. She contacted MIND[52] in Bromley but did not follow up the year before. She reported a history of anxiety and panic attacks (hence she had not been opening her letters).She planned to discuss with her children, the support with bills and was to contact her GP for an urgent appointment to discuss medication.

15.09.2020: Agency- Bromley Healthcare CIC. Recorded contact: A self-referral into Talk together Bromley (TtB) received, which was screened and triaged and an appointment booked for the 18.09.2020. The appointment was provided within 3 days, due to appointment availability and no concerns around triage. Karens are signposted to urgent services at the point of accessing the service. No risks were identified.

18.09.2020 Agency- Bromley Healthcare CIC. Recorded contact: Initial assessment completed (TtB).

21.09.2020: Agency- GP. Recorded contact: Letter to GP from Oxleas regarding a merlin report. Karen reported stress with neighbours and was hearing shouting and banging. Karen advised she will make an appointment with her GP for a review.

30.09.2020 Agency- Bromley Healthcare CIC. Recorded contact: A therapist called CMHT West regarding any possible involvement they have had with Karen. They confirmed she was known to them but had no case currently open. In 2012, Karen was under their service for a year with a diagnosis of recurrent depressive episodes. Approximately one month ago, CMHT did an assessment based on a police merlin report. The service screened her but she was not suitable for their service nor warranted detention in hospital. Karen's GP was informed of the screening. Based on this information and presentation on the assessment and discussion with clinical supervisor, the therapist attempted to call Karen to signpost them to longer term counselling due to not being suitable for TtB. There was no answer. The therapist emailed Karen to inform her of the TtB decision making. (A second referral to TtB was made on 09.12.2020 by Primary Care Plus and was declined due to the decision making in September). It is documented that Karen accessed Westmeria for the first time at this point.

15.10.2020: Agency ASC. Recorded contact: Received email & Adult at Risk from the Residents' association. Senior Care Manager Duty Team- Assessment and Care Management note: A report from Karen's neighbours stated that Karen was wondering around

[51] Cognitive Behavioural Therapy
[52] MH charity

outside her property half undressed and it appeared that she had slept in the hallway. An ASB complaint was received regarding a disturbing 5-page letter that Karen had sent to her neighbour detailing that she wanted to 'batter' a woman who is statedly, trying to steal the neighbour's husband away. Karen was known to Oxleas, but it's unclear if there was a support plan in place. It appears she's in a decline and her neighbours are concerned about her wellbeing. Karen slept in the stairwell all night when she went to put rubbish down the chute at 11 pm and the door blew shut and locked, she had no phone. Neighbours gave her a blanket and slippers. These two incidents had not been reported to the police. Karen was currently still residing in her property and thought to be safe. Several attempts were made to contact Karen by phone but without success. CMHT advised that Karen was known to PCP, and they tried to conduct a telephone triage, but it was closed due to non-engagement. An urgent duty home visit required as requested by Operation Manager.

15.10.2020: Agency- Oxleas. Recorded contact: PCP screening tele-triage was referred by the Adult Early Intervention who had received a report from neighbours who were reported to be concerned about her wellbeing.

16.10.2020: Agency- Clarion Housing. Recorded contact: Recorded offline files (Tenancy Specialist) raised safeguarding alert to London Borough of Bromley for Karen.

16.10.2020: Agency: ASC. Recorded contact: Duty social worker made a call to Karen's' son Mark and recorded the visit. Karen gave an account of her experience of DA and her overall health and wellbeing. Mark said he and his siblings were estranged from Karen because of her behaviour. Mark stated that recently Karen has been having 'lots of MH problems' and although he didn't think Karen had had any formal MH diagnosis. He described Karen was demonstrating a lot of paranoia and anxiety behaviour's . For example, Mark said Karen had made a malicious threat to her neighbours, she had been imagining things that are not in existence or happening. Mark went on to say that he lives not too far from Karen, and he usually visits her every weekend but last week when he visited, Karen was not at home, but he later spoke to her on the phone. Mark said in terms of Karen managing her daily living activities, she was doing these 'reasonably well'. However, there have been times when Karen has left her house bare footed, without her keys and without her phone. Also, there were times when Karen had been away from her home for a long time but made her way back home independently. Lastly, Mark said recently he had called NHS MH crisis team for help, and he has been told, the next time Karen is having a MH meltdown, he should call 999 for an ambulance and once Karen is in hospital, Karen would be mentally assessed. An unannounced duty visit was made to Karen by the duty SW. Karen, herself and her flat presented clean (no signs of self-neglect). Karen expressed that she was an adult with no care and support. Karen responded and said: since the death of her husband back in 1999, 'things took a turn in her life', and after having had two children with her deceased husband, she got into a relationship with John in 2002. While she was in a relationship with John, he abused drugs and was physically and verbally abusive towards her. She stayed in a relationship with him because her MH was deteriorating, and she feared being alone. She later had a set of twins (Robert and Sarah) with him in 2001.

Karen said she became dependent on John for her care due to a car accident where John was the driver. The car accident happened while John was under the "influence of drugs", and the car accident left her paralysed for a couple of years. During this time, the abuse intensified

because John was in control of her care and money. Hence, her MH deteriorated even further. Karen stated that she was unable to adequately care for her two children as she worked as a security office.

One of the twins (Robert) went into care in September 2016, following Robert alleging that she physically assaulted him. The second twin (Sarah) went into care in February 2019 because Sarah was missing away from home for days. Sarah was claiming that she didn't want to come home because Karen was having different men at home every day; men were coming in and out of the family's home.

Karen said she was diagnosed with 'post-traumatic stress disorder' few years back (there are no agency records to confirm this). She was on medication, but she stopped taking the medication because it was making her have 'low mood'. Until August 2020, she left that she was coping mentally without having to take her medication but in August 2020, she attended a party hosted by a friend and she has known her for many years, but she believed she 'spiked her drink at the party because she is jealous of her'. Karen said she has never taken drugs before, hence, X 'spiking her drink, had negative impact on her MH'. She has started imagining things and feeling very anxious.

Karen expressed that she wants social services to assist her to replace her bed and furniture in her flat. Duty worker suggested Karen to go to a charity shop for the items and referring Karen to MH Team. Note: The interface between Initial Response Team and Oxleas MH Team, and the care pathway to follow, timeframe for assessment and intervention, or how a referral to Oxleas MH Team will need to be agreed and circulated to staff. Note: There was no record of any case discussion with a senior to determine the appropriate action following this duty unannounced visit to Karen. It was unclear whether there was any further management oversight of this concerns raised.

20.10.2020: Agency- GP. Recorded contact: Appointment requested.

21.10.2020: Agency GP. Recorded contact: Appointment with MH team arranged- Karen was notified via letter.

28.10.2020: Agency- Oxleas. Recorded contact: Primary care Plus telephone triage. This was remote due to covid but not recorded). On assessment, Karen said she was not aware of the reason for referral and although she stated she kept relapsing, she stated she was stable at the moment. It was suggested that she would benefit from engagement with MIND Recovery and the self-referral process was discussed with her.

30.10.2020: Agency GP. Recorded contact: Thios was a stress-related problem. The GP called Karen, following the letter dated 21.09.2020, and she said she wanted to be left alone, and cannot go back to work. Since she left work in 2018, she said she has PTSD, was trying but not able to work. She had long term MH issues, has four children and feels she failed bringing them up. Two of her children are doing well but the two younger ones got affected as she was in abusive DA situation. Karen said he did not give her any money and everyone is failing her. She lived alone for 2 years, was under MH team supervision and, a social worker saw her last week. A new Fit note was issued with a diagnosis of anxiety and depression. Karen agreed to go on medication.

09.11.2020: Agency: ASC. Recorded contact: An assessment document of 09.11.2020 was uploaded and indicated that Karen showed no sign of self- neglect/hoarding and she reiterated that she is an adult with no care and support needs. The worker concluded that Karen does not meet the eligibility criteria for support as her needs relating to MH (post-traumatic stress disorder) is not preventing her from achieving the set outcomes specified in the Care Act 2014. The assessment noted there was evidence that Karen was not coping with her mental wellbeing as she has been sleeping at the hallway and making threat to neighbours. A risk assessment should have been completed for the concerns raised. This is routine practice for any assessment or safeguarding concerns raised with ASC.

12.11.2020: Agency ASC. Recorded contact: A SW made various attempts to get in touch with Karen via phone calls and letter. There is no information about the outcome.

20.11.2020: Agency GP. Recorded contact: Failed encounter: A message was left on the answer machine when the GP tried to contact Karen.

20.11.2020: Agency ASC. Recorded contact: The SW sent a letter to Oxleas Bromley West Team and made calls to Karen's son (Mark) and daughter (Sarah). A message was left for Mark to contact worker or pass a message to Karen to contact worker. The SW noted the information from 09.11.2020. However, Karen requested a MH assessment because she had stopped taking her medication. She stated she had started 'imagining things and feeling very anxious'. A case discussion should have been held between worker and a senior to decide the appropriate follow-up action, as Oxleas MHT are delegated to carry out a Care Act assessment to determine the care and support needs on behalf of the local authority in view of her diagnosed MH issue (Post traumatic stress disorder). They also have delegated duties under safeguarding.

25.11.2020: Agency ASC. Recorded contact: The SW sent a letter to Karen. There was no recorded follow-up action for engaging Karen and getting an update regarding the referral to Oxleas MH Team. It is unclear whether the case was still allocated to SW although the closing summary was uploaded in document folder stating that no further action.

02.12.2020: Agency- Clarion Housing. Recorded contact: Karen called to talk about her account but they could not hear what she was saying because she was wearing a mask. She advised that she was calling about her last payment which was short. She said that she would be making up the shortfall on 10.12.2020.

02.12.2020: Agency GP. Recorded contact: Karen was seen in Seen in A and E.

02.12.2020: Agency Oxleas. Recorded contact: PCP teletriage (referral by GP). Karen stated, 'I have been abused for over 20 years and every time, I ask for assistance for the fear this person was putting in me. It's the systematic abuse that made me the way I am. I stopped taking my medication, but I am back on it'. Her social circumstances were noted, Karen was living in a maisonette housing association flat with 2 cats, was unemployed and in receipt of universal credit benefits. Karen reported she was not in a relationship at that time. Karen denied any suicidal thoughts or thoughts of self-harm saying, 'Only cowards will do that, I am mentally stressed, don't want to die and I want to be able to see my grandchildren'. Karen reported that her neighbours made fun of her. When Karen was previously triaged (October 2020), the plan was to self-refer to MIND IAPT. Karen did not feel confident enough to do this.

A plan was made to advise her GP to refer to IAPT on her behalf as she had a lack of confidence in accessing IAPT.

04.12.2020: Agency GP. Recorded contact: Karen was seen by MH Team

09.12.2020: Agency GP. Recorded contact: Karen was signposted by IAPT to counselling service.

20.12.2021: Agency Clarion House. Recorded contact: ASB: The complainant did not engage again. The matter was raised as a welfare concern and Karen was currently receiving support. Housing decided the case was to be closed.

20.01.2021: Agency Clarion House. Recorded contact: Re. account: Karen called needing bank details, and for DHP details. Payment and Rent statements were send to Karen.

03.02.2021: Agency GP. Recorded contact: Medication review with Karen.

09.02.2021: Agency GP. Recorded contact: Routine medical care.

12.02.2021: Agency GP. Recorded contact: Medication review with Karen.

24.02.2021: Agency Clarion House. Recorded contact: Karen called and wanted to check they had received the DHP payment and they confirmed the HB payment were received. Karen asked for them to send a rent statement to her email.

26.02.2021: Agency GP. Recorded contact: Email sent to GP surgery- MH concerns regarding anxiety, where Karen revealed stresses with memory, relationship breakdown with her children resulting in them going into care. Karen explained she was 'Constantly overthinking living in the past' and that 'Last September I threw away all my belongings and the neighbour called social services.' She revealed she had again stopped taking her proscribed medication.

12.03.2021: Agency GP. Recorded contact: Karen stated she had started her medication which meant she was coping better. She revealed she had poor sleep, missed the children and accepted she had a poor relationship with them. Karen was given general advice.

27.04.2021: Agency GP. Recorded contact: Karen reported, earache, headache and swollen eye to the NHS 111 service and was advised to attend an emergency dentist.

11.05.2021: Agency Clarion House. Recorded contact: Karen contacted housing requesting a bathroom upgrade. They noted on her file that she had MH issues and asked if her bath can be re-enamelled as it looks dirty. They telephoned to the repair departments to see if this can be done.

14.05.2021: Agency GP. Recorded contact: Karen reported ongoing stress related problems. She stated her accommodation was in poor condition, saying she suffers OCD, was crying a lot, was fearful of going out and was not functioning. She said her friend told her she was rude. She described financial issues. Karen also described thinking of past DA from an ex-partner. The MHT phoned her, rearranged her appointment and assessed no self-harm risk. She

revealed she had again stopped taking her proscribed medication. Karen was issued a Fit note for her stress related anxiety.

19.05.2021: Recorded contact: Karen attended Bromley Police Station to report an allegation of a non-recent (2019) sexual assault on her by her stepson, Richard (son of John). Richard had allegedly stayed over after they had both drank alcohol. Karen gave a confused account to police and did not recall the details of the incident. This caused a later conflict with her daughter who questioned whether Karen had been in a physical contact with Richard, who had given Sarah an account of that evening. Karen stated that since incident she blocked Richard, changed her mobile phone number and had not spoken to him. The investigation was closed as Karen did not wish to support any prosecution; and a statement was not taken due to Karen's vulnerabilities.

