Domestic Homicide Review
Peter/2017
Overview Report

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Kent Community Safety Partnership
Medway Community Safety Partnership

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Domestic Homicide Review
Peter Wright

Purpose

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

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

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

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

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

f) Highlight good practice.

Scope

This DHR examines the contact and involvement that organisations had with Peter Wright between 1st January 2012 and the 19th November 2016.

In order to meet its purpose, this DHR also examines the contact and involvement that organisations had with the perpetrator, Mark Blake.

Terms of Reference

The terms of reference for the DHR are set out in *Appendix A* to this report.

Timescales

This review began on 6th December 2016 following the decision that the case met the criteria for conducting a DHR.

Mark Blake was arrested on suspicion of Peter's murder and was subsequently charged with murder. Mark Blake was bailed to attend Crown Court. At his trial Mark Blake was found not guilty of the reduced charge of Manslaughter, having stated in

evidence that he had acted in self defence during an argument and physical altercation with Peter Wright.

Following the outcome of the trial this review was suspended to consider whether the criteria for the completion of a DHR still remained. DHRs are not inquiries into how a victim died or who is culpable; this is a matter for the coroners or criminal courts respectively to determine as appropriate. The initial review work carried out prior to the trial by the agencies involved with the family identified that Domestic Abuse was a factor within the home. There were also a number of reports made to agencies regarding Mark's behaviour, as well as an emerging picture that the family was experiencing difficulties in trying to manage this positively within the family setting. On this basis it was felt important to continue with the review to examine if any lessons could be learnt that may have prevented the tragic death of Peter Wright.

On the 5th July 2017 the review was resumed.

1. Methodology

1.1 This Overview Report is an anthology of information gathered from Independent Management Reports (IMRs) prepared by representatives of the organisations that had contact and involvement with Peter Wright and/or Mark Blake between 1st January 2012 and Peter's death. In addition to this, represented organisations were asked to report upon their involvement with other family members and in particular, Phillip, Mark's brother. Focus was also given to the relationships between Mark and Peter's two daughters, Georgina and Jessica Blake, and his birth parents Susan and John Blake.

1.2 The report also addressed the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation) prescribed within the public sector equalities act duties, and considered if they were relevant to any aspect of this review. The review considers whether access to services or the delivery of services were impacted upon by such issues, and if any adverse inference could be drawn from the negligence of services towards persons to whom the characteristics were relevant.

1.3 A letter was sent to senior managers in each of the agencies or bodies identified within the scope of the review, requesting the commissioning of the IMR's. The aim of the IMR is to:

a. Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (i.e. culture, leadership, supervision, training etc.) to see whether the homicide indicates that practice needs to be changed or improved to support the highest standards of work by professionals.

b. Identify how and when those changes or improvements will be bought about.

c. Identify good practice within agencies.

d. The IMR is written by a member of staff within the organisation subject to review, and by someone who has not had involvement with anyone subject of the review. It is signed off by a senior manager of that organisation before being submitted to the DHR review panel.

1.4 Each of the following organisations completed an IMR or Report for this DHR:

- NHS Dartford, Gravesham and Swanley Clinical Commissioning Group
- Kent Police

- Sussex Partnership NHS Foundation Trust - Children and Young Persons Service (CHYPS) formally CAMHS
- Kent Education Safeguarding Team
- Kent Specialist Children's Service
- Kent Youth Offending Team
- Kent Early Help and Preventative Services

1.5 In each of the different agencies' IMRs, a low level of interaction with Peter Wright was reported. These in the main related to reports to the Police when Peter had been a victim of crime, and interaction between his two daughters with Early Help and Intervention Services.

1.6 The Kent Youth Offending Service had involvement with Mark following the theft of a Motor Cycle in 2014. However, due to the low level of involvement the panel agreed that a report outlining their work with him would provide the panel with sufficient information rather than a formal Independent Management Report. Kent Early Help and Preventative Services also had a low level of interaction with family members and it was agreed that a report outlining their work with the family was appropriate.

1.7 Throughout this report the use of a CAF (Common Assessment Framework) is discussed and mentioned. A CAF is a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met. All of the agencies contributing to this review engage in the CAF process and any of them at the time set for this review could raise a CAF in circumstances they feel appropriate. This leads to a meeting of all agencies where the needs of the child are discussed. A CAF is a voluntary process and can only take place with the consent and involvement of parents. The process of how the CAF worked during the timescales set for this DHR changed in September 2015. A description of the new CAF process is outlined in the conclusion.

2. The Review Process

2.1 Contributors to the Review

2.1.1 The review panel consisted of an Independent Chair and senior representatives of the organisations that had relevant contact with Peter Wright and/or Mark Blake. This included a senior member of Kent Community Safety Team. In addition, a senior member of a Domestic Abuse Charity in North Kent (Oasis) was invited to sit on the board.

2.1.2 The members of the panel were:

Claire Ray	Kent Education Safeguarding Team
Kate Bushell	NHS Dartford, Gravesham and Swanley CCG
Carson Medhurst	Sussex Foundation Children and Young Persons Service NHS Foundation Trust (CHYPS) formally CAMHS
Gavin Moss	Kent Police
Andrew Rabey	Independent Chair
Shafick Peerbux	Kent Community Safety
Paul Startup	Kent Specialist Children's Services
Bonnie Wyatt	NHS England
Deborah Cartwright	Domestic Abuse Volunteer Support Service

2.1.3 The Independent Chair of the review panel is a retired senior Police Officer having retired in 2014. He now volunteers in the charitable sector and is a trustee for two charities, one of these being a domestic abuse charity. He has no connection with Kent County Council or any of the services contributing to this report. He has experience and knowledge of domestic abuse issues and legislation, along with a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to dealing with domestic abuse. He has a background in serious crime investigation, reviews, multi-agency panel working groups and the chairing of strategic and multi-agency meetings.

2.2 Review Meetings

2.2.1 The review panel initially met on 23rd January 2017 to discuss the terms of reference, which were then agreed by correspondence. The review panel then met on 5th May 2017 to consider the IMRs, and again on 29th September 2017 when the draft Overview Report was considered and amendments agreed.

3. Background Information

3.1.1 The review panel considered which family members, friends, and members of the community should be consulted and involved in the review process. The panel was made aware of the following family members and friends. All of the names of family and friends have been anonymised. (*A Genogram is available at Appendix B)*

Name	Relationship with Peter Wright
Susan Blake	Partner & Co-habitee
Mark Blake	Son of Susan Blake
Phillip Blake	Son of Susan Blake
Georgina Wright	Daughter
Jessica Wright	Daughter
Geoff Wright	Father
Caroline Smith	Mother
Michelle Brown	Sister of Susan Blake
John Blake	Mark & Phillip's Father
Kate Wright	Ex Wife and Georgina & Jessica's Mother

3.1.2 The Independent Chair wrote to family members on 22nd March 2017 introducing himself, explaining the DHR process, and provided them with a Home Office DHR information leaflet. The letters were delivered by the Family Liaison Officers. On 10th July 2017, following the trial of Mark Blake he wrote to the family members again. He offered to meet with them to discuss the DHR process and listen to any views and concerns they had. The letters were sent by recorded delivery.

3.1.3 The Independent Chair met with five members of Peter and Mark's family. Upon meeting, the Chair explained the review process and offered each the opportunity to meet the review panel members. None of them wished to meet the panel or required any further support. Each of them was able to provide background information, including other aspects of family dynamic and difficulties not recorded by agencies. Where relevant to the terms of reference, this information has been included within the report. The chair of the panel again wrote to family members on 9th January 2018 following completion of the report offering to meet and discuss the findings of the report and its content. The chair then met with Susan Blake on 7th February 2018 and Michelle Brown on 16th February 2018. He left them each with a copy of the report. At later dates the chair again met with them individually to discuss their view of the report, additional information was provided by them both and where relevant to the terms of reference this information is added to the report. Geoff Wright's

partner responded to the chair on his behalf. She requested that the meeting be delayed as he was in hospital awaiting heart surgery. His partner informed the chair that he was keen to read the report but would not be able to do so until agreed by his Doctors, this because they believed to do so may have a detrimental impact upon his health. Following contact with Geoff Wright and his partner, the chair met with them both on 16th February 2018. He left a copy of the report with them for him to read. This was collected on 20th March 2018. A longer time period of time was agreed so as to ensure that Geoff felt well enough and could read the report in stages if he felt it necessary. The chair offered the opportunity to all family members to meet with the Panel and explained their role and function. He undertook to keep in regular contact with all family members and provided his contact details to support this. The chair and panel members were extremely grateful to family members and friends for their contributions to this report. It was acknowledged how difficult this was for all who offered help in learning lessons from Peter's death and the panel wished to put on record their condolences to the family and all those affected by this tragic event.

3.1.4 Following a meeting with Susan Blake, the chair received a request from her that he meet Mark to discuss the DHR. Susan felt that this opportunity may provide an outlet to share and discuss his difficulties. Due to his acquittal in court of all charges, and the potential opportunity for services to review practice and procedure, the chair wrote to panel members to seek their view. The Panel members' overwhelming view was that the chair speaking to Mark would not be in the best interest of the review into Peter's death. It was also felt by the chair that the reason for the request was not best served by the DHR process and that other services were better equipped to meet Mark's needs. As a result, the chair wrote to Susan and explained that Mark's view would not be sought in this DHR. The chair also provided alternative agency details that could better support their needs.

3.1.5 Following completion of the draft Overview Report, the Independent Chair wrote again to family members, offering them a further opportunity to meet and discuss the content, conclusions and recommendations of the report

3.2 Events Surrounding the Death of Peter Wright

3.2.1 The criminal investigation timeline informs us that Police attended the family home in response to a call from attending paramedics of the South East Coast Ambulance Service (SECAmb). Details of the call being "cardiac arrest 54 year old male patient is in cardiac arrest – Patient has been assaulted by son who has run off". Peter subsequently died as a result of a single blow to his head. Mark Blake was arrested and charged with murder. A Home Office post mortem was carried out and the cause of death was recorded as being a subarachnoid

haemorrhage. An inquest was opened and suspended to allow the criminal investigation to take primacy.

