Permission has been granted by the Home Office to publish this final report

Report into the Death of Mrs Nkuna

Executive Summary

Report Produced by Graham Bartlett

Date: 20 September 2016

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Mrs Nkuna a resident of Village B, West Sussex prior to her being found dead on 25th December 2014 along with her husband Mr Nkuna. The review will consider agencies contact/involvement with Mrs and Mr Nkuna, the perpetrator, from 1st January 2008 to the 25th December 2014.

1.2 The circumstances of the case are that on the 24th December 2014, the victim, Mrs Nkuna was at home with her husband Mr Nkuna, preparing a family Christmas dinner as he was due to work the following day. They lived at the address with their two children, Daniel aged 6 and Alicia, aged 4. Both children have learning difficulties and Alicia has Cerebral Palsy.

1.3 Later, Mrs Nkuna caught a train and visited first her friend then her mother, Kath, in Horsham. Later that afternoon, Mr Nkuna took the two children to visit a friend of his, Peter, in Crawley. He then picked up Mrs Nkuna from Kath's house just after 5pm. They then took the children home via McDonalds.

1.4 Later that evening an argument is believed to have started that culminated in Mrs Nkuna's death at the family home. The extensive pathological tests have confirmed that she died from pressure to her neck and the investigation has concluded this was caused by Mr Nkuna. Later that evening he took the children back to Peter and asked him to look after them. He said that Mrs Nkuna had hurt herself and needed hospital treatment.

1.5 The following morning, having received a text message from Mr Nkuna, Peter went round to Mrs and Mr Nkuna's house. There he found both dead, Mr Nkuna apparently hanged. He called the police and ambulance and an investigation started.

1.6 The inquest would later conclude that Mrs Nkuna had been unlawfully killed and Mr Nkuna had committed suicide.

1.7 No reports of domestic violence between Mrs and Mr Nkuna had been received by any agency. However, Mrs Nkuna had been victim of a rape from another man in 2008 and assaulted by her brother in 2013.

2. Process Of The Review

2.1 This review was commissioned at a meeting of the West Sussex County Council (WSCC) Domestic Homicide Review Panel on the 11th September 2015 in line with the Multi Agency Guidance for the Conduct of Domestic Homicide Reviews 2011. The chair and author was appointed shortly afterwards and the review started immediately.

2.2 The delay between the death and the commissioning of the review was due to the extensive forensic tests required to establish Mr and Mrs Nkuna's cause of death. It was not until after these had been completed could it be determined that a homicide had taken place.

2.3 The WSCC Domestic Homicide Review Panel who sat on the 11th September 2015 comprised:

Agency	Name	Post
Chair WSSP	David Simmons	Councillor (Chair)
Coastal West Sussex, Crawley, Horsham & Mid Sussex Clinical Commissioning Groups	Alex Morris	Deputy Designated Nurse, Adult Safeguarding
Horsham District Council	Natalie Brahma-Pearl	Director of Community Services
South East Coast Ambulance NHS Foundation Trust	Nichola Douglas	Domestic Abuse Specialist Coordinator-Safeguarding Team
Surrey and Sussex Police Major Crime Team	Adele Robertson	Detective Sergeant
Sussex Police	Jo Banks	Detective Chief Inspector
WSCC	Trish Harrison	Principal Manager Domestic and Sexual Violence
WSCC	Sonia Knight	Multi Agency Risk Assessment Conference (MARAC) Co-ordinator
WSCC	Michelle Mead	Child Disability Team
WSCC	Sam Bushby	Head of Safeguarding

2.4 The specific terms of reference set for this review to consider were:

- Whilst Mrs Nkuna had no known contact with any specialist domestic abuse agencies or services, the review will consider whether there was any history of domestic abuse involving Mrs Nkuna / Mr Nkuna and therefore whether there were any warning signs.

- Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide and what they did or did not do as a consequence.

- Whether there were any barriers or disincentives experienced or perceived by Mrs Nkuna or her family/ friends/colleagues in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.

- Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.

- Whether Mrs Nkuna had experienced abuse in previous relationships during the time period under review, and whether this experience impacted on her likelihood of seeking support in the months before she died.

- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse or sexual violence experienced by the victim that were missed.