19.05.2021: Agency GP. Recorded contact: Seen by MH service.

21.05.2021: Agency ASC. Recorded contact: A police merlin report received and was passed for screening. Senior Care Manger / Social Worker, Initial Response Team advised sending the police merlin report to the MH Team as a referral. The report concerned a DA incident involving Sarah at her boyfriend's address.

24.05.2021: Agency ASC. Recorded contact: A police merlin report was sent to CMHT as a referral. Response / Outcome: No details about this police merlin report were recorded on case notes.

24.05.2021: Agency: Oxleas. Recorded contact: Following a police merlin report, Oxleas had telephone contact with Karen and discussed her broken relationship with her daughter. Karen was emotional and tearful and stated she has been a DA victim historically. Oxleas recommended she see the GP for a review. There was no further contact with Oxleas services.

13.07.2021: Agency GP. Recorded contact: Council tax exemption form completed.

16.07.2021: Agency GP. Recorded contact: Stress-related problem. History was recorded and the GP spoke to Karen regarding the recent police merlin. She spoke about problems with her house, needing a new bath. She confirmed she was attending the 'resilient class' run by MH and said group therapy was helping her. Karen advised her counsellor was helpful. Karen said she was taking her medication which was helping and would continue with the counselling and medication.

04.08.2021: Agency GP. Recorded contact: Routine medical care.

06.08.2021: Agency GP. Recorded contact: Routine medical care.

09.08.2021: Agency GP. Recorded contact: GP e-consult to GP practice: requesting CBT referral for Karen due to MH concerns- anxiety.

10.08.2021: Agency GP. Recorded contact: GP SMS text message sent to Karen, informing her that she could only be referred to CBT via Talk together Bromley. Karen's history was noted in detail.

28.10.2021: Agency- Clarion Housing. Recorded contact: Karen called in to query her balance and discuss a Mutual Exchange (MEX). They confirmed the balance and explained that arrears must be cleared before a MEX can go ahead. Karen requested a rent statement. One was sent.

19.11.2021: Agency GP. Recorded contact: A GP called and a message was left on Karen's answer machine.

22.11.2021: Agency GP. Recorded contact: Karen described she had had anxiety for 2 years since she had a grievance at work for harassment. She had developed panic attacks, which had started to escalate because of recent financial concerns ('don't have enough money live on'. 'Feel like going backward'). Karen described that she could not sleep, cannot enter the bath to bathe herself as she has flashbacks of drowning and she had contacted council to help make the change, so requested a letter from GP to the council for her acute health issue. Karen had counselling from Westeria for 24 weeks to help with anxiety and was trying to adopt techniques. A Fit Note document with a diagnosis of stress related anxiety and depression was issued.

22.11.2021: Agency Clarion. Recorded contact: Karen wanted to discuss arrears and welfare benefits and was transferred to the Customer Accounts Team for advice. Karen had arrears of £891.16 (UC payment received 19.11.21) and asked for a WBA appointment. She advises she was last referred before COVID. She thinks she in receipt of the wrong benefit. Karen described having MH issues and was being supported by her GP, was struggling financially and would like WBA to check her benefits and to advise if there is anything else she can claim. They agreed to refer her due to vulnerability.

01.12.2021: Agency GP. Recorded contact: GP reports that medication gradually improved symptoms, and Karen asked for support for the replacement of her bath for an electric shower, as she is unable to have a bath due to OCD, nausea and panic attacks Karen suffers with.

15.12.2021: Agency- Clarion Housing. Recorded contact: Housing rang Karen to say her welfare benefits advice appointment was delayed but would be contacted with another appointment. They noted that Karen sounded in poor health.

22.12.2021: Agency- Clarion Housing. Recorded contact: Housing spoke to Karen and she explained that she does not feel able to move home (she had depression, anxiety and since 2018 has suffered panic attacks). She described a number of challenges she was experiencing, including struggling to pay her energy bills.

17.01.2022: Agency GP. Recorded contact: An E-consultation was received at the practice detailing recurrent panic attacks, flashbacks of past experiences, and issues identified as a trigger for panic included: financial difficulties, going to or leaving work, leaving the house, attending social gatherings, meeting with friends and family, all which led to anxiety worsening. Srah was reported to be visiting her and she was getting support. Karen described no thoughts of self-harm or suicide. Kran had run out of medication and was requesting more to help with frequent panic attacks.

19.01.2022: Agency- Clarion Housing. Recorded contact: DHP was agreed and was to be paid for the full financial year until April 2022 at rate of £38.40 per week.

31.01.2022: Agency- GP. Recorded contact: Three attempts to contact Karen were listed as a failed encounter x 3 – voicemails were left.

02.02.2022: Agency ASC. Incident OT Duty took a call. Karen sounded frail and tearful on the telephoned and said she has OCD and her bathroom needed upgrading as her bath was tatty. Karen said her talking therapy had finished and she was not currently under CMHT.

08.02.2022: Agency GP. Recorded contact: E-consult was received at GP practice describing flashbacks to historical abuse.

09.02.2022: Agency GP. Recorded contact: Karen reported the previous ongoing challenges connected with finances, depression and anxiety. A Fit Note was issued for anxiety and shortness of breath and she was referred for occupational therapy.

10.02.2020: Agency ASC. Recorded contact: Adult Early Intervention made a referral to LBB OT Duty, Incident: The GP had referred for an electric shower to be installed and taking into consideration of Karen's history of anxiety, depression and panic attacks associated with dyspnoea and previous history of DA and flashbacks of her being drowned, ASC assessed it was unlikely that any equipment will provide any suitable solution. Bromley Healthcare CIC forwarded this to the occupational therapy service to follow up.

11.02.2022: Agency- Bromley Healthcare. Recorded contact: Email received confirming Karen was already known to LBB and they would follow up.

25.02.2022: Agency: ASC. Recorded contact: Case allocated OT.

01.03.2022: Agency GP. Recorded contact: SMS text message sent to Karen ‘Dear Karen, We have received a request from Bromley Well for a supporting letter from the GP for your PIP application’.

03.03.2020: Agency: ASC- TP(OT) OT Client Contact - Outgoing call. Recorded contact: OT was unable to reach and speak to Karen, so a voice message was left for her to contact LBB, which she did.

04.03.2022: Agency: ASC TP (OT). Recorded contact: Outgoing call to client and completed the telephone assessment and planned a home visit on 07.03.2022 at 12:30 to look at bath access.

07.03.2022: Agency: ASC. Recorded contact: ASC visited Karen to complete an assessment. OT posted the report to Karen. Karen advised OT that she has a nervous breakdown and got rid of her mattress and is sleeping on cushions she found. She said she can't sleep, and it hurts her back. She also said she did not have heating on due to the cost and indicated she had contacted the citizen advice bureau to try and get a mattress and asked OT to speak with them. OT explained this was not in her remit. Karen asked for a profiling bed. In the bathroom Karen sat on the edge of the bath, there was not space for a perch stool as bathroom door

opened inwards. Karen asked for a wall mounted shower. OT responded and stated she would discuss the above with her manager as Clarion may be able to provide a wall hung shower.

10.03.2022: Agency ASC. Recorded contact: OT Equipment - Outgoing call. OT left a voicemail message to Karen requesting either an email or a call back.

14.03.2022: Agency ASC. Recorded contact: BP Business Support Assistant. OT Client Contact - OT Referral /Waiting list letter. Occupational Therapy Services.

21.03.2022: Agency: ASC. Recorded contact: OT Client Contact - Outgoing call. A voicemail was received from Karen, stating everything was fine, and she would call the next day.

22.03.2022: Agency ASC. Recorded contact- Outgoing, voicemail received from Karen and then OT left a voicemail message advising she was calling to see how the equipment was and whether an OT home visit was needed to check the sizing of the chair.

23.03.2022: Agency ASC. Recorded contact: OT Case Closure- incoming call from Karen. She advised that she has the bed and there is enough space in her room.

24.03.2022: Agency GP. Recorded contact: Karen was requesting medication for breathing and anxiety. Karen explained her breathing issues only come on when she is in situations that make her anxious (e.g. phone rings as she owes people money, or when she receives letters). Karen reported she had not called talking therapy, as she did not want to be her head or think about these things. Karen said she had no threats of self-harm or suicide or noo auditory or visual hallucinations.

12.04.2022: Agency Clarion Housing. Recorded contact: Karen called to check her balance.

19.04.2022: Agency GP- Karen called to obtain a council tax exemption.

21.04.2022: Agency Clarion Housing. Recorded contact: Completed Universal Credit verification.

25.04.2022: Agency ASC. Recorded contact: OT Client Contact – recorded a telephone conversation with Karen reporting that the bed is not good enough for her and she wanted someone to collect the bed as her children would buy her a new bed. She said it made her feel like she's in hospital or prison and was not good for her MH.

25.04.2022: Agency Bromley Healthcare CIC. Recorded contact: Self-referral into TtB[53] received.

06.05.2022: Agency Bromley Healthcare CIC. Recorded contact: Initial assessment completed. TtB service.

07.05.2022: Agency GP. Recorded contact: Karen was seen in Lewisham Hospital A and E- with MH concerns. She had a review with MH Liaison Team who advised a medication increase and for her GP to review BP.

[53] Talk Together Bromley.

10.05.2022: Agency GP. Recorded contact: Karen was seen in hospital A and E. There was no discharge letter on file but a letter to GP from Talk together advising Karen's low mood and signposted to her to counselling.

10.05.2022: Agency Bromley Healthcare CIC. Recorded contact: Staff member (TtB) took case to supervision with a Senior staff member. The plan was to signpost to longer-term counselling (for continued support with primary goal) and Bromley Well (for financial support). Staff agreed to follow-up with Karen via telephone to check if she had engaged with the plan.

12.05.2022: Agency GP. Recorded contact: Routine medical blood pressure monitoring which noted Karen was not sleeping.

19.05.2022: Agency GP. Recorded contact: Karen was worried not getting enough sleep. Karen says she need to talk to GP, she did not say why, advised her to make appointment.

20.05.2022: Agency GP. Recorded contact: Age related issues were explored with Karen.

May 2022: Agency LAS. Recorded contact: 999 Call Log (CAD 1290). Ambulance attended at Karen's address who had been found by her son that morning. Recognition of life extinct was recorded at 08:52. It is further documented that a suicide note was found on a memo pad in the kitchen.

Section 14 - Analysis

14.1 The statutory guidance clarifies the position to take on suicides where coercive control is known, for example where a victim took their own life, and the circumstances give rise for concern: for example, if it emerges that there was coercive and controlling behaviour in the relationship then a review should be undertaken. The initial Bromley panel considered that recent DA was not present. However, the history of previous DA was evident dating back over 20 years.

14.2 The following specific agency analysis addresses the TOR and the key lines of inquiry within them. It is also where examples of good practice are highlighted. It is presented on a agency by agency format to be clear on the available information.

14.3.1 Agency Bromley Healthcare CIC: Karen was known to Talk Together Bromley (TtB). This analysis focussed on the 5 weeks prior to her death as contact before this time is considered minimal. Karen had a history of recurrent depressive disorder. She self-referred to the service at the end of April 2022 on the advice of her GP.

14.3.2 On 06.05.2022 (09.30), an initial assessment of Karen was undertaken. The purpose of the initial assessment is to identify if someone is suitable for psychological intervention rather than provide a full clinical assessment. It is considered a screening tool to identify the most appropriate pathway for the Karen. Following the assessment being carried out the staff member took the case to Step 2 triage supervision on the same day. Step 2 supervision is to discuss Karens that require low intensity treatment. Due to the complexity of the case, the supervisor advised the staff member to take the assessment to a Step 3 supervisor. Step 3

supervision is provided to discuss Karens that require a high intensity treatment. This decision was made due to the presentation not being managed via the Step 2 team. In conclusion, the initial assessment Karen's scores indicating severe symptoms of anxiety and low mood and a GAD7 score of 11, indicating moderate symptoms of anxiety. She was very clear that she was not experiencing any thoughts of wanting to harm herself or end her life and presented with no risk to herself or others at the time of the telephone appointment. A treatment plan was agreed that Karen stated she was happy with. It was agreed that the therapist would contact Karen in one and half weeks to see how she was but sadly she had taken her own life when she was called.

14.3.3 On 07.05.2022, it is recorded on the portal (that was not visible at the time of the immediate investigation) that Karen attended University Hospital Lewisham. She presented with being unable to sleep for 1 month, she felt as though she was falling from a height associated with shortness of breath and thoughts of not moving forward but backward and since the 06.05.2022, she felt like shaving all her hair off as she didn't like what she saw. She denied any suicidal ideation but was scared of what may happen. She advised that she hadn't taken her medication for her anxiety or hypertension for six weeks. Her blood pressure was high at time of arrival to the emergency department and so was given medication and MH advice. She was given a diagnosis of anxiety disorder. She was prescribed medication for 3 nights to help her sleep, a discharge summary was to be sent to her GP requesting that the GP increase the dose of the sertraline. The staff member took Karen's case to supervision with a Senior staff member on 10.05.2022. A plan was jointly agreed to signpost Karen for longer-term counselling (for continued support with her primary goal) and Bromley Well (for financial support). The primary goal for Karen was to re-access counselling from Westmeria as she found this beneficial previously, however she was unable to financially afford to pay for the assessment. It is usual practice for TtB to signpost service users to Westmeria for Karens that require longer term counselling as their service only provides short term counselling. Karen was advised to discuss further with Westmeria to understand if there are any options to support with her financial situation to enable her to access the service.