3.3 Trial of Mark Blake

3.3.1 At his trial, Mark Blake pleaded not guilty to the charge of murder or manslaughter. He said that he had acted in self defence. He said that he had been attacked by Peter Wright and had struck out at him; this act had caused the death of Peter Wright.

3.3.2 Mark's explanation was accepted by the Jury and he was acquitted of all charges and released by the court.

3.4 Peter Wright

3.4.1 Peter was previously married to Kate Wright, they separated in June 2013. Peter and Kate had two children Georgina and Jessica. Both Peter and Kate agreed they would share the custody of the two girls and they spent four days with Peter one week and three days the second week. The alternating periods were spent with their mother Kate.

3.4.2 In February 2014 Peter began a relationship with Susan Blake, in August 2014 they moved in together and lived in town A. Susan had two sons, Phillip who was the eldest and Mark who was ten months younger. Phillip was diagnosed as having learning and coordination difficulties. At this time Mark lived in the main with his father John Blake, however he occasionally visited and stayed with Peter and Susan. In July 2015 Mark moved back to live with them after starting a course at a college close to town A.

3.4.3 Peter Wright was self employed and ran three companies. He had three show rooms all within the local region. Family members have described that his working life was demanding, he worked long hours, and although successful, his businesses caused him a lot of stress. He was also a keen sportsman who was physically fit and participated in regular sporting activity. He had no history of medical ailments. He was described by others as 'a gentle giant', due to his height and demeanor.

3.5 Mark Blake

3.5.1 Mark Blake was born in 1999. He was the second son of Susan and John Blake. Their other son Phillip Blake was born with a learning difficulty. Family members reported that Mark was a sensitive child. He looked after his brother at school who at times was bullied. In 2007 Mark was taken to his Doctor due to repeated nightmares. His mother suggested that the affect of these nightmares, a lack of sleep, and restlessness caused him to become difficult

and subsequently aggressive to other children and to her. This coincided with a move of house and difficulties experienced at school. Mark was seen by a Community Paediatrician in July 2007 and it was felt the problems had been resolved and he was discharged. The nightmares were a significant issue in Mark's life at that time and his mother reported that following them he slept with either of his parents. Mark's mother described him as a bright boy who was sensitive, and his reaction to the nightmares was evidence of this. His school reports showed that he could be disruptive and displayed a lack of concentration. However, they also reflected that he was a clever child but could try harder. At this time Mark enjoyed numerous after school and weekend activities with both parents. In 2011 Susan and John Blake separated. Susan described that she decided to separate as she felt they no longer had anything in common. John was upset by this and family members reported that he has never got over the separation. Mark is reported to have also reacted badly to the separation. Following the separation Mark and Phillip lived with their Mother and visited their Father at weekends. Family members stated that Mark became quiet and withdrawn. In addition to the separation of his parents, Mark experienced two significant bereavements, his Grandmother and a close school friend. It is strongly felt by family members that dealing with these difficult issues and emotions in quick succession had a detrimental impact upon Mark's coping and behaviour.

4. Chronology

4.1 Introduction

This section considers, in detail, the contact and involvement that Peter and Mark had with agencies during the period covered by the terms of reference. The facts are based on IMRs submitted by organisations, interviews with family, friends, and other organisations that Peter and Mark came into contact with.

4.1.1 On 6th January 2012 letters were sent to Susan and John from Mark's teacher who was concerned about Mark's consistently disruptive and contrary behaviour.

4.1.2 Following the separation of his parents in 2011, Mark's grandmother died in 2012. Later that year a close school friend also died. Family members said that these three incidents in close proximity had an affect upon Mark and caused him to become quiet and withdrawn. Mark's Aunt Michelle reported that the separation between Susan and John was difficult and prolonged, and she felt Mark blamed his mother for the separation. She states that she had offered to help look after Mark and Phillip but at the time Susan did not feel that she

needed help.

4.1.3 Susan recalled that in early 2012 Mark began to get physically aggressive towards her. She said it was usually when he had asked for something and she had said no. She described one incident when he punched her on the arm, and as a result of the pain and discomfort she required a series of physiotherapy sessions that she organised privately through a friend.

4.1.4 On 27th September 2012 Mark received a one-day fixed term internal exclusion; no reason was given or recorded in the school file as to why. A letter was sent home informing his parents.

4.1.5 On 6th March 2013 a letter from Accident and Emergency stated Mark had attended following a fight. He reported being punched in the head and had multiple episodes of vomiting. He had a CT scan which showed everything being normal. This was contrary to information within another letter sent from a CPAU (Centralised Pre-Operative Assessment Unit) dated 13th March 2013, it stated he had an accidental fall at school and hit his head against another person. It appears as a result of this reported incident he had been sent for the CT scan where the causes for the head injury were recorded differently. Both these incidents, although recorded differently, appear to be one and the same.

4.1.6 Susan recalled numerous incidents of Mark being aggressive but was unclear as to the specific dates. One incident she recalled was following a time when she had refused him something and Mark became so angry he smashed his iPad with a hammer. Another incident she reported was when she went into his room and he became very aggressive and pushed her towards the top of the stairs. She recalls fearing that he was going to push her down the stairs and she had to push back hard to stop him. As a result of this she called the Police. Following this incident she said that Social Services had contacted her and asked if she was ok. At the time she told them that things had calmed down and she did not wish to involve Specialist Children Services.

4.1.7 On 12th April 2013 Police attended a call to the home address of Susan Blake due to a verbal altercation that had escalated. Attending officers described Mark as quite reasonable and gave him advice on alternative methods to deal with his anger management. They offered details of Mental Health services in town A. Susan told them that she had already spoken to them and was told that Mark's problems were personality based.

4.1.8 On 1st June 2013 a report was received within the Central Referral Unit from Kent Police (this relates to the incident 4.1.7) It was reported that Mark was presenting aggressive behaviour and his mother was struggling to deal with him. She said that she could no longer physically control him. It was also

recorded in the report that Mark was at risk of exclusion from school. A referral was made for a CAF to be carried out.

4.1.9 On 6th June 2013 discussions between Mark's school and a Social Worker took place regarding the CAF referral. The notes indicate that initially the Social Worker supported the completion of the CAF, but as Mark's behaviour had improved at school, the decision was made not to undertake a CAF assessment, and ongoing anger management work would be carried out by the school. This was supported by the telephone discussion with Susan who stated that Mark was far more able to manage his anger and that the school were being very supportive. She reported that they recently returned from holiday and on one occasion while there Mark became upset but did not attack her. She also stated that she was pleased with the way she had managed Mark, but was not one hundred percent confident that Mark would not attack her in the future as he was still upset about the relationship ending between her and his father. The CAF process was explained by the social worker and although Susan did not reject it totally she asked for time to discuss this with Mark's father.

4.1.10 Susan reported that in 2013 she was in regular contact with the school about Mark's behaviour. During the month of June 2013 Mark was regularly missing from school or home and she often had to call the Police. She spoke to the school about his diminishing behaviour and they agreed to try and support her. She said the school agreed to complete a CAMHS referral but she did not hear any more following this suggestion.

4.1.11 On 29th July 2013 following a GP consultation, a record was made by the GP. It states that Mark was having behavioural problems since his parent's separation; he had become aggressive, sometimes hitting his mother. A referral was made to a psychologist.

4.1.12 On 30th July 2013 Susan Blake called the Police. She told them she was having issues with her 14-year-old son Mark. She said he was damaging the house and had gone 'berserk'. She was calling from outside the house and would not go back in the house. Police attended. The Police report states that Mark had become angry with his brother but no damage or violence had occurred. Mark appeared calm to the attending Officers. Susan told the Police Officers that she was struggling to cope and had contacted Social Services. The Police Officers attending made a report which was sent to Social Services.

4.1.13 On 6th August 2013 a report was received by the Central Referral Unit from Kent Police. The report outlines the circumstances as described in the above paragraph (4.4.12). A referral from the CAF coordinator in the Central Referral Unit was made to the CAF coordinator in town A. A telephone call was made to Susan and a message left offering her the opportunity to discuss the possibility

of accessing support. No further information was recorded about this incident and it is unclear as to whether Susan Blake was spoken to. No further information was recorded about a CAF, and it appears that no follow up was made.

4.1.14 On 4th October 2013 Mark received a one-day internal exclusion for hitting another pupil. He had been bullying a boy for some time by pushing him and calling him names. Mark was put on report, his behaviour monitored and a restorative sanction suggested. There is no record as to whether the restorative sanction was applied and whether any resulting benefit was realised.

4.1.15 On 8th October 2013 a GP record reported that Mark has multiple fractures to his 4th and 5th Metacarpal. A further entry on the 17th October 2013 outlines that a letter was sent from an Orthopaedic Team to Mark's GP, it stated that he had sustained these injuries when involved in a fight. There was no further information about this incident or any recorded follow up.

4.1.16 In February 2014 Susan Blake and Peter Wright began a relationship.

4.1.17 Susan recalled that in February and March 2014 she was struggling to cope with or manage Mark's behaviour. At this time extensive building works were being carried out in her house. The builder carrying out the work told Susan that he would need to stop all works unless Mark stopped damaging the property. Susan also said that during this time Mark destroyed two iPads and a mobile phone. She did not report his behaviour or seek help from any one. Susan said that driving home one day from work she decided that she could no longer cope with Mark's behaviour. She contacted Mark's father, John, and told him that unless he came and picked up Mark she would contact Social Services to have him removed. John came and collected Mark. Susan said to him that she did not want to see Mark until things had calmed down. She did not see Mark for some time but did still receive abusive calls from him accusing her of throwing him out of his home.

4.1.18 On 25th February 2014 Mark Blake started at a new secondary school in town C. This school was in close proximity to his father's house where he was living.

4.1.19 On 3rd June 2014 John Blake contacted Mark's school reporting him missing since the 23rd of May 2014. The school informed the Police. On the same day Susan contacted Kent Police to report Mark was missing. She said that she was in contact with him but he was refusing to return home. She said Mark stayed mainly with his father and occasionally with her. She said that he had been violent in the past. A later report showed that he returned later that night but does not state to which address.