- Whether there were opportunities for professionals to refer any reports of domestic abuse or sexual violence experienced by the victim or committed by Mr Nkuna, the alleged perpetrator, (towards Mrs Nkuna or any other partner) to other agencies and whether those opportunities were taken.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Mrs and Mr Nkuna or the dependent children, Daniel and Alicia, that were missed or could have been improved.

- Whether the homicide could have been accurately predicted and prevented.

2.5 In addition:

- The review will give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- The review will identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in West Sussex.

- While it is not the purpose of this review to consider the handling of child safeguarding concerns related to the case there may be issues that arise from the review that relate to the safeguarding of children who may be affected by domestic abuse. If this is the case these issues will be raised with the West Sussex Safeguarding Children Board.

2.6 West Sussex County Council wrote to Chief Executives/ Chief Officers of the following agencies requesting they return Summaries of Involvement to inform the Independent Chair as to which agencies had relevant involvement with Mrs Nkuna and/ or Mr Nkuna within the time period of this review:

- Brighton and Sussex University Hospitals NHS Trust (BSUH)

- Horsham District Council

- Kent Surrey and Sussex Community Rehabilitation Company

- National Probation Service

- Refuge Information Support Education (RISE)
- South East Coast Ambulance NHS Foundation Trust (SECAMB)
- Sussex Community NHS Foundation Trust (SCFT)
- Sussex Partnership NHS Foundation Trust (SPFT)
- Sussex Police
- West Sussex County Council (WSCC)
- West Sussex Fire and Rescue Service
- Western Sussex Hospitals NHS Foundation Trust (WSHFT)

2.7 Having considered these Summaries of Involvement, it was decided that the following agencies would be asked to submit Individual Management Reviews:

- Riverside GP Surgery
- Village B Surgery
- Courtyard GP Surgery
- Sussex Community NHS Foundation Trust
- West Sussex County Council
- Horsham District Council
- Sussex Police
- South East Coast Ambulance NHS Foundation Trust
- Whilst key issues have been shared with organisations the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of the report were seen by the membership of the Review Panel, and the IMR authors.

2.8 The IMRs will not be published but the redacted overview DHR report and Executive Summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.

2.9 The content of the Overview Report and Executive Summary is anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998.

2.10 Mrs Nkuna's family have been shown a draft copy of this report and will be provided a final copy the day before publication.

2.11 Sussex Police have, through their Family Liaison Officers, facilitated contact with the family members of Mrs Nkuna. The chair has met with Mrs Nkuna's mother (Kath), brother (James) and step-father.

2.12 The Panel is incredibly grateful that, in such trying circumstances, the family have been so forthcoming in participating in this review. They recognized that their active involvement was important for them to fully understand and contribute to the emerging findings and to provide a valuable personal perspective that professionals are unable to.

3. Findings of the Review

3.1 Mrs Nkuna had been in extensive contact with universal and specialist services over the period of time under review. This related to her own health and support needs, those of her children, housing concerns and, on one occasion, the police.

3.2 Most of those services recognized that she and Mr Nkuna were living an unusually pressured existence. Both of them had health needs, their two children have developmental delay and one, Alicia, had cerebral palsy. Their relationship was seen as fractious to the outside world with Mr Nkuna staying over in South Africa for over a year while he tried to arrange a visa. He later left the family home for around four months as the relationship had broken down.

3.3 Their housing was less than ideal as they tried to start off their family life living in one room in Mrs Nkuna's mother's house. Their move to more suitable accommodation was delayed as they did not appear to have submitted the supporting evidence required by the Housing Department so, on two occasions, their application could not be progressed.

3.4 It was known among the family, and to Mr Nkuna, that their first born, Daniel, may well have been conceived as a result of Mrs Nkuna being raped by a former partner. This information was shared four years later with a social worker but, seemingly, to respect Mrs Nkuna's wishes, no further referral was made regarding this.

3.5 Mrs Nkuna once, during the period under review, came to the attention of agencies as being a victim of domestic violence. The perpetrator, in this case, was her brother. While the initial police response was effective, the subsequent investigation and the outcome of the referral into Children's Social Care was not. Efforts to trace James when he failed to answer his bail were perfunctory and, despite being instructed to do so, the social worker did not make specific contact with Mrs Nkuna about this and therefore did not verify the welfare of the children.