During the review, Bromley Healthcare CIC identified that the service provided an appropriate level of support and care for Karen, and at times demonstrated exemplary practice.

14.4.1 MPS: There were a number of incidents reported to police, before and during the scoping period were Karen was identified as a vulnerable DA victim (by two separate perpetrators) and also as someone coming to notice for MH issues. Many of the incidents involved Karen declining to support prosecutions, or officers having insufficient evidence to proceed.

14.4.2 In respect of the DA incident on 06.08. 2008, John was appropriately charged and prosecuted when Karen supported the prosecution. John was charged with common assault, convicted and sentenced to 88 days imprisonment.

14.4.3 On 11.09.2009, after the non-molestation order (NMO) was appropriately granted. John was charged with breach of non-molestation order upon Crown Prosecution Service (CPS) advice.

14.4.4 On 20.09.2012, following a dispute over rent with her son(s), best practice was followed with a police merlin referral completed for the children. Police then received a sanctuary referral for Karen from her social worker as Karen was not happy with her security. There is no information on the report to confirm whether this assessment was carried out.

14.4.5 On 30.09.2009, whilst investigating her son Robert as a missing person, officers failed to take account of the NMO conditions, which prevented contact. This decision would have impacted Karen, who saw that the NMO being used to protect her, was lacking consistency in how the conditions were implemented.

14.4.6 In respect of the DA incident on 23.08. 2018, between Karen and Chris, the investigating officer considered a Domestic Violence Protection Notice (DVPN) and the Domestic Violence Disclosure Scheme (DVDS) otherwise known as Clare's Law. Both were disregarded citing this was due to the fact that Chris and Karen no longer lived together. Despite this, both could still have been implemented. A MARAC referral was not considered, and the report does not clarify if Karen was referred to an Independent Domestic Violence Advisor (IDVA). Karen was offered safeguarding advice on non-molestation orders. Minimum 5-year checks only searched for incidents between Chris and Karen, so it did not include Karen's previous history of DA. Had it done, Karen may have been identified as a repeat or vulnerable victim; and provided with an enhanced level of service and support which met her individual needs.

14.4.7 Following Karen's report on 19.05.2021 about her stepson Richard assaulting her, the investigation was closed as Karen did not wish to support prosecution; and it is noted that a statement was not taken due to Karen's vulnerabilities. However, DASH was completed and graded as medium risk. There was a lack of professional curiosity and supervision, specifically as this incident suggested a potential sexual assault. However, officers applied best practice and followed policies, even showing professional judgement after a contact in 2021, by completing a police merlin ACN.

14.4.8 Karen had repeatedly come to the attention of the Police who liaised with various partners. There are referrals to children's social work services (but nothing to suggest referrals were made to adult social work services). A number of police merlin referrals were made for the children. The panel noted positively the number of times Karen, and her family came to Police attention and the risk assessment processes which were done, however, there was no holistic long-term plan put in place and a multi-agency approach was absent.

14.4.9 Police do not always have access to the full history of police incidents when they attend a call-out. They are responding to the moment and have to make dynamic decisions. Warning markers are placed on addresses for violence risks such as drugs, firearms etc. If children are present there is a requirement for officers to complete a police merlin referral. However, consent would be required to flag a property in terms of re-victimisation, and also the victim may not disclose previous abuse at the time. Overall, Karen was referred to appropriate agencies when risk or welfare concerns were raised.

14.4.10 Except for one incident when Karen was reported by a neighbour behaving erratically, there was no evidence that any other anonymous or 3rd party reports were made. A number of changes have been made in the last couple of years to promote anonymous

reporting and 3rd party reporting to police, to allow information to be captured to enable assessments to take place.

14.4.11 There is also no information to suggest that Karen referred to suicide in any of her conversations with police. The MPS DA policy requires the DASH assessment to be completed in all such investigations, this includes a question specifically about suicide.

14.4.12 Since the review commenced, the Commissioner has launched a 'New Met for London' Plan that includes strengthening local public protection, ensuring officers and staff have the capacity, knowledge and skills to give victims the support they deserve and recognise their vulnerabilities. Historically, criminal justice outcomes for serious sexual offences are incredibly poor. Operation Soteria is a Home Office funded programme led by the NPCC, aimed at improving investigations and outcomes for victims. The MPS have from July 2023 signed up to the new National Operating Model (NOM) for the investigation of rape and serious sexual offence cases.

14.4.13 Demonstrating 'strategic' best practice, the MPS website has a link for members of the public to report DA. There is no reference specifically to anonymous reporting, but the online reporting page does provide a link to advice on hiding an internet search history. The MPS uses College of Policing Authorised Professional Practice (APP) as the primary source for current policy on DA. The APP on DA has been developed by consolidating and updating National Police Chiefs Council (NPCC) Guidance on investigating DA. It responds to a number of developments in the field of DA, in particular a new Home Office definition of domestic violence and abuse.

14.5.1 BLG Mind: BLG Mind actively supported Karen for a total of 12 months (across four instances) prior to her death. The major themes in Karen's interactions with BLG Mind services were identified, and are consistent with those identified by other agencies:

- Historic DA both to herself and, connected with her children. Karen mentioned historic abuse on a total of nine occasions (it is noted that these had all been appropriately investigated by police).
- Acute and recurrent poverty – Karen repeatedly states that she was struggling financially and was actively seeking support for benefits, debt and housing issues. From notes it is clear that she was dependent on foodbanks and often structured her days around access to these. In each instance when she first connected with Bromley Well it was initially a self-referral for support with benefits, employment, debt or housing.
- Inability to access secondary care / counselling services - poverty appears to have been an obstacle to her accessing services. She repeatedly reported that she could not access low-cost counselling as she couldn't afford it and she was also unable to afford the GP fee for a supporting letter (£19) in the last weeks of her life which was an obstacle to her being awarded appropriate benefits. When Karen accessed counselling in November 2021, she reported to BLG Mind staff that it was useful to her. There is a question as to why it took so long for her to access this and, once she had accessed it, how long she was able to engage.

14.5.2 There were opportunities missed in the care provided to Karen through BLG Mind, to summarise:

- Inadequate assessment and support was provided regarding the current impact of historic DA. The provision of this specialised support would fall outside the remit of the services that Karen was accessing through BLG Mind but Karen could have been supported to access relevant external services.
- There was a missed opportunity on 11.08.2021 to explore a safeguarding concern further after disclosure of self-neglect made to GP.
- During the time that Karen was supported by BLG Mind services, she was signposted to a number of agencies, groups and activities. These signposts were not followed up so it is hard to say whether or not she accessed external support and if so, how long for or what the efficacy of that may have been. This is indicative of a wider question as to the effectiveness of signposting as a support tool.

14.5.3 In summary, there appeared to be issues around a whole system approach to assessing risk based on historic trauma. So often risk assessment focuses on direct and immediate real- time risk rather than taking a more trauma informed approach. This could be a question of training and awareness as well as changing and adapting existing tools.

14.5.4 **Good practice** was identified: Karen received a high level of skilled support from the benefits caseworker regarding the mandatory reconsideration of her PIP application. Karen also shared positive feedback about the support she received through both Bromley Well MH and Wellbeing Pathway (16.04.2019) and Recovery Works (17.11.21).

14.6.1 **CSC:** Karen's youngest children, Robert and Sarah were known to CSC (the two eldest were not) and through this they became involved with Karen. Statutory children's services had greater involvement with Karen when the children were much younger and lived in her care.

14.6.2 Having moved to Bromley from Southwark in 2012, there were CIN planning meetings from the Local Authority between December 2012 and June 2013. Bromley children's services were initially contacted when Karen disclosed to school staff at her children's primary school that she had been abused by a former partner. Due to her low mood and having been a victim of previous DA, Karen was signposted to Stepping Stones MH Services. She was separated from John at that time and advised she was going to stop the children from seeing him. She reported that John had intercepted the children on their way home from school, but they denied contact with him.

14.6.3 A NMO had been effective in 2009. She stated that the abuse had restarted in 2012. The family were re-referred in November 2012 after she disclosed she had nearly set fire to the flat by accident and said she was struggling to cope with the children's care due to her low mood. Safeguarding was appropriately considered. The children were seen the same day, and the social worker made a direct referral to Bromley Women's aid and also contacted the liaison intake team regarding following up with a MH assessment for Karen.

14.6.4 Sarah and Robert were spoken to although Sarah in particular was reluctant to speak to the social worker. Karen said she was no longer in contact with John even though it was evident he had collected the children from school.

14.6.5 Karen described that David, the oldest sibling, was still living in the family home and was statedly abusive to her (no evidence has been found to support this from CSC or other agency records). David was assessed to be a protective factor although he was in a full-time apprenticeship and not able to care for the children independently. Karen was signposted to Stepping Stones MH services in her own right and the Freedom Programme in relation to the allegations of DA. Karen showed motivation to engage, also demonstrated some insight into relationships at home and during this period asked Mark to leave the family home as she felt his behaviour was abusive towards her.

14.6.6 In March 2015, Robert approached Youth Justice offices saying he wished to be brought into Local Authority care. Karen gave consent for him to be accommodated, which LAC considered 'very unusual'. At that time, Sarah informed them that Robert had been sleeping in a cupboard. Following a duty visit on 11.03.2015, Karen seemed to blame Robert for her health issues, which contrasted with apportioning blame towards John. The workers felt Robert would be at risk of physical chastisement if he were returned to her care.

14.6.7. John was approached to see if he was a suitable carer, but the investigation did not delve into historic harm which could have identified DA and the previous NMO and there was no challenge to John even though Robert requested placement with him. He was placed with John on 26.07.15 but a few weeks later (14.08.2015), Karen and Robert presented at A&E and Robert asked for injuries by John to be checked. Robert then returned to live with Karen. A child protection conference should have been reopened at this time due to significant harm and unstable care. This may have identified ongoing risks and vulnerabilities which could have been shared more widely.

14.6.8 Initially, Robert was supported to remain in Karen's care, although the local authority initiated a child protection investigation, but Robert retracted his allegation. He was referred for a mentor and the case was closed in November 2015 with a forwarding referral for family support from Bromley Children's Project. The referrer also requested support for Karen regarding her being a victim of previous DA. This is good practice.

14.6.9. In March 2016, Robert asked to be accommodated again after an altercation with Karen. A joint strategy meeting was held but the local authority seemed reluctant to accommodate Robert. Robert continued to meet with social work staff daily and reported that he had in fact slept outside and on night buses and returned to his father at one stage seeking refuge. He was advised to seek support at a police station if he had nowhere else to go. For a child, this would have been a challenging time and would suggest that he was not offered appropriate care. Timescales for an assessment visit were not adhered to, given the significant delay in arranging the visit, which did not take place until July 2016. Robert was reluctant to engage, and Karen later reported him missing on 23.08.2016. Robert made his own arrangements to stay with a friend. This slow response to Robert's needs left him at further risk of harm.

14.6.10 He moved to a friend's house in August 2016 and was visited by a social worker there and disclosed significant physical abuse by Karen. Agency contact with Police suggested strongly that he needed to be accommodated and would be subject to police protection (he was 15 at this point). A joint strategy meeting was held but the local authority still seemed reluctant to accommodate him. He was advised to seek support at a police station if he had nowhere else to go. This was a slow response to Robert's needs that ultimately left him at further risk of harm. On 30.08.2016, Robert was taken into foster placement and received 3 stable years of fostering.

14.6.11 Karen's actions do not appear to have been referred for consideration although CSC considered that Karen's MH difficulties prohibited the relationship being fully repaired.

14.6.12. It appears from the files that some of the issues causing family dysfunction were attributed to Robert and there was less focus on the contributory factors in Karen's care to the family breakdown. The intervention centred on the decision to accommodate and once this happened and Robert settled in placement there was less attention given to repair work on the relationship with Karen or the potential harm to Sarah.

14.6.13 Sarah's assessment showed that CSC had no significant concerns for her. Sarah was assessed in August 2015, and it was determined that she was able to remain in her mother's care. Her case was closed soon afterwards. Sarah was accommodated in February 2019 at her request rather than as a result of social work assessment and intervention. She re-contacted the local authority in December of 2018 saying she was living with her boyfriend and his mum because her mother had been emotionally abusive after she disclosed a historic sexual assault. Whilst unexplored in this report, she offered evidence of historic sexual assault of which Karen did not believe. This is not documented elsewhere but could indicate one of the reasons for Karen's relationship breakdown with her daughter. It was several weeks until she was offered a placement, but Sarah did settle and benefit from being in care and eventually moved into her own accommodation in October 2021.

14.6.14 The care planning for both children appears to be reactive to family crisis rather than proactive and demonstrating professional curiosity. Robert and Sarah were exposed to their mother's mental ill health as well as John's abusive and controlling behaviour for most of their childhood. Both children advocated for themselves to come into care, and both received a slow response to their needs.

14.6.15 Social care should have remained involved following Robert's initial period of care to monitor progress given the allegations of physical harm and disruption in care arrangement. The assessment of both parents' capacity to care was superficial and the incident of physical abuse disclosed by Robert by his mother should have triggered a child protection pathway. This would have provided a stronger framework of multi-agency support that would have met at regular intervals to review progress and engagement. Similarly, when Robert was re accommodated Sarah should have been subject to greater monitoring and review to ensure she was safe at home. The delays outlined in both children seeking support and being accommodated are below the standards set out in the Local Authority's Road to Excellence document dated 2017 in response to a very poor Ofsted inspection in 2016.