4.1.20 On 5th June 2014 Mark was reported by Susan as missing from home. She

described him as being quite emotional having been missing two days earlier. She said she had spoken to him and he was refusing to return home. Mark was located in the early hours of the 6th June 2014 and was arrested together with another person for theft of a moped and motor cycle. Mark was interviewed and admitted his part in the offence and referred to the Youth Offending Team for a decision as to disposal in line with final warning principals.

4.1.21 Susan recalled that in May or June 2014 Mark had turned up at her home at 2am. He told her that he was suicidal. He stayed the night with Susan and the next morning she contacted her GP. She was advised to take him to Accident and Emergency, but decided to contact a Private Consultant Psychiatrist at Hospital T and arranged a future appointment. Mark attended 3 appointments together with his mother but then refused to attend. Susan contacted his father and asked him to attend with them, and as a result Mark continued with two further appointments. Mark had a total of 5 appointments. The assessment conclusions reported by the Psychiatrist were that Mark did not have a Mental Health condition, but that he needed to learn to take responsibility for his actions. During this period of evaluation Mark had said to his mother that he was not angry with her, but just angry. He did not go on to explain or elaborate.

4.1.22 On 10th June 2014 John Blake contacted his GP seeking counselling for Mark. He described Mark as having mood swings since the separation of his parents and a feeling of anger towards his mother.

4.1.23 On 17th June 2014 Susan contacted Mark's GP. She requested a referral regarding his suicidal ideation. She requested that he be referred to a private Psychiatrist.

4.1.24 On 19th June 2014 the Practice Nurse made a referral to CAMHS for Mark as a result of the call from his father (as described in 4.1.22). The decision recorded by CAMHS in relation to the referral was not to accept it and the case was sign posted to Early Help services. A reply letter from CAMHS was received at the GP surgery on 7th August 2014, it confirmed the referral to Early Help and said that a CAF had been initiated and the case closed to CAMHS. There is no record that this CAF was considered by Early Help services.

4.1.25 On 25th June 2014 Susan contacted Kent Police to report Mark missing again. She stated during her report that the previous week he had suicidal thoughts. Mark returned home the same day. The missing person report indicated that Mark had assaulted his mother previously on at least three separate occasions.

4.1.26 On 30th June 2014 Mark was interviewed by the Youth Offending Team in relation to the theft of a motor cycle committed earlier in the month. A final warning assessment was completed; this identified Mark had committed the

offence following an argument with his mother. He wanted to do something bad as he was angry with his mother. He said that he had a good relationship with his father and brother. He had no issues of substance misuse, mental health or ill health. He was remorseful for his actions. On 8th July 2014 a Youth Caution was administered.

4.1.27 Kate Wright recalled that Peter Wright had told her that he was intending to move in with Susan Blake. She said that she was concerned for their daughters Georgina and Jessica as she was aware that Susan had two teenage sons. She said she felt that they had not had a chance to get to know each other and urged Peter to rent a flat for some time to allow Georgina and Jessica to spend some time with Phillip and Mark before moving in on a more permanent basis. Peter did not agree.

4.1.28 In August 2014 Peter Wright moved into live with Susan Blake. They extended the property to allow for all of the children to live with them. Shared custody arrangements with Kate Wright meant that his daughters, Georgina and Jessica, spent four days one week with him and three days the following week, the rest of the time was spent with their mother Kate Wright. Kate said that this arrangement initially worked well. Each of the girls had their own room and Mark lived with his father in town B. Whenever Mark visited and Georgina was not there he would use her room and leave it in a mess. However Susan stated that Mark shared a room with his brother Phillip when he visited.

4.1.29 On 16th October 2014 Mark received a two day fixed term exclusion for a physical assault against a student. The report said that Mark was using his lighter in the corridor and he burnt the face of another student. The description of circumstances is vague and the level of injury not recorded.

4.1.30 Kate Wright recalled that in February 2015 Georgina said to her that she would not go back and stay with her Father due to a diminishing relationship between her and Mark. She had said to her father that she wanted a lock or latch on her door as Mark would walk in uninvited; had thrown condoms into her room and teased her and her boyfriend. Kate said that this was refused on health and safety grounds. Peter was upset by the decision of Georgina not to stay with him anymore, and family members reported that he tried to persuade her to change her mind but she would not. Susan's recollection of this event is different. She recalled the incident but stated this was the only difficult one between Mark and Georgina.

4.1.31 In the summer of 2015 Susan Blake recalled that Mark had settled in well to his new school and had completed his GCSEs. He applied to do business studies in town D but was unsuccessful. He applied to the college in town A and was successful in gaining a place. In May 2015 he moved back to live with his

mother in town A.

4.1.32 Susan recalled that Mark and his brother Phillip had always got on well, and because of Phillip's learning difficulty Mark was quite protective of him. Susan has reflected that at times Mark may have been jealous of the additional attention she showed Phillip due to his difficulties.

4.1.33 Susan recalled that after Mark moved back in things initially progressed well. He was enjoying his course and he would discuss his day and the work he was doing. However, as the course progressed Mark began to struggle with the work and assignments. Susan met with the college to discuss the best way forward and set in place an action plan. A short time later she was called back by the college as Mark was still struggling. After Christmas 2015 Mark left college. Mark was contacted by the Education Department and asked if he needed any help and support. Mark refused but was given a contact number should he change his mind. Mark began to apply for apprenticeships, jobs, and the armed services, but without success. Susan described how this caused Mark to revert to previous behaviours; he became aggressive, would break items in the house and became verbally abusive toward her. She said that at no time did Mark ever show any aggression towards Peter, Georgina, or Jessica, it was only towards her. Mark did eventually find work but it was reported that with the additional money this gave him he began using recreational drugs, in particular cannabis.

4.1.34 On 17th July 2015 Mark's school file showed that he had left school at the end of year 11. Having left school it showed that he was not in Education, Employment, or Training. (NEET)

4.1.35 Kate recalled that Jessica had become increasingly unhappy about staying at her father's and stated that she was frightened by Mark's aggressive and violent behaviour. She also reported witnessing Mark damaging property. In January 2016 when Peter and Susan were planning a family holiday, Jessica stated she did not want to go because on the previous holiday she had been teased and tormented by both Mark and Phillip. Kate contacted Peter to discuss the matter. Peter was reported to have been very upset by this and tried to persuade Jessica to change her mind. Susan's recollection of this holiday is different. She recalls that Jessica rarely left hers or Peter's side and that she was not teased or tormented by Mark and Phillip.

4.1.36 Kate Wright described another incident that had occurred between Jessica and Phillip. There had been a verbal altercation which later led to Jessica being threatened by Phillip with a knife when she entered his bedroom. She had also seen him naked when he was leaving the bathroom. When Jessica returned to her mother's home, her demeanour was described as hysterical. Kate and

Peter met to discuss the issues but nothing was resolved. Susan's recollection of this event is different. She recalled that following the incident she and Peter held a family meeting where Phillip explained he was only waggling the knife and not threatening Jessica and this had resolved the issue. Upon review Michelle Brown doubted that Phillip would behave in this way, she felt that he did not have the verbal capacity to deal with an altercation of this type.

4.1.37 On 11th February 2016 a referral was made to Early Help for Family Mediation. This was made by Jessica's school who reported animosity between both parents, who had separated and were in new relationships. It said that both Georgina and Jessica found staying with Peter difficult, and both reported having difficulties with Mark that made them feel uncomfortable. The report stated that Jessica had not been to visit her father for a week. As a result of this the case was referred to a case worker.

4.1.38 On 18th February 2016 a home visit was carried out to Georgina, Jessica and Kate Wright by the Early Help worker.

4.1.39 On 23rd February 2016 a referral was made by the Early Help worker for Family Mediation following a full family assessment. The referral requested that the wider family were involved. However following contact with family members it was decided that mediation would focus upon the relationship between Jessica and her father. When concluded it was reported that the relationship between Jessica and her Father had improved.

4.1.40 On 25th February 2016 a meeting was held between the Early Help worker and Jessica. It was recorded that Jessica stated she had good relationships with her mother, father, sister and three other adults. She worried about being bullied at school, Mark Blake's anger, feeling scared most of the time, and Phillip and Mark making her do something that she felt uncomfortable about.

4.1.41 On 26th February 2016 an Early Help Assessment was completed. It reported concerns about family relationships and the impact this was having on the children. The assessment indicated that Georgina and Jessica did not feel safe at their Father's house. Jessica had been jokingly threatened with a knife by Phillip. She was frightened of Mark and did not feel she could talk to her father if things went wrong.

4.1.42 On 4th March 2016 Peter attended the Early Help offices and spoke to an Early Help worker. The wishes and fears of Georgina and Jessica were shared with him. He said that he felt powerless.

4.1.43 On 9th March 2016 Kate Wright contacted the Early Help worker. She said that Jessica was very anxious about attending her Father's house and as a result had not gone and returned home with her. Peter also contacted the Early Help

worker and said that Jessica was not willing to discuss any of her concerns with him and did not want to stay at his house.

4.1.44 On 14th March 2016 Peter, together with Jessica, attended a meeting with the Early Help worker. At the meeting Jessica agreed to staying with her Father, how to discuss her anxieties and the planning for a future holiday. Later the same day Kate made contact with the same Early Help worker to say that Jessica had changed her mind and would not now go and stay with her Father.

4.1.45 On 17th March 2016 Peter sent an email to the Early Help worker stating his position with his daughters and that he was considering involving a solicitor in the future. Jessica continued to have counselling.

4.1.46 Kate Wright, when reflecting on this time, stated that it would have been helpful to have had full family mediation, but this was not carried out, Family mediation is referred to in 4.1.39. It was offered but declined by other family members who considered mediation between Peter and Jessica was the priority. Kate described this as an opportunity missed. She also reported that when Peter locked Phillip's knives/tools away, Jessica began to visit him again.

4.1.47 Susan recalled that in July 2016 she had planned to visit family abroad. The night before she was due to go she received a call from a doorman of a night club. Mark had been found in the toilets taking cocaine and they had found a passport belonging to Phillip Blake on him. Susan went to the club to collect it as Phillip was travelling with her. She could see that Mark was under the influence of drugs and was worried about him so she contacted the drugs helpline FRANK. As a result of what she was told she decided to take Mark to his GP the next day. Mark however said that he would go alone and urged Susan to continue with her trip as planned, which she did. When Susan returned she found that Mark had not gone to the GP and was continuing to smoke cannabis. Later that month Mark gave up his job. Susan felt that this was due to the amount of Cannabis he was smoking. Susan saw that Mark was becoming more and more restless, and she urged him to get a job, but he refused saying he would not work in the summer as this is when all of his friends were off and not working. In September 2016 Susan contacted the Education Department as she thought returning to education would be good for him. Susan was told that a letter had been sent to Mark but he had not responded.