3.6 On reflection, various factors such as the intensity of the relationship, Mrs Nkuna's social isolation, her dependence on Mr Nkuna, their periodic inability to attend or fulfil appointments with professionals or respond to requests for information together with the unusual pressures of living with two children with additional needs in inadequate accommodation, their own health needs,

Mrs Nkuna's history of witnessing domestic violence and experiencing a rape may have triggered some concerns.

3.7 Some of these factors were only known to single agencies. However some, when faced with specific concerns, missed opportunities to enquire deeper. Had they done so, in all likelihood the other impacting factors would have been shared. It is improbable that Mrs Nkuna would have disclosed that she was suffering from any kind of psychological or physical abuse from Mr Nkuna – she only shared that in the strictest confidence with Kath – but a fuller picture could have been gained by professionals being more curious.

3.8 None of these factors alone could be said to be indicative of domestic violence and abuse but could have highlighted a greater degree of risk. CSC and SCFT acknowledge that their assessments could have been deeper or a greater degree of inquisitiveness applied. SCFT have changed their systems accordingly by requiring that questions around domestic violence are included in all paper and electronic recording.

3.9 As is often the case, with families who do not present overt signs of violence and abuse but are well known to services, no one has a complete overview of what is happening for them. Had there been a lead professional 'holding the ring' on the case, perhaps their risks and vulnerabilities would have been seen in the round and a more bespoke package of care and support applied which **may** have revealed the harm she was suffering.

3.10 Many people in Mrs Nkuna's life recognized that her relationship with Mr Nkuna was difficult. Sometimes their cultural differences were regarded as creating conflict between them, sometimes the plethora of health issues and their housing problems were seen as catalysts to their occasional relationship breakdowns.

3.11 It seems the only person who was aware that Mrs Nkuna was being psychologically abused by Mr Nkuna was her mother. She recognised very similar behaviour from Mr Nkuna to that exhibited by her ex-husband, Mrs Nkuna's father. The financial control, the way by which Mr Nkuna tried to isolate Mrs Nkuna, the way he spoke to her and, latterly the marks on her body which she attributed to be grabbed or burned 'while he was playing' were all things that deeply concerned Kath. She also knew of the rape and the assault by her son on Mrs Nkuna.

3.12 Kath's single concern was the safety and welfare of her daughter and grandchildren. She had been through very similar experiences so was well placed to understand how Mrs Nkuna was feeling. She had conversations with her around accessing support. Mrs Nkuna was adamant that she did not want to tell anyone at all about what she was going through. There is some evidence, albeit refuted by Kath that Mrs Nkuna was in a very dark place when Mr Nkuna left. However, what the family do say is that she was terrified of doing anything behind Mr Nkuna's back. This was almost certainly the reason why she did not want to access help. It is entirely understandable that Kath would want to respect her daughter's wishes, even if these were against her better judgement.

3.13 It was very apparent that Kath would have liked Mrs Nkuna to access support so that she could keep herself and her children safe and happy. The single reason why Kath did not seek support on her daughter's behalf was that Mrs Nkuna had expressly said that she did not want to go behind Mr Nkuna's back.

3.14 When asked, however, Kath did not know of any specialist services either Mrs Nkuna could access herself or that she could make a third party report to. While this is not unusual, such lack of profile of services commissioned to support victims of domestic violence and abuse restricts the options people have, especially if they are apprehensive of the statutory services.

3.15 Mrs Nkuna had said that she wanted couple's counselling but Mr Nkuna declined. It appears that he was adamant about this. Both were referred for talking therapies, which may have lifted the lid on the abuse Mrs Nkuna was experiencing but neither responded to the request to 'opt in' and therefore were discharged from the service.

3.16 Following the two incidents of domestic and sexual violence that did come to the attention of the statutory services, no specialist support services were offered to Mrs Nkuna. Those agencies to whom the incidents were reported, the police and Children's Services, would have known the options available and could have been more supportive in helping Mrs Nkuna accessing them. It is not known whether these omissions dissuaded Mrs Nkuna from seeking help around her more ongoing abuse but they certainly appear to have been missed opportunities to engage her in the supportive services.