14.6.16 It is noted that procedures were not followed for children returning from care. There are no records of discussion between adult and children's social care, even though in 2012 there was liaison with Stepping Stones around the Child in Need planning. Karen advised at this point she was going to engage.

14.6.17 CSC ensured that support was put in place for the children via CAMHS but both children were quite reluctant to access support with a MH tag. This should have been an opportunity for further referral into ASC.

14.6.18 Between 2015-2016, Bromley Children's Services were rated inadequate by OFSTED, leading to a significant improvement journey. CLW advised that significant progress has since been made, with greater resources available.

14.6.19 **Good practice identified:** Appropriate referrals were made to other services when the children came to notice. Both Robert and Sarah people have benefitted from some positive experiences in care. They both had some stability in their foster placements and have successfully transitioned into their own accommodation. They have received good support from their young person's advisor who reached out to them following their mother's death to offer emotional support.

14.7.1 **LBB ASC:** A review of Karen's social care record was undertaken, and the record indicates that ASC's involvement with Karen's lasted for 10 years (i.e., between Sept 2012 and March 2022). Within 65 case notes there were 29 ASC contacts and 13 OT contacts with Karen. 11 documents were uploaded on LAS and there is only one initial assessment completed on 09.11.2020. LBB ASC had been involved in assessing her care and support needs under the Care Act 2014 and providing support to help Karen live independently in her own home.

14.7.2 LBB ACS appropriately referred to relevant supporting agencies, on each occasion they interacted with Karen. LBB's response was compliant with the policy and practice; however, a full community care needs assessment (at the time prior to Care Act 2014) should have been offered and completed in 2012 to identify Karen's eligibility for support with her MH and living situation. Information and advice regarding local resources available should have been given for Karen to access support with DA or childcare issues.

14.7.3 A singular incident revealed that ASC did hold some information about Karen. A police merlin report of 04.09.2020 was found in the document folder on LAS which highlighted **7 different domestic violence incidents** over a period from 18.03.2018-04.09.2020 in which Karen and her daughter, Sarah, her son Robert were subjects/ victims of domestic violence. Police indicated that it was a safeguarding issue, so a referral should be made to LBB ASC.

14.7.4 Persons causing harm in these domestic violence incidents were found to be:

- Karen to her son
- Karen's ex-partner Chris (to her and her children)

14.7.5 Notification of Pre-Assessment Checklist from the Police indicated that Karen was in distress (crying and shouting) & under stress. Karen was said to be struggling emotionally and

mentally. Karen wanted to get help from MH service, her non-engagement was due to Covid lockdown. Karen agreed to contact her GP for help. It is clear that Karen did not follow up on this contact.

14.7.6 LBB ACS did not seem to have or hold any information which may have contributed to the death of Karen. There was no decision made or action taken or not taken regarding Karen's situation in May 2022. However, an OT was involved in assessing Karen's living environment and offering practical support around maintaining her independence. OT involvement lasted from 02.02.2022 to 25.04.2022.

14.8.1 **Primary Care GP:** The analysis focusses on significant chronological entries within Karen's records from her residential area and her full Medical Record following registration at a Medical Practice which was from Jan/ Feb 2012 onwards.

14.8.2 Throughout the chronology, it is clear that Karen was prescribed medication for depression and anxiety, and she would pick and choose when to take them – the services and responses were available, but she did not always engage. (It was noted by the panel that people suffering with MH notoriously do not take medication for periods of time).

14.8.3 Karen had multiple care needs not just around MH but ongoing medical, poverty, vulnerabilities, and psychological concerns. These also linked into social and economic needs. GP services appropriately referred Karen for onward MH triage services. Karen was also appropriately medicated, however she continued to be selective about taking medication. The mitigating circumstances/pressures surrounding Karen's' life could have caused lapses in her compliance with medication.

14.8.4 Systems and services have changed dramatically with GP services since Karen's registration with her GP, but the analysis identified some learning around onward referral and more signposting/support.

14.8.5 The review highlighted that Karen had long term trauma and PTSD (15 years). She was receiving food vouchers and had looked for a refuge. The DA which Karen suffered was historical and wasn't therefore discussed at MARAC. There was, however, ongoing harassment and Karen described that she found it hard to live in her own home. It seems that Karen could well have fallen through the gaps of DASH assessments.

14.8.1At BCWA, women are asked if they have been in touch with abusive perpetrators within the last 3-5 days – there could be some potential changes made to eligibilities. Karen was trying to sort herself out but on occasion she became overwhelmed.

14.8.6 The 10minute physical consulatation slot at Doctor appointments should result in appropriate signposting to services, however, although routine enquiry is embedded, historical DA is not part of this routine enquiry and support may not be readily signposted at this point. Dependent on the borough, not all local services will have funding and long-term risks may not be captured. In terms of provision, this is an evolving area – very few providers within Bromley can deliver this specialist counselling. It is also noted that that counselling and immediate crisis do not fall together, therefore creating a potential gap in overall service provision.

14.8.7 Karen was reviewed on a regular basis in Primary Care and there were a series of declarations regarding DA from 2005 until the entries in 2022. Her earlier entries from between 2005- 2011, described current DA to include physical abuse, attending court in 2011 for a Restraining Order and spending time in a Refuge in 2011. The medical entries describe that she was placed in 'sub-standard' accommodation since 2009 following an urgent placement needed due to DA. She described symptoms of Post-Traumatic Stress Disorder (PTSD) with flashbacks related to previous DA. She was referred to MH Services and was offered counselling and Cognitive Behavioural Therapy (CBT).

14.8.8 Karen also described episodes of poverty with being unable to pay the rent and be in arrears for a year. She was in receipt of Universal Credit and became unemployed, requesting support with a foodbank as she had minimal food to eat[54].

14.8.9 Karen was signposted for support to Citizens Advice Bureau and was seen for regular review of her Physical and MH in Primary Care. There were also relevant entries that outlined Child Protection reports being requested[55].

14.8.10 A police merlin report was also received to Primary Care and discussed with Karen on 16.07.2021, which mentions a 'resilient' class that Karen attended, led by MH, and accessing a counsellor. There may have been opportunities to signpost Karen to specific support services for DA and also for survivors of DA during the timeframe of the review[56].

14.8.11 Good practice was identified: Karen was offered regular review of her mental and physical health by the General Practice team and was followed up appropriately. She was also regularly offered counselling and was signposted to 'TalkTogether' Bromley. Karen also received a course of long-term counselling provided by Westmeria Counselling services.

14.9.1 **Oxleas:** Karen disclosed that she was a victim of DA at several points during her engagement with Oxleas MH services. This was initially disclosed on 13.09.2012 when she reported that the father of her twins physically abused her and the eldest children from a previous relationship. This person also abused alcohol and drugs in the presence of the children.

14.9.2 In a fuller assessment completed the day after (14.09.2012), Karen gave more details around the DA which included being burnt with cigarettes, physical violence and setting a rottweiler dog onto her and the children. Karen also disclosed that John also used drugs and referred to him smoking crack cocaine in the house and in front of the children[57]. Karen and John were separated, and custody of the children was determined by the courts and Karen had access, but John was granted visitation rights, these occurred "several times a year" and caused Karen apparent fear and distress. She reported in the assessment that she has lived in lots of different addresses to get away from him before residing in Bromley.

[54] Source: GP entries dated 05.11.2016, 05.06.2017, 07.10.2021 on the chronology.
[55] Source: GP entries dated 20.11.2012, 24.03.2015, 05.08.2016 on the chronology.
[56] Source: GP entries dated 27.01.2012 06.09.2012, 08.12.2018, 30.10.2020, 26.02.2021, 14.05.2021 on the chronology.
[57] There was no other evidence provided of these claims

14.9.3 There was no clear planning detailed from the assessment, but an MDT discussion was arranged, an outpatient appointment was planned with the Liaison and Intake Team to refer onto appropriate services after the outpatient appointment and liaison with Bromley Social Services and possibly Southwark (as previous residence). No direct referral into local authority and/or safeguarding alert was raised at that point to consider DA.

14.9.4 On 17.09.2012 a multidisciplinary discussion confirmed the need to be seen by a doctor from the Liaison and Intake Team. This was booked for 22.10.2012. On 22.10.2012 an outpatient appointment was completed, and care plans agreed. These were to provide psychoeducation (in the form of leaflets) on life events and stress, common thinking distortions in depression and bereavement and medication and the side effects. Also, to commence medication (Citalopram), complete blood tests and to be referred to the Short-Term Intervention Team for a 6 week follow up. At this point, no plan or support had been offered or considered to acknowledge DA as a contributory factor in Karen`s MH.

14.9.5 On 07.11.2012, Children and Family Social Services called to raise concerns that Karen was not coping and requested an urgent review of her MH. A telephone call was made to Karen from the Liaison and Intake Team and MS reported heightened fears and anxiety that her ex-partner (John) had been knocking on her door at night and this had affected sleep and increased her anxiety and was in the context of previous DA and John finding out where she lived. Following discussion with Children and family Social Services, they were advised to call an ambulance for MH support if needed (at the planned home visit). This advice should not have been recommended and Oxleas MH services should have proactively engaged at this point due to MH concerns. This was also an opportunity to consider wider social and DA issues with the right teams i.e., local authority social care.

14.9.6 On the 28.11.2012, an invite was made for the Liaison and Intake Team to attend a CIN meeting planned for the 4.12.2012 but Oxleas have no record that representation was offered. This was another opportunity to consider wider social and DA issues with the right teams i.e., local authority social care.

14.9.7 On the 24.01.2013, Bromley social services safeguarding, and care planning children's team reported concerns for both Karen and the children and requested a joint visit to assess. This was arranged for the 12.02.2013. Following this joint visit, a core assessment and risk assessment was completed that highlighted the history of DA and recorded the risk as historical and that not apparent within the last 6/12 (as per risk assessment template).

14.9.8 A joint home visit was completed and risk to self was assessed as low and to others as moderate, as children were open to social services. Plans were agreed to refer to Short Term Intervention Team, review medication and that social care would address children concerns and Karen's practical support needs. This plan is evidence of a siloed approach to health and social care that was apparent at the time of these interventions and can give rationale to issues such as DA, that was not identified as a direct component of Karen`s MH, not being addressed at this point. There is an apparent focus on the wellbeing of the children as part of the family network, but no connection made to the DA as a contributory risk factor.

14.9.9 On 14.02.2013 a referral was made to the Short-Term Intervention Team (SIT) and a care coordinator was allocated, and initial contact / assessment was completed. This

assessment identified trauma from previous DA and a referral for psychological treatment was considered, this referral was sent for screening by the psychology team but deferred pending allocation of a care coordinator. A care coordinator (social worker) was allocated and although referred to psychological therapies (19.03.2013) this does not appear to have been actioned by the care coordinator (as nil further referral is evident).

14.9.10 It appears that the intention to refer to psychological therapies was to be made following discussion with Karen. This was side-tracked by a focus on the SW CIN plan, Karen's intention to attend counselling via women's aid and her focus being predominantly on housing. Counselling via Womens aid would have been suitable had Karen engaged at this time. Whilst the IMR authors reflection that this was a missed opportunity. Karen's inconstant engagement and altered priorities throughout this period (minimising her symptoms) may have led the CCO to consider her needs differently.

14.9.11 19.03.2013: Assessed face to face (Oxleas) which is an in-depth assessment considering all aspects of social needs and MH needs and agreed psychological intervention. Referral made and accepted on 21.03.2013, and she was put onto cancelation list. An appointment was made for the psychologist on 22.04.2013, for the 09.05.2013 however Karen cancelled. The next appointment on 27.06.2013 was cancelled as the Psychologist was unwell. This appears to have been repeated on 13.09.2013, and another appointment was agreed on 05.12.2013, which took place.

14.9.12 Notes indicate that for Karen 'risk was rated as low'. Her presentation was quite insightful, she stated 'she is in a good relationship with herself, more compassionate with self and taking control of her life'. Karen was happy to be discharged back to her GP and is aware that she could be re-referred in the future if necessary. Karen was content to be discharged to her GP. Due to Karen's' perception of her MH at this time, the need for psychological intervention may have been considered unnecessary.

14.9.13 There was continued engagement with CSO throughout this period, who liaised with CSC. This included home visits. This Oxleas offer was of an excepted standard. Karen was well supported by CSC in partnership with the CCO during this time, and there was consistency of care provision and Karen was fully engaged.

14.9.14 A home visit by the CCO was carried out on 26.06.2013, and it was found that Karen's MH and home and social stability had improved. Children and Social Services Team plan was to close the case as the family were stable.

14.9.15 Karen attended for a MH review on 29.07.2013 and continued to report and identify needs relating to DA, she asked for therapy relating to past trauma of DA and Karen was signposted to Bromley Women's Aid and Women and Girls' network for 1-1 counselling, Karen was happy to self-refer.

14.9.16 Karen attended for a MH review on 09.09.2013 and confirmed intervention from Women's Aid on the 13.09.2013. The next face to face appointment was on 21.11.2013 and Karen reported that she had discontinued 1-1 counselling with Women`s Aid due to it reminding her of feeling unwell and wanted to move forward. An outpatient appointment on 05.12.2013 confirmed her discharge from Short-Term Intervention Team, but there was no

direct discussion re DA although CBT was discussed, and she was advised to self-refer via her GP or IAPT. This is accepted practice for a service user to empower them to reach out for support that they may want or need.

14.9.17 There is a significant period between 2013-2020 where Karen neither sought nor obtained MH support. Whilst there is information within the other agency analysis that Karen engaged GP, ASC and CSC services, it is clear from records that when specifically asked, Karen minimised her care needs and instead focused on practical support for housing and her children.