4.1.48 On 16th November 2016 Peter contacted Kent Police to report an incident. The Police report indicated that as a result of a verbal altercation between Phillip and Mark both Susan and Peter had intervened. Mark had begun to argue with Peter and was abusive about Peter entering his personal space. Mark grabbed Peter's t-shirt, Peter pulled away from Mark and the T-shirt ripped. Police

reported that they took Mark to his father's house, although this account is different to Susan's account. She says that John Blake attended their address and took Mark with him. However it transpires that he dropped Mark at his Grandfather's home which is close by. This resulted in Mark returning to the address the following day. The attending Police Officers completed a DASH questionnaire (Domestic abuse, stalking, harassment, and honour based violence risk assessment toolkit) and assessed the risk posed by Mark as Standard on the matrix. Within the risk assessment in response to the question "is the abuse getting worse" Peter replied, "Not worse but the first time the Police have been called". A further comment made by Peter was recorded within the attendance report, it said; he and his partner were afraid of Mark, and had tried to block the door as they slept in the past. Officers attending this call were asked about these two comments by the author of the IMR. They said, they had been told by Peter that other incidents had always been of a verbal nature and not been physical. In response to the other comment Peter explained that on one occasion Susan had placed a pillow by the bedroom door, as she believed Mark may have stolen money from them in the past. Susan disagreed with this and recalled that the pillow was placed against the door because of her fear of Mark and what he might do to her in the night. This fear was based upon another incident with Mark during which he had been violent towards her.

4.1.49 Susan recalled that on 17th November 2016, whilst at work, she spoke to a colleague for advice. She told her about the situation with Mark and was urged to contact Social Services. She stated that she tried to call them but was cut off so decided to send an email. Later the same day she met with Peter and they decided to call Social Services together. During the call Susan became upset so Peter took over the conversation. An appointment was made for them to meet on 21st November 2016.

4.1.50 On 17th November 2016 an email was received by Social Services from Susan. It described the situation on the 17/11/2016 as described above. (4.1.49)

4.1.51 On 18th November 2016 a telephone call was made to Susan from the Central Referral Unit. Susan described the situation with Mark. She provided a history of the difficulties she had been experiencing and was having with him. The advice provided to Susan was that Early Help Support would be provided and that this would be linked to advice about Mark's drug addiction. Susan was told that they would support her with strategies to help her cope better, but their involvement would be short term until Mark was 18 years. Susan was advised to ring the Police should Mark become aggressive and that being arrested may act as a wakeup call for him and help him understand the consequences of his actions.

5. Overview

5.1 Susan explained in her report that at 12 years old she had witnessed domestic abuse against her mother. This was of a violent nature and carried out when her mother's partner was drunk. This had continued for seven years. Eventually Susan spoke and told a teacher at school she trusted. Following good advice she and her mother left to a place of safety. Susan said as a result of witnessing this she would not accept any form of violence towards her in a relationship. Susan's sister Michelle recalled that as children they both witnessed the violence towards their mother. Michelle being ten years older than Susan recalled the profound effect witnessing violence against their mother had upon Susan. Michelle believes that to this day Susan will get scared quickly in volatile situations and when around people who are very drunk.

5.2 Susan Blake described that following her separation from John Blake she noticed Mark was agitated and aggressive. Mark would punch the doors and walls within the house. He was also abusive towards Susan and she recognised that some of the things he said were reflective of things said by her husband during the difficult period of separation. On one occasion Mark said to her that he no longer wished to go to see his father as he would always say bad things about her. Susan asked Phillip about this and he said he did not listen and would put his head phones on and listen to music. Susan said she asked John about this but he denied that it ever happened.

5.3 Kate Wright recalled that Jessica had often mentioned incidents of violence and aggression displayed by Mark. Jessica told her of an incident shortly after a new kitchen had been installed; Mark picked up a chair and threw it across the kitchen work tops smashing everything on them. Jessica said she ran to her room frightened. Susan does not recall this incident and says the only incident involving Mark causing damage to their kitchen was when he threw a glass, causing damage to the oven door. Susan says that Jessica was not present during this incident but was upstairs. Michelle also doubts that this incident occurred due to Peter's insistence that he would not be able to bring his girls to the house if Mark was aggressive or violent.

5.4 Peter's mother, Caroline, recalled that Peter and her were very close, there was only 20 years between them and she described him as a friend as much as a son. She said he would talk to her about everything and phoned her regularly. In the last year ninety percent of their conversations revolved around Mark. Peter is reported to have told her he was frightened of him and what he might do. She said she knew both Peter and Susan were frightened of Mark and that

Peter had told her things were getting worse and worse. He tended to leave Susan to deal with Mark and said he did not want to interfere. Peter had told her that he had text Mark's father asking for help, but he had not received a reply. She says Peter had described the situation to her in that everyone gets angry at times but that they take control, but in Marks case he simply does not get control of his anger.

5.5 Michelle, Susan Blake's sister, reported that during the time of the house renovation she did not visit the family home as she suffers with asthma. She stated she was aware that Mark was living with his father at the time and visited Susan every two weeks to stay. She observed that when Peter moved in life and the home seemed very busy. She said that she felt at times Susan and Peter were too busy and very absorbed in their new life together.

6. Analysis

6.1.1 Information available to the review panel shows that Peter was a victim of Domestic Abuse in an incident with Mark the day before his death. This incident followed an altercation in which Peter had his T Shirt ripped by Mark. The Police were called and Mark removed from the property and taken to his Grandfather's home. There is no evidence to suggest that Peter had been a perpetrator of violence towards Susan or his ex-wife Kate. However, the circumstances presented to the panel in reports from agency contacts, family and friends, do indicate that Mark Blake was a persistent perpetrator of Domestic Abuse towards his mother. The cross-Government definition of domestic abuse says;

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

The definition is affective of those aged 16 and over. Home Office Guidance Information guide: *adolescent to parent violence and abuse (APVA* available at: http://www.gov.uk/domestic -violence-and-abuse) describes circumstances when the definition of Domestic Abuse can be applied to those under the age of 16. There is currently no legal definition of adolescent to parent violence and abuse; however guidance provided says *"it is important to recognize that APVA is likely to involve a pattern of behaviour. This can include physical violence from an adolescent towards a parent and a number of different types of abusive behaviour, including damage to property, emotional abuse, and economic/financial abuse. Patterns of coercive control are often seen in cases*

of APVA, but some families might experience episodes of explosive physical violence from their adolescent with fewer controlling, abusive behaviours."

The first large scale study of adolescent to parent violence and abuse in the UK was conducted by the University of Oxford between 2010 and 2013. Practitioners and parents interviewed in the study described the abuse as often involving a pattern of aggressive, abusive and violent acts across a prolonged period of time. As well as physically assaulting their parents those interviewed said their teenage children had smashed up property, kicked holes in doors, broke windows, had thrown things at their parents and made threats. Verbal abuse and other controlling behaviours were also commonly present. This pattern of behaviour creates an environment where a parent lives in fear of their child and often curtails their own behaviour in order to avoid conflict, contain or minimise violence. This study found that there was no single explanation for this problem. Families described a range of reasons which they saw to be the reason for APVA, including substance abuse, mental health, learning difficulties or a family history of domestic violence or self harm. Some families were at a loss to explain why their child was so aggressive towards them, having raised other children who did not display such behaviour. The information provided to this review about Mark's behaviour, would indicate that both definitions apply within the time scales set for the terms of reference.

6.1.2 The impact upon Mark of the break up of his parent's marriage is described by many family members as significant and having a detrimental effect upon his behaviour and mood. It is described as the catalyst to the problems that followed. His behaviour in school, and relationships with his peer group, were described as aggressive, with numerous examples of bullying and fighting reported from agencies. Family members were aware of his violent out bursts and abusive language towards his mother in particular. Georgina and Jessica highlighted fear, anxiety and vocalised concerns about staying with their father and going on holiday with him because of Mark. Susan eventually sought help from Mark's father as she no longer felt able to cope with his behaviour and did not feel safe with him living in their home.

6.1.3 The review looked carefully at the role of agencies in supporting the management of Mark's behaviour both at home and within school, in particular the numerous opportunities to carry out a Common Assessment Framework (CAF). Susan had, on a number of occasions, raised concerns with agencies about her ability to cope with Mark. She had asked his school for help, her GP, social services, the Police and a referral had been made to CAMHS. On each occasion a recommendation was made for a CAF to be carried out. But on no occasion did this happen. Information provided shows that Susan declined to engage on one occasion but there is no detail recorded as to why other recommendations to carry out a CAF were not pursued. A consistent theme is

that no face to face follow up contact is made with Susan. This would have provided an opportunity to gather more information about the situation and to discuss the value of a CAF with Susan, as well as an opportunity to speak to Mark about his anger. A lack of follow up, as well as a clear lack of management oversight of the referrals is evident in each of the cases referred for a CAF. Both of Peter's daughters described Mark as aggressive and violent during contact with mediation services, and they stated that they were frightened of him. This information, if seen in the context with the other referrals and information, would have provided an opportunity to explore further and more holistically into the family situation, and with greater professional curiosity may have created links that could have led to different interventions.

6.1.4 The initial attendance by Police to incidents when Susan was concerned for her safety, in the main, was good. An assessment of the situation together with adherence to Domestic Abuse Protocols and the completion of a DASH questionnaire followed. Upon attending the address in April 2013 the decision was taken to refer the case to Social Services via the Central Referral Unit. However the referral was not received until the beginning of June 2013. This delay in sharing the details of the incident led to Susan not being contacted until six weeks later. As a result she said that the situation had improved and it was decided not to carry out the CAF. If the referral had been received earlier this may have changed that outcome and a CAF undertaken. There is no explanation for the delay and it is not repeated on future incidents. It is acknowledged that this was a missed opportunity.