3.17 The lack of knowledge that Kath, and probably Mrs Nkuna, had of the services that were available to support victims of domestic violence is entirely in keeping with the findings of many Domestic Homicide Reviews, certainly in West Sussex.

3.18 In this case, Kath did discuss support options, in their broadest sense, with Mrs Nkuna but she was adamant that she did not want anyone outside of the two of them knowing about what she was experiencing. Arguably, therefore, even if Kath had known about the services available she would not have persuaded Mrs Nkuna to contact them nor contacted them herself.

3.19 Mrs Nkuna was accessing various services regularly so would have been in buildings operated by those services. Otherwise she was regarded as socially isolated. Therefore, for her and her family, it is possible that if the profile of specialist services available for victims were higher in the venues she would be routinely attending or better signposted she **may** have known more about them and **may** have sought to access them.

3.20 This is a very qualified position to take as all the indications are that she did not want any services to support her but the fact that Kath did not know about services may indicate that, with more knowledge of them, Mrs Nkuna may have felt differently.

3.21 This judgement is also not to say that there is no profile in premises operated by the statutory services. It is somewhat a Holy Grail to achieve universal knowledge and understanding of all the services available to domestic abuse

victims let alone achieving confidence in them. However this does not mean that it should not be an aspiration.

3.22 The only incidence of domestic abuse in any of her previous relationships was the rape that may or may not have resulted in the conception of Daniel. This did not come to the attention of statutory services for four years and, at Mrs Nkuna's request, no further referral was made. Prior to that it seems that she only told Mr Nkuna and Kath. There is no evidence to suggest that they sought support, quite the contrary in fact. Kath says they did not.

3.23 Whether the lack of further support following the disclosure of the rape to Children's Social Care affected her decision not to seek support for the abuse from Mr Nkuna would be conjecture. It seems she did not want any outside intervention into what she was suffering but had she been persuaded then perhaps she would have had confidence in the services offered and availed herself of them.

3.24 The same point applies to the apparent lack of any referral to supportive services by the police following the assault on her by James. Had she been referred in to and accessed services following this incident, she may have been more confident to seek help for the abuse Mr Nkuna was inflicting on her.

3.25 The help that she was offered (talking therapies and couple's counselling) were not taken up by Mrs Nkuna.

3.26 There were several opportunities for professionals to be more professionally curious as to whether there was any domestic or sexual violence being experienced by the victim.

3.27 The health visitor, who otherwise seems to have provided an exemplary and attentive service, did not ask at any point whether Mr Nkuna was being abusive to her. The risks and issues were widely known but it seemed that this never led to a conversation about how the combination of these were manifesting themselves.

3.28 Children's Social Care were aware that Mrs Nkuna was isolated, financially dependent, had been assaulted by James, had a history of witnessing domestic violence and suffered sexual violence. They were also aware of the friction between Mrs and Mr Nkuna having witnessed and challenged it themselves. However, they too did not enquire of Mrs Nkuna whether she was suffering violence and/ or abuse from Mr Nkuna.

3.29 Riverside Surgery were informed that Mrs Nkuna had been assaulted by James and of the complexities in the family's life. They did not flag any of the family's records to indicate that there had been a domestic violence incident. Therefore, on future presentations, no information was available that would have allowed medical staff to enquire about Mrs Nkuna's wider experience of domestic violence.

3.30 Sussex Police investigated the assault on Mrs Nkuna by James as an incident in isolation. There is nothing to suggest that they took the opportunity to understand the bigger picture and enquire whether she was experiencing

abuse from Mr Nkuna, especially as they might have easily discovered that he had recently left her.

3.31 Of course it cannot be said that had any of these opportunities been taken that Mrs Nkuna would have responded to them. However they were not and, sensitively put, she might have done.

3.32 There were two opportunities for agencies to refer domestic or sexual violence to other agencies. Firstly the report of the rape that may have resulted in the conception of Daniel. This was disclosed to a social worker who was told by Mrs Nkuna that she did not want the police informed nor did she want any counselling services. The second, which falls outside of this term of reference as it does not relate to Mr Nkuna, was the assault by James.