14.9.18 Karen contacted Oxleas (crisis services) crisis line (13.09.2020) for advice, she reported that she had stopped her anti-depressant more than 1 year ago, she had previous anxiety and panic attacks and felt that she needed CBT or counselling – this was not made clear what for. Karen also requested support for budgeting and bills which caused increased anxiety. The plan from crisis services was to refer to GP to discuss medication, self-refer to IAPT for counselling, and to contact crisis services if the need arises. This was an opportunity to refer into community MH services in the context of MH history and the need for MH and social care support.

14.9.19 On 15.10.2020, a referral was received into the MH hub from adult early intervention after a neighbour reported that they were concerned for Karen's wellbeing due to apparent bizarre behaviours. An assessment was completed (28.10.2020) and Karen reported a relapse in her MH and talked about her intelligence being manipulated, low mood, constant tiredness and referred to social issues regarding her children and the custody issues between herself and her ex-partner. Risks to herself and others were identified alongside a disclosure of the historical DA she experienced. The plan was for a referral to the local recovery college who would provide advice on MH issues. This plan continues a pattern of referrals to outside agencies i.e., GP, IAPT, 3rd sector services including recovery college and DA services (Women's Aid). This pattern reduced Oxleas` ability to provide a holistic approach to Karen`s overlapping MH and social care needs.

14.9.20 On the 23.11.2020, a referral was made to the MH Hub from Bromley ASC team. Karen was reported to be sleeping in a stairwell (as per previous concerns) and was anxious and imagining things. Karen had also stopped taking her medication. An assessment took place on 02.12.2020 and a core topic of the assessment was trauma and abuse that Karen had suffered and she was asking for a referral to 'fix my head'. Poor sleep and appetite were reported, and mood was reported as up and down. The plan was to discharge back to GP and a referral to IAPT (completed 04.12.2020), but no confirmation or follow up received.

14.9.21 If a full history was understood at that time and recent signals were connected then an internal referral to secondary care for more complex psychological therapy for trauma may have been considered. There was a gap in contact until the 24.05.2021 when a police merlin is received concerning safeguarding issues that are not directly MH related, it was advised that the report be sent to the GP who could arrange a review. No further contact was made to Karen from MH services before she died.

14.9.22 Experiences of trauma and referrals to DA services between 2013-2020 were not always followed up. The impact of trauma was sometimes overlooked and there were no safeguarding processes evident from the Oxleas records.

14.9.23 As care plans were not accessible to the IMR Author, it is challenging to comment. There appeared to be a gap when Karen was not accessing statutory services (but was accessing other services). This presented challenges in trying to ascertain whether she had a social need. MIND offer both social and MH support and at times this is picked up at a more severe stage. No referrals were made to ASCdespite there being an opportunity to do so when she was found on the stairwell.

14.9.24 Records indicate that there were several disclosure points of DA, initially including risk to children when safeguarding measures were not considered or connection made considering impact upon MH is not formulated. Karen further disclosed increased anxiety and fear that perpetrator was trying to locate her, but no safeguarding processes were evident. There were missed opportunities to assess DA, the impact of DA on her MH and to initiate process and policy.

14.9.25 There was evidence of good assessments with an amount of quality information concerning Karen's MH and social circumstance offered and documented and although some evidence of multidisciplinary team working and discussion there was a lack of ownership around tasks i.e., psychological therapy, management of risk, and clinical intervention (these were routinely referred to external agencies).

14.9.26 The risk assessment and core assessment highlighted DA as risk concerns. The risk was acknowledged in several contacts and recognised in the formal risk assessment, but management was deferred to the local authority social worker and no feedback or joint management of risk was evident.

14.9.27 The Bromley MH Hub can now deliver a range of brief interventions that can support someone's MH at a primary care level, this includes psychology-based group work that can address various MH functioning and support an individual crisis plan. If there is then a need for further clinical intervention from one of the secondary care teams then this will be assessed, and a referral considered via an MDT discussion with the appropriate team. The Bromley MH Hub also operates with an integrated model of care, there is ability to complete a full Dialog+ assessment that is person centred and needs focused and enable immediate access to a range of clinical and social interventions delivered between clinical and voluntary sector staff, this includes access to psychology-based intervention with an ongoing assessment of psychological needs with access to a wider range of secondary care psychology intervention if required.

14.9.28 There were opportunities to support Karen and engage with external services for support, including an opportunity to attend child in need meetings, this may have given an opportunity to discuss holistic issues connected to Karen's MH in a wider audience with more considered thinking and connected planning (29.07.2013: Signposted for DA support via recognised external services, when Karen disengaged from this offer, no contingency support or planning was considered i.e., internal psychological therapies).

14.9.29 There were several examples of DA and impact of DA being disclosed and documented with all care planning deferred to external agencies i.e., GP, IAPT or local recovery college for support without recognising the impact upon MH and to then consider available internal resource.

14.9.30 When Karen engaged with services in 2020/1, the team were not able to provide the intervention that Karen required so signposting to external agencies was used. As gatekeepers to secondary care there was opportunity for care to be delivered within one of the secondary care CMHT`s i.e., ADAPT Pathway (Anxiety, Depression, Affective disorders, Personality Disorders and Trauma). It is not evident that this pathway was considered as Karen's presentation may not have met this threshold at the point in time. If a full holistic, needs led assessment was completed this may have then been considered.

14.9.31 In services prior to the current Bromley MH Hub (the previous PCP service) there was no direct provision of primary care MH or social interventions.

14.9.32 Good Practice was identified:

- Initial contact from MH services in 2020/2021 was frequent and supportive.
- Some evidence of joint working with local authority child and family social care team.
- Good evidence of understanding of community support pathways (2020/2021)

14.9.33 There was clear and frequent disclosure of DA with assessments recording this within clinical notes, MH assessments and risk assessments. Despite these disclosures there appears to be little or nil formulated care that should have involved considering a holistic, Karen focused, and needs led assessment that concluded with an agreed care plan with appropriate interventions, in this case a trauma-based package of psychological intervention supported by a package of MH and social care support.

14.9.34 It is unclear and hard to understand why this did not happen as there were mechanisms in place to support this including policy, guidance, and access to internal and external treatment pathways. The difficulty is that this review is 10 years post first contact with MH services and staff, teams and services have changed dramatically within this time.

14.10.1 Clarion Housing: Karen was housed by Clarion in a general-needs property in Bromley. The probationary tenancy started in January 2014. There were a number of issues raised in the Clarion review material, mainly concerning her ability to pay her rent and also the arears she accrued between 2014-2018.

14.10.2 In 2018, Karen's ex-partner made contact to say she was withholding his belongings. This was seen as a relationship breakdown with no red flags. DA was not considered at this point and Karen made no disclosures.

14.10.3 A welfare benefit referral was made and Karen was struggling. She was not working due to ill health. Sarah was living with her, and Karen became unable to pay the rent. She revealed that her father had advised she didn't claim benefits and to look for work. This is noted as an unusual comment and is not reflected in any other agency information. Karen did not want her daughter to be aware of financial discussions.

14.10.4 There was no re-engagement between November 2018 and January 2019. An assessment and action plan was undertaken, and Karen agreed to a number of actions including contacting DWP. She was on Statutory Sick Pay (SPP) and had arrears of over £3k. A property inspection revealed no issues within the home. There was a Stay Hearing held in 2019 and an Eviction application but Karen applied to not be evicted. The judge allowed Karen a last chance to get resolve her issues. Karen received financial advice from Penny Smart.

14.10.5 In September 2020, an Anti-Social Behaviour process was started following the call from the neighbour on Karen's mental breakdown. It was noted that the neighbour did not contact the Police.

14.10.6 Karen applied for a Personal Independence Payment (PIP) in 2020 which was turned down. There was a welfare benefit referral, and the bedroom tax was in place at the time; Karen was advised to speak with MIND.

14.10.7 Karen presented with full capacity and advised she was engaged with her GP and MH. There is no statutory obligation on housing to make referrals to other agencies. It is uncertain whether this is written into any of the housing policies. Based on the knowledge of her MH issues, a multi-agency approach could have been advantageous in order to provide greater support. There was no response from safeguarding referrals on what action was being taken.

14.10.8 Karen was accessing welfare benefit support from February 2022 until the time of her death. Karen requested a balance on her rent about 1 month before she died and this indicated that she was responsibly attempting to manage her housing whilst under financial difficulty.

14.11.1 **LAS:** There were only two contacts specifically with the LAS. LAS staff following National Clinical Guidelines to aid their decision making. The LAS has not identified any issues arising from its management of Karen's death.

14.12 In summary of the agency analysis, Bromley CSP made the decision that the tragic death of Karen did not satisfy the criteria for a DHR/DA death, but they did recognise that historic DA does not negate the significance. The panel were able to study and analyse the agency information held on Karen's experiences and ensure the social and economic factors faced are correctly interpreted. It became clear that Karen's DA vulnerability was quite heavily separated into 2 time periods. From 2007/8- 2013, Karen was known to agencies due to the DA she suffered. Whilst not attempting to summarise all of her vulnerabilities, some incidents stood out that are worthy of further mention, which identified agency concerns, where Karen sought help or alternatively where Karen failed to engage with services that had been identified for her. This period included her taking refuge from John, with her children which led to a significant trauma in her life.

- ASC were informed (12.09.2012) that Karen had self-diagnosed dyslexia (potential disability), and this coincided with a SW worker raising concerns about Karen's MH and the welfare of her children.
- Oxleas revealed (06.12.12) that Karen had failed to appear for a psychiatry appointment. She disclosed that her abusive ex-husband had left and remarried.

- In September (14.09.2012), Oxleas noted that Karen had found the court experience of dealing with her ex-husband to be traumatic, and this was aggravated, they considered, by the lack of financial support that Karen had and some difficulties with English as a second language.
- In 2013 (29.07.2013), Karen presented with problems with her children, feelings of negativity towards her own mother and wanting therapy for her previous DA trauma.
- Karen reported difficulties with housing and a struggle to pay her bills (09.09.2013) but was able to positively engage with DA group counselling.

14.13 The period between 2013- 2019 was limited in terms of agency engagement for Karen. Records show there was routine GP support and a range of children's services contacts associated with difficulties with her youngest children, specifically Robert (2015/16).

14.14 Karen did come to notice during 2018 when she reported recent DA with her new partner Chris. There was agency contact (limited to police and CSC) as Karen refused to substantiate any allegation. Karen also reported to the GP harassment by a colleague at work. In 2019, Karen began to experience multiple housing issues, but it was 2020 where Karen started to show signs of deteriorating MH.

14.15 There was a notable gap in engagement with MH services between 2013-2020 when Karen did not access any MH or counselling services, until after an incident on 03.09.2020. Despite opportunities to consider and support previous DA and associated trauma none were followed through, and no significant support was requested or received following Karen's previous period of initial engagement with different agencies listed in the chronology.

14.16 A police merlin report was received into the MH Hub on 07.09.2020 where a neighbour had reported screaming, shouting, and banging coming from her flat, no direct indication of the need for MH support so plan was to send the report to her GP who could arrange a review. It is not documented that Karen`s full history was considered at this point and whether DA was considered and if any connections could have been made and safeguarding issues raised.

- Neighbours reported concerns about Karen's MH (03.09.2020).
- Karen's son contacted Oxleas crisis services crisis line (12.09.2020). He reported that Karen's MH was deteriorating.
- Further concerns were raised (15.10.2020) when Karen was reported to have sent a threatening letter to a neighbour, was seen sleeping in her hallway and her son David reported concerns to ASC.
- On 20.10.2020, Karen requested a MH assessment after she had stopped taken her prescribed medication.
- On 09.11.2020, ASC concluded that Karen's reported PTSD did not qualify for support under the Care Act. Karen stated to ASC that she had no care and support needs and they specifically noted there was no self-neglect and no hoarding, which informed their assessment.
- When seeing her GP (02.12.2020), Karen disclosed that she 'had been abused for 20 years and felt let down every time she had asked for assistance'. Karen's assertion that it was 'systematic abuse' indicated that she felt vulnerable. However, she was back on her medication. When specifically asked about thoughts of self-harm or

suicide, Karen responded, '*Only cowards do that. I am mentally stressed but don't want to die. I want to be here for my grandkids'*.

- On 26.02.2021, Karen disclosed to her GP that she struggled with budgeting and expenditure and felt guilt over her children. She revealed she had stopped taking her medication again.
- When Karen saw her GP again on 14.05.2021, she again advised she was not taking her medication but was under stress.
- By 17.07.2021, Karen resumed her medication and presented as more stable in the opinion of her GP.
- By 10.08.2021, Karen informed her GP she was worried about her bills but also wanted more counselling.
- On 22.11.2021, Karen informed her GP she had had panic and anxiety for 2 years, revealed a grievance at work and again specified financial concerns.
- On 17.01.2022, Karen informed her GP she was having recurring panic attacks and disclosed that financial worries were a trigger for her attacks.
- Over 12 months later (07.03.2022), Karen informed ASC that she had experienced a nervous breakdown, she couldn't sleep, and she was upset by the cost of heating.

Section 15 - Conclusions

15.1 Dealing with the specific lines of inquiry, the panel were asked to examine a range of specific issues in the TOR.

- ***Whether there were any barriers experienced by the victim or her family/ friends/colleagues in reporting any abuse in Bromley or elsewhere, including whether she knew how to report DA should she have wanted to.***

15.2 From the evidence within police records, Karen was able to report abuse. There is evidence that when Karen supported prosecutions, that police were able to effectively arrest, interview and charge individuals. Karen also was supported to obtain an injunction (NMO). The panel were satisfied that Karen knew how to report DA and there were no obvious barriers to her reporting the abuse she had suffered.