6.1.5 Mark was reported as missing to the Police on three occasions during the month of June 2014. During this time he was living with his father and visiting his mother occasionally. On one occasion Mark had been missing for about a week before this was reported and there is no explanation as to why this was not explored with his father. When Mark returned home a follow up visit should have been completed by the Police or Children's Social Services, in line with established good practice. This would have provided an opportunity to speak to Mark and to gain understanding as to why he had been going missing, as well as exploring further with the family as to the presenting issues. On the 25th of June 2014 Susan reported that Mark was missing again. She disclosed to attending officers that she had been assaulted by Mark in the past. This information was not recorded as a crime, in line with the crime reporting and recording standards of Kent Police. The affect of not recording this as a crime meant that the information used to assess the risk posed by Mark when carrying out DASH questionnaires after that date, was incomplete, and could have led to an understated evaluation of his risk. During a period when Mark was missing he committed an offence of theft. He was arrested and subsequently received a caution. Mark was interviewed by the Youth Offending Team and the reason he

gave for committing the offence was because he was angry with his mother. This statement was not explored further, nor was it linked to or referred onto the other agencies that had received ongoing reports regarding Marks behaviour.

6.1.6 There were three incidents reported at schools involving Mark and highlighting him as being involved in fights or incidents of bullying whereby another pupil received an injury. On one occasion this occurred outside the school grounds at a bus stop and the others were within school premises. The Department of Education guidance to schools in the Education and Inspections act 2006, under section 89 (*Appendix D refers*), provides head teachers with information and advice designed to promote good behaviour and discipline. Section 89 of the act provides specific guidance in relation to bullying incidents, whether on school premises or not. While Head Teachers are provided with this guidance, it is subject to the rules and regulations as determined by the school governors and set out in a statement of general principals to which the head teacher is to have regard in determining any measures under section 89 of the act. Separate guidance for Police, through the Home Office counting rules for recorded crime, crime recording (school protocol) (*Appendix E)* provides guidance to Police as to when incidents in schools should be recorded as a crime incident. For incidents within the school, guidance says the nature of injury and the threat should be assessed and considered along with the wishes of the parents or guardians of the pupil affected. The nature of the incident whereby a pupil sustained an injury from the misuse of a lighter in school appears to be serious enough to meet the criteria for recording as a crime. However no information is held by either Police or Education to indicate how the school considered this incident and whether they followed the protocols as outlined under section 89 of the Education Act 2006. Further guidance in *Safeguarding Children and Safer Recruitment in Education (January 2007)* outlines the importance and necessity for the keeping of records of incidents occurring in schools and the outcome of actions taken. In one incident (4.1.14) a restorative sanction was suggested but no record was available as to whether this was applied or any outcome. In the other cases only brief details of the incidents were recorded with no further records found describing levels of injury inflicted or sanctions applied.

6.1.7 The evidence provided tells of a family that is struggling with a complex mix of issues and circumstances. There is evidence that co-parenting arrangements were unstable, significant difficulties were experienced by all the family with regards to Mark's behaviour, his levels of anger and aggression fluctuated but were escalating, and there was evidence of this violence occurring both within the family home and at school. In addition, Mark had contact with the Criminal Justice system due to his offending behaviour and had commenced taking drugs. All of these issues were signs enough that this individual, Mark, and the family as a whole, were in need of support. Information provided indicates that

Susan as the primary person to deal with Marks behaviour, at times played down the extent of his behaviour and the impact it was having upon her. She also clearly struggled at times to cope but never the less tried to manage independently. Peter was clearly upset at Jessica and Georgina's decision not to visit him at the home he shared with Susan and her sons. The evidence shows that he did all he could to try and encourage them to change their minds, but possibly in trying to do right by all and balance everyone's needs in the household, maybe he didn't hear their concerns clearly enough. This resulted in them not feeling safe nor protected in his care.

7. Conclusions

7.1 The evidence available to the review panel from agency contacts, family and friends shows that Peter was a victim of Domestic Abuse by Mark on one separate occasion prior to his death. Susan was a victim of Violence and abuse from her son Mark, as were other family members. This is evidenced by family members and reports to professional agencies. Jessica and Georgina were fearful of Mark and did not feel safe in his company. The violence, abuse and fear created by Mark is defined in the *Adolescent to Parent* abuse as outlined in 6.1 of this report, and is relevant to Mark's behaviour in this context. The application of the Public sector equality act duties shows that no one subject of this review received an adverse service from agency or staff member due to their membership of any of the nine characteristics outlined within the Equalities Act 2010.

7.2 Susan struggled to manage Mark and his behaviour. She did not feel safe having him living with her. Susan often sought help from professional services and whilst initial calls were made seeking help, these were often withdrawn or not followed through.

7.3 Professional Services did not engage fully with Susan and Mark. Numerous referrals about Mark's behaviour were made. These were not responded to adequately, professional curiosity was lacking, and opportunities for assessment and intervention missed. At no time was a holistic assessment or overview of the family dynamics undertaken and repeated referrals for a CAF were not followed up and lacked management oversight.

7.4 Information Sharing Protocols are well established between professional agencies, however, at times opportunities were missed to share concerns with other agencies. The CAF would have provided this forum for the sharing of information by developing a team around the family, but in its absence agencies worked in isolation, dealing with individual issues as they were presented.

7.5 The disparity between the guidance for schools in managing incidents of bullying and poor behaviour as outlined in *the Education and Inspections Act 2006* and the Home Office crime reporting and recording standards led to a lack of available information about incidents involving Mark as a perpetrator. This occurred on two separate occasions. Firstly, the time Mark was missing and his mother reported to the Police he had assaulted her on three separate occasions. Secondly, at school when staff were made aware of incidents when Mark had been accused of assaulting other pupils. At the time of these incidents the school protocols for reporting and recording crimes appear ambiguous. The Home Office guidance for the reporting and recording of crimes was only applicable to Police forces. At this time it appears that no protocol providing guidance to schools as to when incidents should be reported to the Police existed. The only protocols in place at that time issued by the Education Authority were designed to assist schools in dealing with minor incidents giving no guidance as when to report or how to differentiate minor from more serious incidents. In September 2017 updates to the Standard Operating Procedure for Kent Police under policy *N17a Reporting incidents in Schools* were introduced giving guidance to school managers, Police, and the newly introduced specialist Police Community Support Officers. The purpose of the policy is to outline the responsibilities of schools when incidents occur; how the incident should be handled if the Police need to be involved; guidance on the type of incidents where the Police should be involved and those that should be dealt with by the school. Although recently updated the policy uses previous Home Office guidance to identify when incidents should be reported. (Appendix B outlines the flow chart to be used in reaching a decision) In addition updated guidance from Kent County Council's Education and Young People's Services Directorate issued in November 2016 provides templates for Safeguarding Record Keeping in Education Settings. The guidance provides instruction for record keeping of Safeguarding incidents and templates to use ensuring continuity across all Schools and Educational establishments.

7.6 A lack of management oversight or practice scrutiny of process and decision making meant that referrals for action were not fully explored or completed. Recorded statements by Susan identifying very concerning information about Marks behaviour was not picked up on. As a result opportunities for intervention and support following initial calls from the family did not happen. This demonstrates a lack of professional curiosity within these teams and is evidence that poor practice standards existed.

7.7 A lack of knowledge around Adolescent to Parent Violence and Abuse within agencies was apparent. Identifying the signs and exploring the support options available to her and Mark may have enabled Susan to make different decisions. Home Office guidance exists around this growing area of Domestic Abuse and

local Domestic Abuse Services do have skills and resources, albeit limited, to support individuals in such circumstances.

7.8 A comparison and explanation of the CAF process used for Mark Blake and the changes made since 2015:

The Common Assessment Framework process involved all agencies working with children and families where the threshold for support was assessed as being below the level for statutory intervention. The responsibility for the completion of the CAF was with the agency identifying the need in conjunction with the family. It was a voluntary process which required the consent of the family. Once the CAF was completed the lead agency would coordinate Team Around the Family (TAF) meeting with all agencies involved to develop a plan of support for the family. A CAF coordinator in each district would monitor the numbers of CAFs and refer to commissioned services if the assessment suggested that specific support was required. It was recognised that some families would remain supported by a TAF for long periods without active intervention and in some cases a CAF was not completed by the responsible agency. As a result a new system of identifying and assessing for Early Help support was introduced in September 2014. Families are now referred via an Early Help Notification which includes consent from the family for the notification to be made. If the family meet the threshold for Intensive Early Help support, they will be allocated to an Early Help worker or suitable commissioned service to undertake an assessment and developed a plan with a dedicated worker. Management oversight of the triage threshold, allocation, quality of the assessment, ongoing case supervision, and closure decision are all recorded. From June 2015 all Early Help Notifications that meet the threshold for intensive support are allocated into the newly formed Early Help units. From November 2015 all notifications, assessments, and contact records are now kept on a new case management system. This includes management oversight and updates on reviews. As part of this process the views of the subject are sought and included within the assessment framework.

8. Lessons to be learnt

8.1 This DHR identifies that Peter was involved in a Domestic Abuse incident with Mark on 17th November 2016 and that a DASH risk assessment form was completed. However this did not identify any lessons that relate specifically to Domestic Abuse towards Peter. It does identify the impact that Adolescent to Parent Violence and Abuse can have upon parents and other family members. Susan was clearly frightened of Mark, as were other members of the family. This was not adequately identified nor responded to by agencies consistently, and the complexities of emotions that are associated with any type of

experienced abuse were not acknowledged, understood, nor supported.

8.2 The factors outlined within this investigation identify opportunities to improve how services respond to referrals by the review of practice and procedures, with the sole objective of improving outcomes for people. It is clear that services were not joined up in their thinking or approach in dealing with Mark and each referral was dealt with in isolation. As a consequence the broader picture and scale of the difficulties the family faced were not understood. No overview of Mark's behaviour and the impact this was having upon other family members ever took place. At no time did any face to face contact take place with Mark or Susan to understand the context of the difficulties. Both Georgina and Jessica raised concerns about Mark's behaviour and spoke of being frightened by him. No action followed that appeared to make them feel safe or reduce their anxiety. As a result they took the only action they could and that was to stop visiting the family home.