3.33 In respect of the rape it would have been possible for the social worker to have made a third party anonymous referral to the police, notwithstanding that Mrs Nkuna did not want the matter formally reported. This would have allowed the police to assess any intelligence and potentially sought to protect any other vulnerable victims.

3.34 The lack of any referral to any supportive services for Mrs Nkuna herself following the assault by James (rather than the referral to CSC that was made) deprived those services of the opportunity to make a proactive approach to Mrs Nkuna through which they might have been able to understand and then support her regarding the abuse being inflicted on her by Mr Nkuna.

3.35 There were no overt reports or referrals regarding domestic abuse committed by Mr Nkuna on his wife, only by other parties. The missed opportunities and gaps regarding those, together with the lack of professional curiosity have been discussed previously.

3.36 There was no evidence either within the statutory services or the family that the nature of abuse was such that it could escalate to the level it did. Other than one mention of Mr Nkuna considering self-harm that was appropriately referred, no one reported knowing or suspecting that he fostered a suicidal ideation nor that he wanted to kill Mrs Nkuna.

3.37 Despite the learning identified from this review it would be unreasonable to link that to an inevitability or suspicion that the deaths would be a consequence. Therefore, the conclusion would be that the deaths were neither predictable nor preventable.

3.38 Mr Nkuna was black South African, whose first language was Tswana and Mrs. Nkuna was White British. Within health records, there were differences in the recording and sometimes no recognition to the cultural background of the family. The dual language was recorded on the paediatric speech and language case notes. However, in a copy of the acute hospital notes for Daniel, his ethnic group is recorded as White/Caribbean. In another it is Mixed Black/White.

3.39 Mr Nkuna told the Social Worker that Mrs. Nkuna did not understand or respect his culture, and Mrs. Nkuna said it impacted on his expectations of her as a wife. There is insufficient detail in the assessments and records to establish the impact of the cultural differences between the parents and their wider family and how this affected the parent's relationship and the children. There is also little detail of the children's identity and cultural needs.

4. Lessons Learned

Lessons Learned 1

There is a lack of clarity in primary care regarding their role in providing information and analysis to Domestic Homicide Reviews. This is not just around information sharing but also payment for time. This leads to delays in reviews and could lead to incomplete information being available.

Lessons Learned 2

Knowledge around the scope and nature of domestic violence and abuse within primary care may be inadequate leading to professionals not recognising 'other family member' domestic incidents as requiring the same level of attention as those that occur between partners or former partners.

Lessons Learned 3

When patients do not take up referrals made to other services by GPs there may be no follow up or enquiry made to understand the reasons why. This can lead to conditions remaining untreated and therefore recurring. There is no specific recommendation around this but, as a practice observation, professionals should be alive to and aim to mitigate the ongoing risks that may prevail if referrals are not taken up.

Lessons Learned 4

Repeated episodes of patients either not attending or not brought to appointments across different services are not considered holistically, nor in the context of other pressures, as being symptoms that there may be domestic violence or other safeguarding concerns present.

Lessons Learned 5

There can be a tendency for practice to be underpinned by a single static risk assessment rather than that assessment being a continuous process with practice being modified as assessed risk changes.

Lessons Learned 6

Considering the whole family dynamic, including using attachment knowledge to inform judgements around the children/ parent relationship, in the context of other pressures and problems being experienced can provide a greater insight into how a family functions and their needs.

Lessons Learned 7

There may be an assumption held by professionals that where people are able to disclose some incidents of abuse they will disclose all. This may not always be true as the perceived consequences of disclosure can vary according to context and alleged perpetrator.

Lessons Learned 8

There may be an inclination to accept a victim's personal views regarding disclosure of them having suffered a serious sexual assault as being absolute. Options such as third party referral and information about the many and varied supportive services available may, therefore not be discussed. This can impact on the wellbeing of the victim themselves as well the safety of others who may have contact with the alleged perpetrator.

Lessons Learned 9

Verification by CSC managers that their directions have been followed up is less than robust potentially leaving children in situations where they may be subject to ongoing emotional abuse.

Lessons Learned 10

When assessing the welfare of children at domestic violence incidents, police may not always do so thoroughly, thereby risking that vulnerabilities may not be fully recognised.

Lessons Learned 11

The police do not always refer victims for domestic violence to specialist support services, nor advise them to make contact themselves.