- ***What did services know about the abuse and whether there were opportunities for professionals to 'routinely enquire' as to any DA experienced by the victim that were missed.***

15.3 Routine enquiry is a term used to describe asking all service users about their experience of domestic and sexual violence. No signs of abuse or suspicions of abuse are needed as routine enquiry involves asking every person about their experience. In this review, the evidence from multi-agency partners indicated that Karen talked openly about the abuse she had suffered, seeking appropriate advice, support and assistance. No routine enquiry was missed.

- ***What was or could have been put in place for victims who exited abusive relationships.***

15.4 It is clear that Karen experienced some difficulty in 2007-2008 whilst exiting her abusive relationship and spent time in a number of DA refuges before appropriate housing was found. For a number of years thereafter, Karen was supported with GP care, and referrals for MH support and counselling (2008-2013 and again from 2020 onwards). Police provided support in proactive prosecutions where Karen supported the allegations.

- ***Whether there were opportunities for agency intervention in relation to DA regarding the victim or stated perpetrator that was missed.***

15.5 The panel found no evidence that intervention opportunities were missed in relation to a named/stated perpetrator. Where an alleged named perpetrator was identified, appropriate action was taken to protect and support Karen (through arrest / information sharing / prosecution). In section 14, there are stated incidences where agencies, on reflection during this review, have identified additional opportunities to support Karen. These have been noted as learning points for agencies, with a recognition that since 2008, practice and policy have developed and improved.

- ***Whether family, friends or colleagues were aware of any abusive behaviour (including coercive or controlling[58]) from any perpetrator to the victim, prior to the death……***

15.6 The Review Panel and Chair discussed additional enquiries that the Chair would pursue with friends and family members but due to non-contact, the Chair was unable to establish what was specifically known by family and friends. Agencies records speak to the fact that Karen's children had also been victims of abuse (emotional and physical). There is no evidence however, for many years before her death that Karen was a current or recent victim of abuse.

15.7 An initial decision panel met on 25.07.2022 to review the referral and consider the circumstances leading to Karen's death. At that meeting, the panel heard updates from Police, MH and GP services and there was information shared around the siblings. That initial panel determined that 'there was no explicit evidence that historic DA had *directly* contributed to suicidal thoughts. There was no *recent* coercive control or DA, rather there were issues around her relationship with her children and long-term anxiety, low self-esteem'. At the point of her death, she was living alone and had been for some years, albeit her son David had temporarily moved in.

15.8. The decision of the local authority and local decision makers in this case, the Safer Bromley Partnership, was based on the information provided by partners, who initially determined that the matter should be referred for a Safeguarding Adults Review. The DHR panel agreed with that finding at the conclusion of the review.

15.9 To come to their conclusions, the DHR panel further explored Karen's background. She had been known extensively to MH services and had been supported with significant

[58] In March 2013, the Government introduced a cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviours in intimate or familial relationships (section 76).

engagement and referrals. As early as 2012, she was diagnosed with depression and anxiety, having exited an abusive relationship 4 years earlier (2008) with twins. Although initially engaging with counselling, this was not maintained by Karen, and she was discharged in 2013.

15.10 Karen came to notice of agencies again in 2020 with anxiety about finance, possible stress reaction to difficult relationship with her children, and was again discharged following self-referral to IAPT and her GP.

15.11 Karen had been engaged with policing and criminal justice services (as a victim and as an offender) over many years. Where she supported prosecution, swift and appropriate action took place. It is noted however that she was subject to repeat victimisation.

15.12 During various engagements with agencies, Karen reported a long history of DA[59] and the impact and effects on her including PTSD. She had anxiety caused by her relationship with her estranged daughter and allegations made by Sarah about her stepson. Specifically in 2021, Karen's declining MH was noted. Karen reported ongoing stress, concerns about poor accommodation, and she stated she was suffering with OCD and crying a lot.

15.13 Her GP noted that Karen had not been able to work and was on Universal Credit. She was on medication, but she was not really functioning, had low self- esteem, and reported thinking about the past abuse. She had limited contact with her children and a history of workplace grievance, suffering from frequent panic attacks. Her last attendance at the GP was in May 2022 where she reported feeling more positive. There had also been a referral into OCC health for bathroom adaptions. A short time later, in May of 2022, Karen took her life by suicide at home whilst alone. She had been repeatedly asked about thoughts of self-harm, or suicide but denied them. She had not indicated any suicidal ideation in the immediate time before and there are no agency records to indicate, despite her overlapping MH and social care needs, that she felt suicidal.

15.14 Despite significant MH support, BLG Mind were limited in the support that they were able to provide to Karen as her MH needs (support with severe anxiety and compound trauma) were beyond those of the services she was accessing through them. Improved assessment could have led to escalation of her case to more appropriate agencies. However, there are wider questions for the system as they considered what led her to seek support through self-referral to the services as opposed to professional referral to secondary care/ DA specialist support.

15.15 There is some evidence across the records examined to suggest that Karen was confused by the system and the plethora of different agencies that were offering support. In particular her housing and benefits which caused her to fear homelessness caused her a level of stress and anxiety. Since 2022, steps have been taken to further integrate statutory and third sector provision (under the community transformation agenda). The Bromley MH Hub which has taken the place of the Bromley Well MH and Wellbeing pathway (in terms of BLG Mind provision) is an integrated service with both Oxleas and BLG Mind. There is now a shared Karen records system and regular MDTs which could go some way towards tackling the issues of silo working evident in this case.

[59] Recorded throughout the chronology.

15.16 A wider question raised by the case is the value of signposting as practitioners are unable to check whether or not a signpost has been followed up by the client, it is difficult to determine whether or not support has been received and if so, at what level it has been accessed. The challenge is also influencing the client to take up the service. Motivation to seek help is a personal choice.

15.17 The focus of CSC was on Karen's two youngest children during the time they were living with her. They had both moved out in placement some three years before her death. CSC had made appropriate referrals, and throughout had engaged with other agencies and supported Karen to achieve a relationship with her children. At the time of her death, CSC were not engaged with Karen, as the children were now considered adults, however indications are that her fractured relationship with them played heavily on her mind. Her enquiries about fostering at a time of deteriorating MH perhaps gave the biggest indicator to the loneliness that she was experiencing.

15.18 Bromley children's services were rated inadequate by Ofsted in February 2016. The practice relating to the children's reception into care that took place *during this time* was not child centred for the entirety of this family's time in CSC (2012 onwards) and Robert and Sarah's experience was reflective of that. Bromley undertook an improvement journey that resulted in a good Ofsted inspection in November 2018. There have been significant changes in how they work with teenagers including an intensive staying together team that are part of the referral and assessment service to ensure families receive rapid follow up and support when children are at the edge of care. Note: It is important to note that OFSTED's judgement was 'Inadequate' in 2016, and for part of the time until the re-inspection this statement is correct. It is equally important to note that prior to 2016 (as recorded in OFSTED's site) from 2008 – 2012 (there is no inspection between August 2012 – February 2016), it was 'Good/Performs Well', and returned to that in 2018 when re-inspected after the improvement journey was completed.

15.19 The HO direction to conduct a DHR specified that the review should aim to understand what services knew of the abuse and what was or could have been put in place to recognise the root cause of Karen's trauma and to prevent her from taking her own life and enable a review of support for victims who have exited abusive relationships and the efficacy of this support over the longer term. As discussed in the analysis above, this extensive review has identified that there were a range of contributory factors which impacted Karen, and the root cause of her trauma has never been singularly identified.

15.20 There also appear to be two distinct phases in Karen's life where she was vulnerable. Phase one which was from 2008 and including the period up to 2013, where Karen did experience DA, which undoubtedly led to her PTSD self-diagnosis (there is no formal diagnosis of PTSD coded in her GP records and the GP panel member considered that Karen may be her referring to the condition informally rather than a formal diagnosis). Significant medical, psychological, housing and legal support was put in place, some of which Karen engaged with. There were identified occasions where Karen chose not to engage with services. Throughout this period, there was no indication of suicidal ideation.

15.21. During the second phase (2020 onwards), Karen appeared to descend into depression and anxiety, with poor mental ill health and physical ill health, which was compounded by poverty and concerns about employment and housing. It is important to stress that her housing issues had been resolved for a significant period before her death. There were tensions within the family, as her youngest children had entered the care system and there was and conflict between family members, which Karen indicated caused her stress.

15.22 In conclusion, Karen had been significantly impacted by historic DA. However, at the time of her death a range of other complex issues impacted her including poor MH, her economic environment of which minimum wage working, unemployment, rent arrears, featured impacting her ongoing poverty, her relationship with her children, which all increased her despair and hopelessness. Whilst referencing DA, at times she also variously blamed her sons for the situation she found herself in. Loneliness could also have impacted her. Her attempt to foster demonstrated her need for feel connected. Karen had consistently reached out for help, but nothing changed for her. Even though alternative suggestions of help were offered, there were occasions where Karen disengaged or stopped medication.

Section 16 - Lessons Learnt.

16.1 The panel considered that policy and practice has developed and improved since 2013, and presented with Karen's domestically abusive circumstances in 2023, more robust support would be available to her should she present today. Legislation has been implemented, support services more widely understood, and the academic research enables a greater understanding of trauma informed practice.

16.2 Each of the services engaged in this review considered what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action.

16.3 BLG Mind: A number of points could have been improved in Karen's engagement with BLG Mind services.

- Risk assessment on the client should have been updated as further elements of risk (e.g.. details of historic abuse) were uncovered, this in turn could have led to further escalation of the case firstly internally and then to statutory/specialist services.
- As part of a more comprehensive risk assessment process, there could have been more attention to/exploration of indications of historic abuse.
- Karen was accessing two services within the organisation at the same time, greater continuity of care could have been enabled if the Recovery Works and Bromley Well services had worked more closely together to discuss provision.
- It is clear that Karen was accessing a number of different services simultaneously. Sometimes for support in the same areas e.g., housing. Greater communication with other agencies including housing and social care could have enabled a more positive outcome.

16.4.1 CSC: There is learning for the local authority about their response to adolescents in crisis in terms of being more proactive and recognising their vulnerability. Robert seems to have been identified as a cause of the family dysfunction and treated as a much older child by agencies. The risks around adultification are clear. Robert was a young boy of Black Mauritian

heritage and there is concern about Bromley Children's Services response to his needs which resulted in him being exposed to further harm.

16.4.2 Sarah's lived experience should have attracted greater scrutiny and there were a number of missed opportunities to assess and monitor her safety at home. Karen, as the parent was offered services around her experience of DA and MH.

16.4.3 The chronology does indicate that she was not able to meet the children's needs but that she also struggled to really demonstrate capacity for change. She repeatedly requested for the children to be taken into care as a strategy to support her needs and neither child benefitted from stable care giving arrangements. Had social care been more robust in responses to the children's needs both children may have come into care sooner, but this does not determine that outcomes for Karen would have been different. However, a stronger multi agency child protection planning approach may have offered greater opportunity for partnership working across agencies to monitor and review the progress she was making and measure of her progress on her parenting at a much earlier stage.

16.5.1 LBB ASC: The practice issues and learning from this case review identified that ASC need to raise awareness and understanding among all frontline practitioners about the impact of DA on victims and their families. This can be achieved via training and e-learning. Multi-agency working is essential for improving the response to DA, helping to prevent offending, protecting victims and ensuring that they have the support they need.

16.5.2 There is a need to review the multi-agency partnership working protocol and procedures in terms of responding to DA in Bromley and develop or review the multi- agency working /operating policy for responding to DA.

16.5.3 One of the lessons learned is that different agencies have different definitions of domestic violence / safeguarding concerns regarding DA. The understanding is varied in what domestic violence is and the interpretation of the legal definition of domestic violence and abuse. The Local authority has DA training available for frontline staff, but ASC recognised that they may need to mandate this training or source further, more specific training or e-learning for staff within Adult Services to ensure they gain a good understanding of statutory duties and what measures need to be put in place to protect and support victims of DA.

16.5.4 The DA Act 2021 creates an opportunity to review the ASC operating policy and procedures to improve responses to merlin reports and safeguarding concerns regarding domestic violence incidents, raised by other agencies. ASC identified the need to consider how best LBB adult social care staff should work with partner agencies effectively to help protect victims (including young adults) of DA and make sure they are safe and free from harm. Frontline staff and managers need to be familiar with the Care Act's definition of the safeguarding duty, and it applies when a person:

- Has care and support needs.
- Is experiencing, or at risk of abuse or neglect; and
- Is unable to protect themselves from the abuse or neglect, or the risk of it as a result of those care and support needs.

16.5.5 Frontline managers should familiarise themselves with and follow the Council's Safeguarding Policy and Procedure (1), paying attention to the Social Care Institute for Excellence (SCIE's) explanation of adult safeguarding, to give an appropriate and proportionated response to concerns regarding domestic violence / abuse. SCIE is explaining adult safeguarding more widely and its practice questions details clearly who the duties apply to, that is, adults with care and support needs:

'An adult with care and support needs may be:

- an older person
- a person with a physical disability, a learning difficulty or a sensory impairment
- **someone with MH needs, including dementia or a personality disorder.**
- a person with a long-term health condition
- Someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.