8.3 All agency staff coming into contact with this family at times lacked professional curiosity. On numerous occasions it was too readily accepted that things had improved and services or intervention were no longer needed. Having good management oversight at key times in the stages of a referral is essential and if this had occurred when decisions were made by staff not to progress interventions and close the case, the need for further investigation could have been identified and actioned.

8.4 The recording of Crime incidents committed by Mark against his mother and other people at times did not happen. Changes to the process of recording crime and incidents within schools were introduced to allow schools to manage bad behaviour and to ensure that young people were not criminalised for minor incidents. New guidance was agreed to allow schools to take better control of incidents happening upon their premises. However, it appears there was confusion or a lack of understanding which led to protocols for the recording of crime not being followed and records of how incidents were dealt with and their outcomes could not be found. The recording of crime and Safeguarding protocols also serves as information for assessments to be made of the risk posed by an individual and serves as a means to protect the public. In not recording all the incidents a proper assessment of the risk posed by Mark was not possible. In this case Police were not regularly in attendance or aware of the incident that had occurred. If they had been aware of the circumstances the guidelines provided to them would have meant these incidents would have been recorded and investigated. Better guidance from the Police to schools at that time would have allowed the reports to be made and therefore investigated and a record of the incident available for future risk assessment. Furthermore the absence of a full description of the action taken by the school following the incidents could not be found. The result of this being that information was not

available to other services in assessing the risks posed to other people by Mark. New protocols in both crime reporting and safeguarding incident recording by schools aim to tighten up on these procedures ensuring relevant detail is made available for future assessment.

8.5 The panel has outlined six recommendations based upon the findings of the IMRs and reports submitted.

9. Recommendations

9.1 The review panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1	That a better understanding of Adolescent to Parent Violence be established with professional services. To raise awareness and to train staff so they can spot the signs and impact on families and be aware of the support options available for referral.	Kent County Council Children and Adult Social Services
2	The development of programmed activity designed to help Parents, Guardians and other family members affected by Adolescent to Parent Violence.	Kent & Medway Domestic Abuse and Sexual Violence Group
3	To review the new principals as outlined in Kent Police policy N17a and their application in schools. To ensure Educational establishments are aware of them and to ensure that the changes are proportionate and do not create a process that criminalises young persons for minor incidents.	Kent Police
4	A review of the current Early Help Notification process and Early Help Intensive support to families. To ensure processes are in place to engage with family members within Early Help intensive support. To ensure clear management oversight is recorded within the case management system.	KCC Early Help & Preventative Services

5	To ensure incidents reported to the Police whether recent or historical are recorded correctly and in line with crime recording standards. This must occur at the earliest opportunity to ensure that all action and activity is in line with crime investigation principals and practice. This can lead to ensuring delays in referrals to other agencies are avoided.	Kent Police
6	A review of information sharing protocols between statutory and non statutory agencies. Ensuring principals and practice guidance is adhered to and in line with Kent and Medway information sharing protocols.	KCC Early Help & Preventative Services/KCC Specialist Children Services

Appendix A

DHR Terms of Reference

Kent & Medway Domestic Homicide Review

Victim – Peter Wright

Terms of Reference - Part 1

1. Background

1.1 Following a verbal altercation Peter Wright was punched by his step son Mark Blake and subsequently died from the resulting injury.

1.2 Mark Blake was arrested and was subsequently charged with his murder and has been placed on bail awaiting trial.

1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on the 6th of December 2016. It confirmed that the criteria for a DHR have been met.

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

2. The Purpose of this DHR

2.1 The purpose of this review is to:

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

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

iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working.

iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

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

vi. Highlight good practice.

3. The Focus of the DHR

3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Peter Wright.

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

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

4. DHR Methodology

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

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

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include

issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Peter Wright, Mark Blake, Susan Blake, Phillip Blake, and the two daughters of Peter Wright, Georgina Wright and Jessica Wright from the 1st of January 2012 until November 2016. If any information relating to Peter Wright being a victim, and Mark Blake being a perpetrator, of domestic abuse before the 1st of January 2012 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Peter Wright and/or Mark Blake. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2015, X was cautioned for an offence of shoplifting).

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

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

5. Specific Issues to be addressed

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

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

ii. Did the agency have policies and procedures for the ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Peter Wright and Mark Blake. (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools,

procedures and policies professionally accepted as being effective? Was Peter Wright subject to a Multi agency risk assessment conference? (MARAC)?

iii. Did the agency comply with information sharing protocols?

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

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

vi. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Peter Wright and Mark Blake (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?

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

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

ix. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Peter Wright and promote their welfare, or the way it identified, assessed and managed the risks posed by Mark Blake? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

x. How accessible were the services to Peter Wright. (as applicable)?

xi. What services were available or highlighted towards the parents of Mark Blake to cope with his increasingly difficult behavior?

xii. Why did the family find it necessary to deal with Mark Blake's escalating behavior internally rather than seek help?

Document Control

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

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

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

END OF PART 1

Terms of Reference - Part 2

1	**Decision to hold DHR**	
1a)	Add date when notification to the CSP was made:	
	22/11/2016	
1b)	Add date when the Chair of CSP agreed to hold DHR:	
	06/12/2016	
1c)	State names and roles of DHR Panel:	
	Kent Police DCI	Gavin Moss
	Kent Children's Services	Paul Startup
	North Kent CCG	Kate Bushell
	NHS England	Bonnie Wyatt
	Sussex Foundation Children and Young Persons Service NHS Foundation Trust CHYPS – Formally CAMHS	Carson Medhurst
	Kent Education Safeguarding	Claire Ray
	Kent Youth Offending Team	Louise Fisher

	Domestic Abuse Services Deborah Cartwright KCC Community Safety Partnership Shafick Peerbux
	Where apologies are received from members and/or substitutes sent this will be recorded in the minutes of Review Panel meetings.
1d)	Provide detail as to why DHR was necessary
	Section 9 of the Domestic Violence, Crime and Victims Act 2004 and a meeting of the Kent and Medway Domestic Homicide Review core panel, considered that the criteria for a DHR had been met.
2	**Key Issues**
2a)	What specific issues or questions does this case raise?
	i. Following the breakdown of Mark's parents' marriage his behavior is described as deteriorating what services identified this and what was done. *ii. Were there any other incidents of DA between family members? This to include previous relationships* *iii. What support or intervention work is in place to victims of DA at the hands of siblings* *iv. Did friends of Mark notice a rise in aggression or anxiety? Within School or outside friends.* *v. Were there any signs of substance misuse, including legal highs that may have added to any anxiety or behavioral issues demonstrated by Mark?* *vi. Had Mark displayed any signs of aggression towards other family members?* *vii. What was the relationship like between Peter Wright and Mark and Phillip Blake?* *Why did Georgina and Jessica Wright decide that they would not stay with their father? Was this because of Mark alone?*
2b)	Are there any unusual factors in this case, what are they?

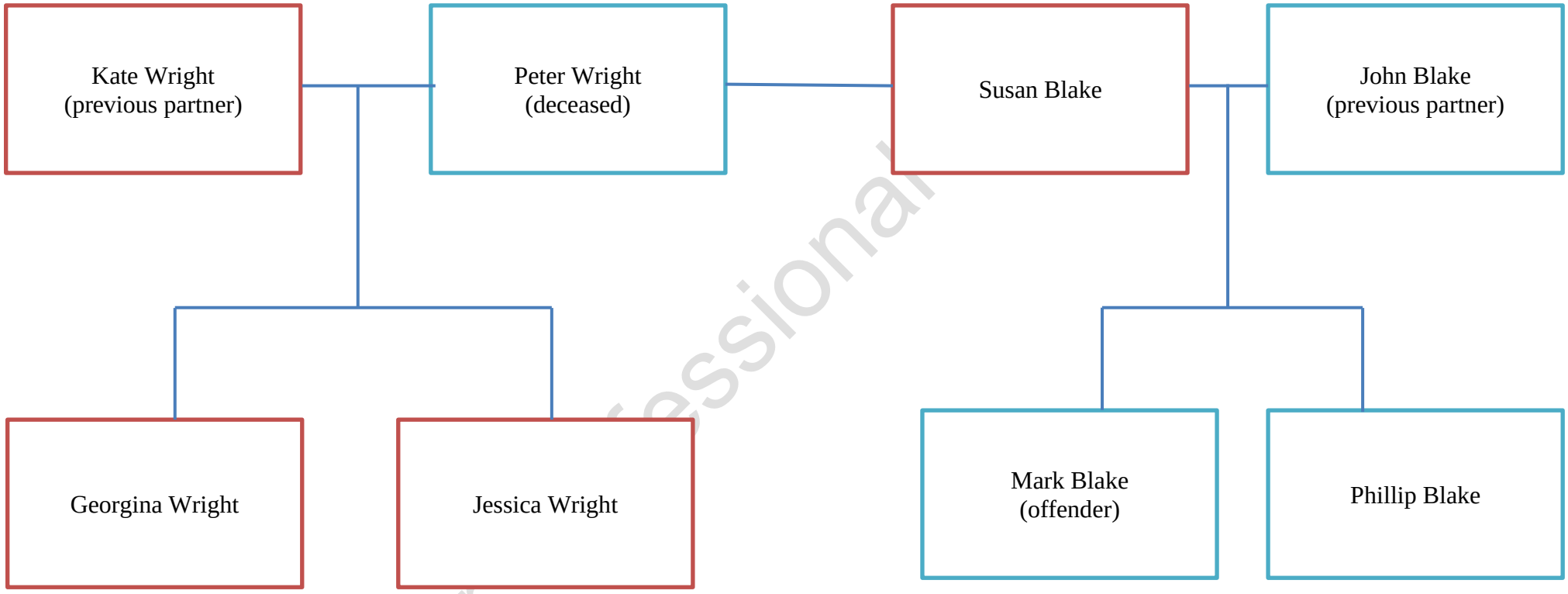
	Although not unique there is a growing propensity of violence and controlling behaviour from children towards parents. (usually in adolescence) There is very little opportunity for Parents or Professionals to seek support, training, workshops, or general intervention points to assist parents in managing this problem or support for those engaged in the behavior.
2c)	Are there similarities with any previous DHR in Kent or Medway? What are they?
	Unknown
2d)	Are there any failings which appear obvious at this stage?
	No
2e)	Do there appear to be any gaps in multi–agency working?
	Unknown at this time
2f)	Are there any issues which relate to ethnicity, disability or faith which may have a bearing on this review?
	No
2g)	Is there any known research which may assist?
	Home Office Document adolescent to parent violence and abuse (APVA)