Lessons Learned 12

The ongoing risk a perpetrator may pose to a victim of domestic violence may not always be recognised by the police leading to a lack of urgency in investigations and static risk assessments.

5. Recommendations

Recommendation 1

That the Coastal West Sussex, Crawley and Horsham & Mid Sussex Clinical Commissioning Groups produce health specific guidance regarding Domestic Homicide Reviews and the need for information sharing, to supplement that available from the Home Office.

Recommendation 2

That the Domestic and Sexual Violence Strategic Board ensure that all agencies review their domestic violence training to ensure that it clearly explains the definition and scope of domestic violence especially that it can be perpetrated by 'other family members.'

Recommendation 3

That Coastal West Sussex, Crawley and Horsham & Mid Sussex Clinical Commissioning Groups gain assurance from GP surgeries that they are aware of the importance to code any entries relating to domestic abuse on both the victims notes, and any dependent children.

Recommendation 4

That the Coastal West Sussex, Crawley and Horsham & Mid Sussex Clinical Commissioning Groups work with providers to ensure the training of professionals

includes both that 'was not brought' may be a sign of non-engagement and an indication of risk together with raising the awareness of available pathways of support in cases of concern.

Recommendation 5

That Sussex Community NHS Foundation Trust Review the risk assessments used by therapists to consider the whole family risks especially when there are multiple children with disabilities.

Recommendation 6

Sussex Community NHS Foundation Trust should audit Health Visiting and Enhanced Health Visiting cases to assure themselves that 'routine enquiries' into whether domestic abuse is a factor in clients' lives are made in line with their revised policy and expectations.

Recommendation 7

West Sussex County Council should continue to embed the Signs of Safety Framework, to drive up practice standards by ensuring the children's voices are heard, chronologies are on file and interventions are outcome focused and that Social Workers consider children in the whole family context and use attachment expertise to identify any signs of trauma.

Recommendation 8

West Sussex County Council ensure steps are taken so that social workers and their managers are aware of the risks of hidden harm experienced by domestic violence victims and their children and therefore embed and support practice that demonstrates a high degree of professional curiosity.

Recommendation 9

Agencies should ensure that where professionals have disclosed to them reports of rape or serious sexual assaults they endeavour to inform the victim of all options available to them especially around reporting the matter to the police and availing themselves of counselling services. At the very least, where a victim is not inclined to report the matter to the police, agencies should make an anonymised Third Party Report through a victim support service.

Recommendation 10

Measures should be put in place by Children's Social Care that children will always be seen in a timely manner and seen alone where they have directly or indirectly witnessed violence and managers should ensure that happens, especially when they have specifically directed that it should.

Recommendation 11

That Sussex Police ensures that full consideration be given to the vulnerability and needs of children connected with domestic violence incidents, even though they may not be in the same room at the time. This comprehensive information must be shared with Children's Social Care to allow accurate and timely assessment of risk.

Recommendation 12

That Sussex Police review its procedures to ensure that all domestic abuse victims that come to their attention are referred to or advised to make contact with specialist support services.

Recommendation 13

That Sussex Police ensure that domestic violence investigations are progressed expeditiously and, when the whereabouts of a suspect are unknown, robust measures are put in place to trace them while ensuring that any risk assessment of the victim or their family reflect their status.

Recommendation 14

That the Domestic and Sexual Violence Strategic Board works with all agencies to develop a wide reaching communication strategy that demonstrates the full nature of domestic abuse and the breadth of services available to those suffering.

Recommendation 15

That the Coastal West Sussex, Crawley and Horsham & Mid Sussex Clinical Commissioning Groups seek further assurance from all providers that they are accurately recording the ethnicity of patients. This would help meet those needs as well as ensuring patients' cultural requirements are respected.

Recommendation 16

That West Sussex County Council ensures that social care assessments and records take full consideration of the cultural needs and differences of service users to ensure that those are being met.

6. Good Practice

Good Practice Point 1

The Health Visiting service was very pro-active in seeking support for this family in many ways and helped them access services that they may have otherwise struggled with.

Good Practice Point 2

The manner by which the Housing Sustainment Visits are carried out and the subsequent notes provide a good opportunity for risk to be identified unless, as in this case, it appears to be deliberately masked.