16.5.6 In its definition of who should receive a safeguarding response, the Care Act legislation also includes people who are victims of sexual exploitation, **DA** and modern slavery. These are all largely criminal matters, however, and safeguarding duties would not be an alternative to police involvement and would only be applicable at all where a person has care and support needs that mean that they are not able to protect themselves.'[60]]

16.5.7 Based on the recording of contacts with Karen's and her self-disclosure, it was apparent that she may have MH needs. Because of this 'appearance of need', Karen was eligible for an assessment of her care and support needs, and this should have been offered.

16.5.8 There is one initial assessment dated 09.11.2020, marked as an Action Plan, this was a brief action plan rather than a formal Care Act Assessment; it was completed by the duty worker who had been asked to carry out an urgent home visit to Karen. There should have been a document detailing how Karen was coping with her activities of daily living, and a determination of eligibility. The duty team was given a direction from the Operation Manager to undertake an urgent assessment of Karen; because they had received a counsellor enquiry and a request from the counsellor to be kept up to date as to the progress of the assessment.

16.5.9 In addition, there was a merlin report and an email from the police raising concerns that Karen might be at risk (Dated 04.09.2020). Also, the duty team received a phone call on 15.10.2020 from the Chairman of residents' association reporting serious concerns about Karen's unusual behaviours, e.g, 'wandering half-naked, sleeping in a hallway, and threatening neighbours'. The worker should have considered all the recent safeguarding concerns while she was assessing Karen's 's vulnerabilities and her eligibility for care and support due to her MH issues.

16.5.10 The conclusion of the above assessment was that:

[60] Source: https://www.scie.org.uk/safeguarding/adults/practice/questions

'Karen doesn't meet the eligibility criteria for support as her needs relating to MH (post-traumatic stress disorder) is not preventing her from achieving the set outcomes specified in the Care Act 2014'.

16.5.11 In 2019, there is a note from Karen's son stating that his mother is independent with activities of daily living and that it was unlikely she would engage with an assessment of need, however it is clear that Karen was a victim of numerous domestic violence incidents and some evidence that she was self-neglecting her personal care.

16.5.12 There is a need to review and update the LBB ASC's Adult Safeguarding Policy and Procedure

- Introduction section 5 definition & abuse,
- 8 Mental Capacity and
- 10 Risk Assessment, Management & Empowerment and,
- the 4 stages process and procedure - stage 1 concern regarding DA. ASC need to provide update practice guidance to frontline managers who screen incoming safeguarding referrals and make decisions on s42 threshold.

16.5.13 According to the above existing procedure- Introduction section 4.3, the threshold for safeguarding is not the same as for the provision of care and support to meet unmet needs that local authorities normally apply. If the adult in question has needs for care and support then the LBB must carry out, or have others carry out for them, safeguarding actions that it deems proportionate regarding any relevant allegation, whether those needs are being met or not.

16.5.14 The frontline senior social workers and managers need to refer to this procedure 1 policy (section 11.1). Aside from adults with MH needs as the primary need for requiring care and support, the lead agency for oversight of Section 42 cases remains the local authority in Bromley; the lead service for this are those that make up Adult Services.

16.5.15 The Safeguarding Adults Manager or Team Lead had opportunity to pull in the expertise of the Consultant Practitioner Leads (CLPs). Although this is optional, this could have been beneficial to this case. Further promotion of these posts is required. It was good to note that worker made many welfares checks and telephone calls to Karen and her adult children.

16.5.16 LBB ASC staff should be working more reflectively with risk and holding 'signs of safety and wellbeing in mind.' The Care Act (2014) has introduced practice imperatives based on wellbeing, strengths, rights and resilience. The challenge for practitioners is to offer 'person-centred and rights-based practice' while working with the various risks people live with, in particular victims of DA. The challenge for vulnerable people (such as Karen, a victim of DA suffering from undiagnosed MH issues), is to be heard and included in decision-making based on risk and safety conversations.

16.5.17 There were missed opportunity to complete and review risk assessments. There was reference to a 'fire risk' assessment mentioned in one of the contacts dated 01.12.2018. More work needed to happen around building a relationship with Karen. There was a lack of record of conversation with Karen particularly around how she could protect

herself from DA. LBB ASC may have been able to move Karen to a place of safety if she had expressed this as a need. Case notes or case recording should also have provided an overview of the safeguarding issues that needed addressing for Karen.

16.5.18 LBB ASC staff need to take a 'strengths-based' approach to working with victims of DA. Alongside with the Care Act legislative framework for safeguarding, the MSP (Making Safeguarding Personal) places human rights and social justice ideas at the forefront of practice. Practitioners are encouraged to see the person's situation as more than a set of problems and should at least have a belief (i.e., social work value) that victims of DA, like Karen, are worth working with them to address the issues and supporting them to use their own strengths to make change because they want to be safe and free from DA.

16.5.19 The key lesson learned from this case review is that identifying and responding appropriately to DA is now an essential part of adult safeguarding practice. Practitioners need to recognise that DA can necessitate a safeguarding inquiry and it is defined in the Care Act guidance July 2022[61].

16.5.20 In this case , DA was seen as a 'children and families' issue or a 'MH issue.' Despite that there were two merlin reports dated 04.09.2020 & 21.05.2021 highlighting safeguarding concerns; and various phone calls expressing concerns about Karen from the school, housing, and children services over a period of 10 years, the case notes should reflect that these were safeguarding concerns.

16.5.21 LBB ASC staff could have responded more appropriately to these safeguarding concerns (i.e., just by sending the police merlin reports to OXLEAS) and they should have recognised that DA is a safeguarding issue. There was risk of MS self-harming, self-neglecting and suffering from DA by at least three adults (two ex-partners and daughter's boyfriend) were omitted from case notes.

16.5.22 There is a higher prevalence of DA among people who experience poor MH and DA is likely to have a negative impact on victims' MH. At times, victims of DA will interact with services, and there are key opportunities for intervention. Every point of interaction with a survivor is an opportunity for intervention and should not be missed.

16.5.23 Agencies and the professionals working for them can help to provide opportunities for disclosure of abuse. The ideal response to a disclosure is one that empowers the victim, through the provision of non-judgemental support and information, to explore the options available to them and assist them to take the appropriate action. Effective multi-agency working is recognised as crucial to address/ manage challenging situations of both DA and safeguarding adults.

16.5.24 An analysis of this Domestic Homicide Review highlights that multi-agency working is a key factor in providing a good response. Each agency in the social care and

[61] See link to this guidance.
DA Statutory Guidance (publishing.service.gov.uk)

health system has a role in co-ordinating a response. Key partners include police, housing, children's social care and DA services.

16.5.25 In Karen's case, local authority ASC should have recognised that DA is a safeguarding issue and no s42 enquiry has been considered. Adult social care practitioners have a key role to play in supporting people with care and support needs who are experiencing DA, in both detecting coercive control and responding to it. Where practitioners are leading safeguarding enquiries related to DA, working with people in a strengths-based and person-centred way can support people to regain control over their lives.

16.5.26 A way to address this multiplicity of issues is by establishing a new practice framework, which offers a mapping out of what ASC do and why, offering a rationale for practice actions and decisions, and promoting a range of practice tools in carrying out assessments and interventions for victims of DA. This practice framework needs to provide a guide to undertaking person-centred and whole family assessment; and offer practitioners an intervention logic that is theoretically and ethically grounded and supported by a set of practice questions.

16.5.27 The aim is to help practitioners develop better understanding of people's situations and finding solutions through their working relationships with the victims and other professionals involved. This framework should provide a format for undertaking comprehensive risk assessment – assessing for danger, strengths and safety. **This forms the basis for a recommendation.**

The recommendation is underpinned by a series of observations to support the recommendation-

- LBB ASC through the Learning and Development board to review the DA training to frontline staff and mandate it to ensure full take-up of this training, including e-learning.
- The Principle Social Worker to Review and update multi-agency working protocol, policy, and procedures for improving responses to DA.
- The Principle Social Worker to Review and update ACS operating policies and procedures to improve response to police merlin Reports and safeguarding concerns regarding domestic violence incidents.
- Work is already underway within the Safeguarding & Quality Division to outline the referral care pathway indicating when and how LBB Adult Service should/ could make a referral to OXLEAS MH Services; explicitly explain the role and responsibilities of ASC staff for responding to safeguarding concerns regarding adults with MH issues; and establish that the lead agency for oversight of Section 42 cases remains the local authority in Bromley.
- The Principle Social Worker to ensure through the Learning and Development board and the Senior Practitioner Forum to ensure frontline staff and managers to have detailed understanding of the statutory duties under section 9 of the Care Act 2014 on Assessment of Needs.
- The Principle Social Worker to review and update LBB ASC Adult Safeguarding Policy and Procedures including care pathway and process in terms of responding to DA.
- Ensure that there is management oversights and support provided for frontline staff and managers in giving response to domestic violence incidents and safeguarding concerns regarding DA, e.g., accessing CLPs and managers for case discussion and decision-making.

- Ensure strengths-based approach is embedded in safeguarding practice.
- A Leaning Workshop to be held for sharing learning from this DVHR and enabling practice reflection, all adult social care staff including occupational therapists to be invited.

16.6.1 Primary Care- GP services: Primary Care identified opportunities to

- Consider referral to DA support services when a Karen describes historical or current DA and to also be aware of local support groups for survivors of DA. This should be addressed by training specifically for local healthcare groups and should focus on management of cases of historical DA and may be delivered as part of a safeguarding practice lead session.
- Consider use of a Social Prescriber within Primary care to give additional support for a Karen with concerns regarding housing, debt or needing extended periods of time off work. Social Prescribers are in place in Primary Care and their use should be promoted as part of ongoing work within Primary Care. This could be addressed as part of the Primary Care practice visits that are provided.

16.6.2 Karen received regular assessment and treatment from Primary Care and described symptoms of Trauma from previous DA. Learning for Primary Care should focus on increasing referrals to DA services for Victims and also awareness of support groups for Survivors of DA, specifically when Karens present with symptoms of Post-Traumatic Stress Disorder.

16.7 LAS: LAS staff following National Clinical Guidelines to aid their decision making. The LAS has not identified any issues arising from its management of this incident but is fully prepared to take on board any issues that may come to light.

16.8.1 Oxleas: Due to the significant impact of Karen's MH engagement, Oxleas considered lessons across a range of areas.

16.8.2 Disclosure of DA (DA) and response:

- Several disclosure points of DA, initially including risk to children when safeguarding measures were not considered or connection made considering impact upon MH is not formulated.
- When MS further disclosed increased anxiety and fear that perpetrator was trying to locate her no safeguarding processes were evident.
- Missed opportunities to assess DA, the impact of DA on MH and to initiate process and policy.
- There was evidence of good assessments with an amount of quality information concerning MS` MH and social circumstance offered and documented and although some evidence of multidisciplinary team working and discussion there was a lack of ownership around tasks i.e., psychological therapy, management of risk, and clinical intervention (these were routinely referred to external agencies).

16.8.3 Policy and Guidance

- DA Policy and process was first published in 2006, there has since been 5 updated versions available to staff. Author is unable to view 2010 (V2.0) version to understand

guidance available at the time of MS`s initial contacts with Oxleas NHS Foundation Trust. V2.3 and 3.0 would have been most relevant in MS`s second period of main contact.

16.8.4 Lessons

- Staff awareness of DA intervention may have been less, and the distinct connection between DA and poor MH and trauma may not have been considered as a holistic aspect of MS` MH.
- Oxleas DA Policy was updated in November 2022 to reflect the DA Act 2021 changes and statutory guidance. In addition, Oxleas DA intranet resources include a comprehensive MARAC and DA guidance handbook.
- DA awareness is included in mandatory levels 1-3 safeguarding children and adults training and staff can access our online training package to complement this offer. Furthermore Level 3 DA training, meeting NICE guidance (2016) and DA Pathfinder (2020) recommendations, is now available and recommended for staff in direct contact with clients.
- To ensure optimum reach of key DA messages and practice guidance all Oxleas teams are offered a 1-hour DA training sessions face to face, this includes routine DA enquiry, trauma informed practice, intersectionality, and awareness of referral pathways. The MH hub has accessed this training.
- **Safeguarding:** All staff would have been expected to have completed mandatory safeguarding training relevant to their role.
- The allocated care coordinator was a social worker and would have been expected to have a higher level of understanding of safeguarding processes.
- The Safeguarding Adult's Guidance was first published in 2007 (V1) with 11 further updates to date. Although the allocated care coordinator was a social worker the author is unclear if an integrated model of health and social care was in place in services at the point of Karen's initial contact with MH services. This model is now in place with improved implementation of safeguarding processes and joint intervention for health and social care and the management of associated risks.
- With the current model of integrated health and social care in Oxleas community MH services there is an improved ability to assess and manage and safeguarding concerns within our MH teams, this includes the new Bromley MH Hub which has developed from the primary care plus team.

16.8.5 Treatment Pathways

The risk assessment and core assessment highlighted DA as risk. A psychological therapy referral was indicated but never followed through – this was screened by the psychology team but deferred pending care coordination allocation and care coordinator did not complete. The risk was acknowledged in several contacts and recognised in the formal risk assessment, but management was deferred to the local authority social worker and no feedback or joint management of risk evident.

16.8.6 Lessons:

- At the point of referral for psychological therapy communication between the team MDT should commence and not cease until treatment has been completed or deemed not necessary via a multidisciplinary team decision.

16.8.7 Any assessment, including an assessment of risk should formulate a care plan agreed with the Karen and delivered within the multidisciplinary team, this was not completed for Karen and no care plan was accessible to the author. Karen was signposted for external DA psychology support via recognised DA agencies but when Karen did not engage with these services nil alternative planning was considered or agreed.