2h)	Are there other DHRs in the region or nationally which are similar?
	Unknown
2i)	What good practice was there?
3	**Expert Opinion**
3a)	Might it help the Review Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case? Who?
4	**Time Periods**
4a)	Over what time period should events be reviewed i.e. how far back should enquiries cover and what is the cutoff point?
	1st of November 2012 to November 2016
4b)	What is the relevance of selecting this time period?
	The date is to include the new relationship between Peter Wright and Susan Blake. This may show how this had a bearing, or not, on the relationship within the family. It also covers a significant period of Mark Blake's life to identify any relevant information that may have led to the outcome of Peter Wright's death.
4c)	What family history/background information will help to better understand the recent past and present?
	The relationship between Mark Blake and Peter Wright. *The relationship between Mark Blake and his brother Phillip and Peter's daughters Georgina and Jessica Wright.* *Mark Blake's relationship with his birth parents.* *The overall atmosphere within the family between all members within it.*

5	Organisations to be involved in this DHR
5a)	Which organisations and professionals will be asked to contribute to this review and submit an IMR, information report or otherwise contribute?
	The following will be required to submit an IMR: *Child and Adolescent Mental Health Service (CAMHS)* *KCC Education Safeguarding* *North Kent CCG* *Kent Police* *KCC Specialist Children Services* *The following will be asked to submit a report or be interviewed by the Independent Chairman:* *KCC Youth Offending Services*
5b)	What action will be taken if there is a failure to co-operate with this review?
	The initial action would be for the Chair of the Review Panel to contact the relevant agency at a senior level to discuss the failure. *Escalation beyond that point would be through the Chair of Kent CSP to the Home Office.*
5c)	Who will make the link with relevant interests outside the main statutory organisations e.g. independent professionals, voluntary sector agencies?
	The initial notification of this homicide was sent to all agencies represented at the Kent & Medway MARAC. On the basis of the responses received, the agencies represented at paragraph 5(a) above are those which are relevant to this review. If it appears during the review that any other agencies have relevant involvement or interest, they will be requested by the Chair of the Review Panel to take part in it.

PRIVATE & CONFIDENTIAL
(OFFICIAL SENSITIVE)

Appendix B

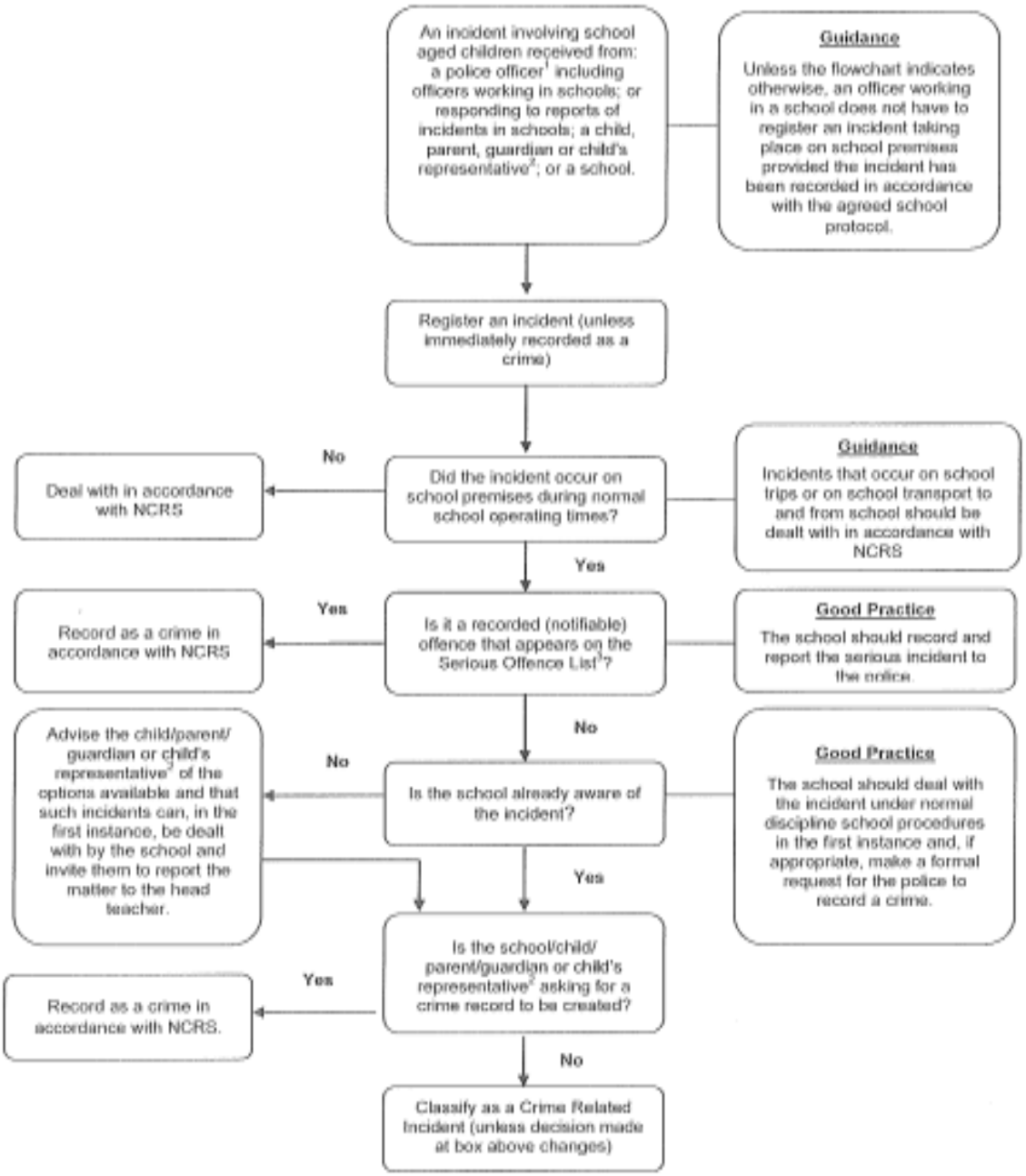


Appendix C

ANNEX B

Crime Recording (Schools Protocol) (1 of 2)

Recording of incidents on school premises



[1] Police officer includes appropriate members of the extended police family e.g. Special Constables, PCSOs.
[2] Representative means "A person reasonably assumed to be acting on behalf of the victim".
[3] A list of serious incidents (previously known as "serious arrestable offences") is defined on page 2 of 2. The list is extracted from the annex to the revised Crime Recording by Police Officers Working in Schools document jointly issued by the Department of Children, Schools and Families, the Home Office and the Association of Chief Police Officers in July 2007.

All Counting Rules enquiries should be directed to the Force Crime Registrar

Appendix D

Section 89 Education and Inspections Act 2006. Determination by head teacher of behaviour policy.

(1)The head teacher of a relevant school must determine measures to be taken with a view to—

(A)promoting, among pupils, self-discipline and proper regard for authority,

(b) encouraging good behaviour and respect for others on the part of pupils and, in particular, preventing all forms of bullying among pupils,

(c) securing that the standard of behaviour of pupils is acceptable,

(d) securing that pupils complete any tasks reasonably assigned to them in connection with their education, and

(e) Otherwise regulating the conduct of pupils.

(2)The head teacher must in determining such measures—

(A)act in accordance with the current statement made by the governing body under section 88(2)(a), and

(b) have regard to any notification or guidance given to him under section 88(2)(b).

(3)The standard of behaviour which is to be regarded as acceptable must be determined by the head teacher, so far as it is not determined by the governing body.

(4)The measures which the head teacher determines under subsection (1) must include the making of rules and provision for disciplinary penalties (as defined by section 90).

(5)The measures which the head teacher determines under subsection (1) may, to such extent as is reasonable, include measures to be taken with a view to regulating the conduct of pupils at a time when they are not on the premises of the school and are not under the lawful control or charge of a member of the staff of the school.

(6)The measures determined by the head teacher under subsection (1) must be publicised by him in the form of a written document as follows—

(a)he must make the measures generally known within the school and to parents of registered pupils at the school, and

(b) he must in particular, at least once in every school year, take steps to bring them to the attention of all such pupils and parents and all persons who work at the school (whether or not for payment).

Appendix E

Kent Police

N17a Reporting Incidents in Schools

- 1. Summary of Changes

1.1 This Standard Operating Procedure has been reviewed in September 2017 to comply with changes introduced by the force's new model New Horizon.

- 2.What this Procedure is About

2.1 This procedure is a guide for School Managers, Police and Specialist Police Community Support Officers (PCSO's) dealing with schools based incidents.

2.2 The purpose of this policy is to outline the responsibilities of schools when incidents occur; how the incident should be handled if the police need to be involved; guidance on the type of incidents where the police should be involved and those that should be dealt with by the school.

2.3 Additionally, the purpose of this revised policy is to outline how local staff should manage incidents reported to the police. The oversight of school based incidents lies within the local Community Safety Units (CSUs) regardless of who investigates. Guidance can be sought from the Youth Engagement Officers or County Professional Lead for Schools.

Compliance with this procedure and any governing policy is mandatory.

- 3. Detail the Procedure

3.1 The term school refers to any number of educational establishments, i.e. primary, junior, secondary, grammar, private, independent, pupil referral units, community colleges and alternative curriculum providers. The principles of the policy should also extend to sixth form colleges.

'School premises' refers to the whole of the school grounds, including its buildings, detached and onsite sports fields while open for the purpose of teaching its pupils, or while undertaking after hours activities with its pupils. Where a school occupies more than one site, premises include those public areas (roads, paths etc) between those sites during the period that the school is open as discussed above.