16.8.8 The Bromley MH Hub can now deliver a range of brief interventions that can support someone's MH at a primary care level, this includes psychology-based group work that can address various MH functioning and support an individual crisis plan. If there is then a need for further clinical intervention from one of our secondary care teams then this will be assessed, and a referral considered via an MDT discussion with the appropriate team. The Bromley MH Hub also operates with an integrated model of care, there is ability to complete a full Dialog+ assessment that is person centred and needs focused and enable immediate access to a range of clinical and social interventions delivered between clinical and voluntary sector staff, this includes access to psychology-based intervention with an ongoing assessment of psychological needs with access to a wider range of secondary care psychology intervention if required.

16.8.9 External Agencies and Support. There were opportunities to support Karen and engage with external services for support. Opportunity to attend child in need meetings, this may have given an opportunity to discuss holistic issues connected to Karen's MH in a wider audience with more considered thinking and connected planning. 29.07.2013: Signposted for DA support via recognised external services, when Karen disengaged from this offer, no contingency support or planning was considered i.e., internal psychological therapies.

16.8.10 Lessons:

- It is evident that approaches to Karen's care were siloed and communication between agencies or joint working were limited and lacked coordination. The approach to health intervention was predominately medicalised with no evidence of a holistic, needs led assessment or care planning process. Karen identified her needs on several occasions and felt that she needed psychological therapy to deal with the trauma she had experienced from DA.
- The transformation community MH services delivers care within a holistic, needs led model that uses a Dialog+ assessment tool that is needs led and Karen focused, this enables the Karen to identify and prioritise their own needs and to plan the delivery of any care or intervention.
- Ensure staff are given opportunities to learn and reflect on best practice to help us understand the impact of psychological trauma and how to respond in a sensitive and compassionate way and ensure we 'do no harm' through care delivery that, without thought or intention, could retraumatise individuals.

16.8.11 Signposting / External Referrals; Several examples of DA and impact of DA being disclosed and documented with all care planning deferred to external agencies i.e., GP, IAPT or local recovery college for support without recognising the impact upon MH and to then consider available internal resource.

16.8.12 Lessons:

- The PCP team operational policy (V28, 04/2016) for locality adult MH services incorporating primary care plus) identified 4 service aims.
  1. Assessment and referrals management, operating as a single point of access and gate gatekeeping into secondary adult MH care.
  2. Allocation to locality teams.
  3. Relapse prevention and shared care with GPs.
  4. Health promotion.

- When Karen engaged with services in 2020/1 the above policy was operational, and the team were not able to provide the intervention that Karen required so signposting to external agencies was used. As gatekeepers to secondary care there was opportunity for care to be delivered within one of the secondary care CMHT`s i.e., ADAPT Pathway (Anxiety, Depression, Affective disorders, Personality Disorders and Trauma) is not evident that this pathway was considered as Karen presentation may not have met this threshold at the point in time, if a full holistic, needs led assessment was completed this may have then been considered.
- In services prior to the current Bromley MH Hub (the previous PCP service) there was no direct provision of primary care MH or social interventions. The current MH hub service identifies key aims and principles as set out in the operational policy (V1, 2023):

Aims

- *To offer a diverse and personalised range of interventions to people experiencing MH problems within the community setting considering psychological, physical, and social needs*
- *Enable earlier access to support; to enable people to recover and stay well; to prevent progression of MH issues and need for crisis intervention.*
- *To reduce inequality in access and experience of MH and physical health care for people with severe, moderate, and mild MH conditions across the borough*
- *To be compatible with the local authority's responsibility under the Care Act 2014 to prevent, delay or reduce the development of need for care and support.*

Principles

- *The service is delivered across primary and voluntary care sector (VCS) with close links to secondary care. No wrong door into services and frictionless movement between them facilitated using common assessment approaches and cross-team working.*
- *Holistic approach to assessing and meeting needs, with a focus on the wider determinants of MH considering psychological, physical, and social needs.*
- *Integrated, multi-disciplinary team providing clinical and non-clinical support.*
- *Service works to the Care Act principles of empowerment, protection, prevention, proportionality, partnership, and accountability.*

16.8.13 Good Practice Identified

- Initial contact from MH services in 2020/2021 was frequent and supportive.
- Some evidence of joint working with local authority child and family social care team.
- Good evidence of understanding of community support pathways (2020/2021)

16.8.14 There was clear and frequent disclosure of DA with assessments recording this within clinical notes, MH assessments and risk assessments. Despite these disclosures there appears to be little or nil formulated care that should have involved considering a holistic, Karen focused, and needs led assessment that concluded with an agreed care plan with appropriate interventions, in this case a trauma-based package of psychological intervention supported by a package of MH and social care support.

16.8.15 It is unclear and hard to understand why this did not happen as there were mechanisms in place to support this including policy, guidance, and access to internal and external treatment pathways. The difficulty is that this review is 10 years post first contact with MH services and staff, teams and services have changed dramatically within this time.

16.9.1 LAS: LAS had minimal contact. **Good practice** was identified: Staff followed National Clinical Guidelines to aid their decision making.

16.9.2 The panel considered how engagement may have supported Karen's needs. The MPS panel representative helpfully made engagement suggestions / recommendations. It is important when professionals attempt to engage with difficult to reach adults that they apply the key principles of respect, equality, partnership, social inclusion, and empowerment. Practitioners should show compassion and understanding of the complexity of the person's background and how this has led to their current circumstances and why they are resistant to services and support.

16.9.3 To maximise engagement consideration should be given to:

• Who is best placed to work with and build a trusting relationship with the adult, and who should be the lead professional/agency? Who else can support with this, e.g., a family member, advocate, other professional?
• Find the right tone. It is important to be honest about potential consequences while being non-judgemental and separating the person from the behaviour.
• Progress at the adult's pace. Allow conversations to take place over a period, and to focus on finding what motivates the person.
• Ensure that the adult receives information about practical options for support in a format they can understand. Check whether the person understands these options and the consequence of their choices.
• If there is doubt about a person's mental capacity, carry out a decision specific mental capacity assessment.
• Develop a plan which clearly sets out options and agreed actions. It is important to offer choices and have respect for the person's judgement.
• Ensure the person is involved as much as possible, for example making sure the person is invited to attend meetings.
• It is also important that front-line practitioners have access to effective supervision and training within their organisation.

16.10 Conclusion of agency analysis

16.10.1 During the review period, Karen presented with a history of DA, declining MH and with a diagnosis of post-traumatic stress disorder. The Diagnostic and Statistical Manual

(5th edition), which is used to diagnose post-traumatic stress disorder (the clinical approach) describes traumatic events as: 'exposure to actual or threatened death, serious injury or sexual violation'. The exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event.
- witnesses the traumatic event in person.
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences first-hand repeated or extreme exposure to aversive acts

16.10.2 Judith Herman (1992) notes that complex trauma has a more profound effect on an individual when:

- it is caused by humans rather than by a natural disaster
- it is caused by a person known to the victim, rather than a stranger
- it is repeated rather than an isolated incident
- it occurs in a [previously] safe environment
- it includes rape or sexual violence
- there is continued contact with the perpetrator
- the experience is personal and individual, rather than shared by many
- there is little sympathetic social support
- there is a history of previous abuse or violation e.g. in childhood
- details of the traumatic event (not through media, pictures, television or movies unless work-related)."
- Overall agencies all identified, in different ways, that trauma informed practice was a necessary tool which could have benefitted Karen's lived experience. Understanding trauma informed practice is crucial to understanding survivors and providing effective support services.

16.10.3 Key principles of trauma informed practice:

- Choice – survivors are supported in taking control of their lives. The first step is enabling survivors to choose how they access the support that is offered.
- Collaboration – service provision is a partnership between staff and survivors. This is a stepping stone to developing trust as well as the foundation for empowerment.
- Trustworthiness – trustworthiness is in the middle of our model as building trusting relationship with survivors is key to being trauma informed.
- Safety – services should feel physically and emotionally safe to survivors.
- Empowerment – survivor's self-efficacy is promoted.

16.10.4 Due to the nature and context of suicide there is no way to directly understand the thinking behind this choice. In Karen's case, she had not given an indication to family or any of those agencies with whom she was involved that she felt suicidal. The notes that she left gave an indication of her despair but did not reference her reasoning. What we can understand in this case is how Karen's experience of DA contributed to her poor MH for

significant periods of her adult life and how this may have been a contributory factor in ending her life.

Section 17 - Recommendations

17.1 Without specifying a recommendation, each agency engaged in this review, noted opportunities to implement changes to working practices and are mindful of the impact of adult safeguarding issues. These are articulated as either a recommendation or an improvement to practice and many have been actioned during the timeline of this review.

17.2 Trauma informed care enables partners to consider and develop trauma informed practice. This can be enhanced with the inclusion of DA policy and increased safeguarding support for adults who present as especially vulnerable.

17.3 Whilst there is no specific multi-agency recommendation in respect of the following, the panel identified a number of areas which impacted Karen's life for multi-agency consideration and inclusion in their working practices.

- All agencies should work together to develop a different practice framework for working with victims of DA and their families and children.
- All agencies need to recognise that DA can necessitate a safeguarding inquiry and follow the Care Act guidance on DA July 2022.
- All agencies need to recognise that multi-agency working is a key factor in providing a good response to DA. Each agency in the social care and health system has a role in co-ordinating a response. Bromley Adult Safeguarding Board needs to consider commissioning training and workshops for practitioners from multi-agencies to raise awareness and understanding about the devastating impact of DA on victims and their families; and improve our responses to DA.
- There should be a review of GP policy of charging for supporting letters (for those on low income)
- There should be a review of availability of low cost/free counselling in the borough and wait times for these services for those with high levels of previous trauma.
- There should be consideration of more points of contact for case management discussion between statutory and non- statutory service providers.

17.4 This DHR panel noted that Karen had been significantly impacted by historic DA and at the time of her death a range of other complex issues impacted her including poor MH, including her economic environment which impacted on her ongoing poverty, and her relationship with her children, which all increased her despair and hopelessness. The initial CSP panel had considered this complex picture of social needs when deciding that this case did not meet the DHR criteria. They also recognised that through this review that Karen may well have not satisfied the statutory nature of other reviews.

17.5 It is understood that the HO is developing practice for a proposed fatality review. Until that work is complete, it is a recommendation of this panel that the HO DHR decision team proactively engage with the CSP decision panel through a face-to-face meeting to understand the CSP decision rationale and, to equip a future panel with the tools to satisfy a review where

social determinants and not DA (in isolation) complicate the vulnerability of any individual who takes their life by suicide.

Recommendation 1

The Home Office should provide clarity at local and national level on how to risk assess in cases of historic abuse (trauma informed approaches to risk), specifically where suicide is a factor. This could include a national learning event.

Recommendation 2

MPS: South (SN) BCU Senior Leadership Team (SLT) to debrief both the reporting officer and investigating officer for crime report ref: 3310628/22 (the unexpected death incident reported on May 2022) to remind them that all seized property must be booked into the property system and clearly labelled and exhibited in accordance with MPS policy. This has been actioned.

Recommendation 3

BLG Mind: To address potential gaps in service delivery, BLG Mind to incorporate review, training, and engagement through:

- Training in trauma informed safeguarding
- Further DA training
- Review of safeguarding training and procedures within Recovery Works service
- Review of risk assessment training and implementation of stronger risk management protocol
- Greater links with statutory services and DA specific agencies such as Bromley and Croydon Women's Aid

Recommendation 4

LBB CSC: To ensure the policies around unplanned return home from care are implemented in Quality Improvement Service.

Recommendation 5

Primary Care - GP services: To consider referral to DA support services when a Karen describes historical or current DA and to also be aware of local support groups for survivors of DA (This work has proactively commenced in Bromley).

Recommendation 6

Primary Care - GP services: To consider use of a Social Prescriber within Primary Care when a Karen presents with concerns regarding housing, debt or needing extended periods of time off work (This work has proactively commenced in Bromley).

Recommendation 7

Oxleas: Whilst staff awareness of DA and the impact on MH has developed with increased support and training available, Oxleas to ensure this training and awareness, including policies and trust strategy and support is widespread.

Recommendation 8

All agencies: Ensure all staff are given opportunities to learn and reflect on best practice to help everyone understand the impact of psychological trauma and how to respond in a sensitive and compassionate way and ensure that staff 'do no harm' through care delivery that, without thought or intention, could retraumatise individuals.

MPS Glossary of Terms

Terms	
Adult Coming to Notice	(ACN)
Borough Intelligence Unit	(BIU)
Child Abuse Investigation Team	(CAIT)
Children's Social Care	(CSC)
Crown Prosecution Service	(CPS)
Crime Related Incident - (*non-crime report with investigation*)	(CRI)
MPS Intelligence System	(CRIMINT)
Community Safety Unit	(CSU)
DA Risk Assessment	(DARA)
DA Stalking Harassment	(DASH)
Domestic Homicide Review	(DHR)
DA	(DA)

Emergency Life Support	(ELS)
Home Office large Major Enquiry System	(HOLMES)
London Ambulance Services	(LAS)
Life Pronounced Extinct	(LPE)
Multi-Agency Risk Assessment Conference	(MARAC)
Multi-Agency Safeguarding Hub	(MASH)
Major Investigation Team	(MIT)
Metropolitan Police Service	(MPS)
Non-Crime Book Domestic	(NCBD)
Police National Computer	(PNC)
Police National Database	(PND)