3.2 Pupils' behaviour outside school, but on school business – e.g. school trips, away schools sports fixtures, work experience placements, school activity holidays etc, where pupils are under the supervision of school staff, is subject of the schools behaviour policy. Bad behaviour in such circumstances should be dealt with as if it had taken place in school. Incidents taking place

outside school after hours cannot be dealt with under schools policy. For example, fights outside of school gates. Such matters must be recorded as a crime even if it may then be appropriate to allow a school to continue dealing with an incident, particularly where they are already actively engaged in resolving an ongoing incident.

Current practical guidance for schools on how to deal with crime incidents

3.3 Where an incident is reported to a school, the seriousness of the incident will be a judgement for the school to make. In making this decision, the injury/damage/theft, any history behind it and the antecedents of the pupil(s) concerned, would be considerations for the school to take into account as well as the local police staff, in an advisory capacity. Any incident involving a knife or offensive weapon must **always** be referred to the police for appropriate action and any necessary subsequent intervention.

3.4. Aggravating and mitigating factors are set out in Appendix B, to assist decision makers in determining who should deal.

3.5 Whilst the school, in consultation with the parent/carers and where necessary, the Youth Engagement Officer or CSU Supervisor will decide upon a course of action, the school retains the right to report the incident for police investigation at a later stage should the matter prove to be more serious than it appeared at first. When the decision is made that the school will deal with the incident internally, it remains the prerogative of the school to investigate the incident and resolve it in the manner it thinks is appropriate.

3.6 If the school, having considered all the circumstances, makes the decision to request the police to take over the investigation, it still remains for the school to co-operate fully in that subsequent investigation.
The procedural guidance is summarised in a flow diagram at Appendix C.

Incident recording – schools dealing

3.7 The thrust of the jointly published policy (DfE, Home Office and ACPO) here: **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/267387/count-general-dec-2013.pdf** is to ensure school managers, not the police, have primacy for the recording and management of incidents that occur on school premises. In cases of uncertainty, schools should be encouraged to discuss incidents with their Youth Engagement Officer.

3.8 Whilst schools are not bound by PACE, good practice dictates that a written record should always be made of the accounts of all parties in respect of an incident reported to and being dealt with by the school, with all subsequent procedures and findings being documented.

3.9 Where school managers determine that the incident is one which should be handed over to the police for investigation, all questioning of the suspect(s) by school staff should cease, with only questions to determine the facts of the case permitted i.e. names of witnesses, what happened, details of the aggrieved and suspected offender(s) etc.

Incident recording – police dealing

3.10 When the police are to be involved in an incident at school, no investigation should be undertaken by the school other than is necessary to establish the basic facts to make the reporting decision. There should be early engagement with the Youth Engagement Officer. Every effort should be made by the school to preserve any evidence i.e. property, drugs, CCTV etc and where

applicable, the scene of the crime.

3.11 Any initial inquiry undertaken by the school in the first instance should be fully documented, as it may be needed later if the matter goes to court. Copies of any documentation generated in respect of the incident should be handed to the police. Original documents should be retained by the school in the first instance.

3.12 The investigating officer will ensure that the head teacher and/or Youth Engagement Officer are kept informed in line with the victims' code. Any actions resulting from the investigation should be undertaken taking into account the school's recommendations and policies.

3.13. It will be the duty of the investigating officer to work in consultation and liaise with the Head Teacher, or Youth Engagement Officer at all times.

3.14 Crimes reported to the police by the schools should be recorded on Genesis. The crime reference number of any crime report so generated should be passed to the school for future reference by them.

3.15 During the investigation police may only make enquiries at the school with the permission of the Youth Engagement Officer. This may entail taking statements from witnesses i.e. pupils/staff, and where known, interviewing the offender. Only in unusual and exceptional circumstances will the interview or arrest of a suspected offender take place on school premises. Again, this must be with the permission of the Head Teacher or Youth Engagement Officer.

3.16 It will first be necessary to determine if the incident being reported took place on school premises as defined above. If the incident did not take place on school premises, a crime report should be generated in accordance with existing crime recording policy.

3.17 There may be instances where the victim, victim's parent, carer etc, having reported the incident to the school initially, still wish to make a formal allegation to the police. It may be that the school has already dealt with the incident and consequently the pupil(s) concerned may be subject to "double jeopardy". Where this is the case the matter should be referred to the Community Safety Unit (CSU) who will liaise with the school and the caller to ascertain the full circumstances and whether a police investigation is still appropriate. No crime report should be raised until all parties have been consulted, although a CAD log should be raised to record the allegation in the first instance. After liaison with the CSU and having been made aware of the schools potential acility to deal (providing the matter is appropriate), if the school/parent/child or guardian ask for a crime report to be created than poilce must record as a crime in accordance with the National Crime Recording Standard.

3.18 If the matter has been dealt with by the school under this policy, but the caller feels that any sanction issued by the school is inappropriate, they should be referred back to the school to make a formal complaint through the Governing Body. It is not for the police to consider the level of sanctions issued under a school discipline policy.

3.19 A crime report must be generated in the first instance, in respect of those incidents deemed serious incidents (see Appendix A) or where there are aggravating circumstances as outlined in Appendix B.

What is classed as an incident on school premises

3.20"Any incident at a school, during school hours, extended school hours or on a school trip, where the victim, offender or suspect is a pupil at the school. In these circumstances the school managers should deal with the incident within the school disciplinary procedures."

3.21 Examples:

- Pupil assaults pupil or staff
- Pupil steals from pupil
- Pupil damages school property
- Pupil steals school property

What is not classed as an incident on school premises

3.22 "Any incident at a school where the victim, suspect or offender is not a pupil at the school."

3.23 Examples:

- Parent assaults teacher
- Teacher or school staff steals school property
- Pupil breaks into school out of school hours
- Stranger steals school property
- Incidents on public transport out of school hours. Public transport that happens to be a bus that school children use, that has the general public on board, is not an incident to be dealt with under this protocol.

3.24 These incidents are not part of the school's disciplinary procedures, and must be recorded as a crime in the first instance.

3.25. Incidents where a member of staff allegedly assaults a pupil should be reported by the school to KCC. Thereafter a joint investigation may take place between KCC and Police (Vulnerability Investigation Team). A CAD log should be created to record this allegation and tagged for the Public Protection Unit to decide on the appropriate course of action.

School or police to deal

3.26 The ACPO/DfE guidance is clear as to what constitutes a serious incident. That said, however, there may well be circumstances where school managers may wish to refer their pupils to the police in the first instance for committing other than a serious incident, e.g. where the pupil concerned is deemed to be a 'prolific offender' by them.

3.27 Assaults: In cases where there has been fighting which has resulted in minor grazing and/or reddening of the skin, pushing, threatening acts, words or gestures, hair pulling, are

considered a common assault which should be appropriately dealt with by the school. Where more serious injury results, or where weapons other than physical force is used, consideration should be given to passing the incident from the school to the police for further investigation by them.

3.28 Damage: Minor acts of vandalism, or other acts of damage, should be dealt with by the school. More serious damage by value and the method by which it is caused, may be better dealt with by the police – i.e. where extensive damage to property is caused, arson or large scale graffiti.

3.29 Theft: Minor incidents should be dealt with by the school, but school managers should consider referring incidents to the police for further investigation by them, where a series of incidents have been identified, where the suspect is considered to be a prolific offender, or the property is deemed to be substantial in monetary terms.

Glossary

Abbreviation/Acronym	Explanation
DHR	Domestic Homicide Review
IMR	Independent Management Review
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service
CPAU	Centralised Pre-operative Assessment Unit
CRU	Central Referral Unit
CAF	Common assessment Framework
A&E	Accident and Emergency
CAMHS	Children & Adolescent Mental Health Services
KCC	Kent County Council
NKCCG	North Kent Clinical Commissioning Group
SECAMB	South East Coast Ambulance Service
GP	General Medical Practitioner (Doctor)
DASH	Domestic abuse, stalking and honour based violence risk assessment toolkit

CT Scan	Computerised Tomography scan
GCSE	General certificate of secondary education
NEET	Not in Education, Employment or Training
APVA	Adolescent to Parent Violence and Abuse

Explanation of Terms

The following is an explanation of terms that are used in the main body of the Overview Report.

Central Referral Unit (CRU)

The multi-agency central referral unit is the primary access point for new contacts and referrals to Specialist children services. It provides multi-agency screening and decides on whether thresholds for service eligibility have been met. The process may provide information and advice, no further action, forward to the Early Help Co-ordination Team or that a child and family assessment is required. Only referrals requiring a child and family assessment will be forwarded to the responsible Children's Social Work Team.

OASIS

OASIS is a community based charity offering vital and practical support to anyone experiencing Domestic Abuse.

Common Assessment Framework (CAF)

The Common Assessment Framework for children and young people is a shared assessment tool used across agencies in England, some authorities have developed this tool and it is also known as other names such as Early Help Assessment. It can help professionals develop a shared understanding of a child's needs, so they can meet more effectively. It will avoid children and families having to tell and re-tell their story. The CAF is an important tool for preventative services. The assessments are designed to allow professionals to assess the needs at an early stage and then work with families together with other professionals and agencies. The provision of Early Help services must take a pro active approach to working with children and families. Efforts should be made to re-engage adolescent children to ensure they get support at the earliest opportunity.

CT Scan

A CT or CAT scan is specific x-ray tests that provide a cross sectional image of the body using x-rays and computer.

Information Sharing Protocols

The Kent and Medway information sharing agreement was introduced in recognition of the need for agencies to share information to ensure services are effectively delivered. Individual Chief Executives representing various organisations (this does not currently include Health providers who are not signatories) formally undertake to ensure protocols and procedures to share information accord with the agreement.

The agreement has been developed to:

Provide a framework for embedding best practice with regard to the exchanging of information.

Acknowledge the need for partners to share information proactively. Set out the legal gateway through which information is shared.

Describe the security procedures necessary to ensure compliance with legal and regulatory responsibilities.

Provide a generic standard to be applied for the various specific purposes.

Clarify the understanding between signatories.

Describes the roles and structures that will support the exchange of information between parties.

Ensure compliance with individual partners' policies, legal duties and obligations.

FRANK

FRANK is a national drugs education service jointly established by the Department of Health and the Home Office in 2003. It is intended to reduce the use of both legal and illegal drugs by educating teenagers and adolescents about the potential effects of drugs and alcohol. It has run many media campaigns on radio, television and the internet.