

Domestic Homicide Review

Overview Report

B/2012

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

1 Introduction

1.1 Background to the Review

- 1.1.1 The domestic homicide review was held as a result of the unlawful killing of B by her estranged husband S on the 30th April 2012.
- 1.1.2 The Chair of the Kent Community Safety Partnership agreed on the 17th May 2012 to hold a domestic homicide review in accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004, because there had been a death of a person aged over 16 years, which appeared to result from an act of violence from a person with whom she had been in an intimate personal relationship. The first stage of the review was completed by December 2012 and it was finalised in May 2013 following the conclusion of S's trial in January 2013. This delay enabled additional material revealed during the trial to be considered and enabled B's family to participate in the review.

1.2 The Terms of Reference

- 1.2.1 The purpose of a domestic homicide review as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Review is to:
- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
 - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and, what is expected to change as a result;
 - Apply those lessons to service responses including changes to policies and procedures as appropriate; and
 - Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- 1.2.2 The specific terms of reference agreed for this review were:
- Were practitioners knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
 - Did agencies have effective policies and procedures for Domestic Abuse Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have effective policies and procedures in place for dealing with concerns about domestic abuse? Was the victim subject to a Multi Agency Risk Assessment Conference? (MARAC)
 - Did agencies comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?
 - What were the key points or opportunities for assessment and decision making in this case?

- Was the quality of assessments undertaken adequate? And were the decisions and actions that followed appropriate?
- 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?
- In what ways were the victim's wishes and feelings ascertained and considered? Was the victim informed of options/choices to make informed decisions? Was she signposted to other agencies?
- Is there evidence to suggest that the victim's decision to engage with services was affected by the perpetrator's former employment?
- What was known about the perpetrator?
- Were there indicators of abusive behaviours or risk factors identified that could have mitigated future risks?
- Was race, religion, language, culture or disability a factor in this case? And was it considered fully and acted on if required?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Did resources/workload/staff supervision and support have any impact on agencies' practice in this case?
- Are there any examples of good practice?
- To what degree could the homicide have been accurately predicted and prevented?
- Are there any lessons to be learned for this case relating to the way in which an agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

1.2.3 The timeframe of the review was from the 1st July 2003 to 30th April 2012 and agencies were asked to provide a detailed chronology for this period. The timescale was from the date when S joined Kent Police and the couple were believed to have met. Subsequently, it became known that the couple had met in 2002 but all agencies were also asked to provide a summary of any significant events prior to this period.

1.3 Review Process

1.3.1 Individual management reports were received from the following sources:

- Kent Police
- Kent and Medway NHS and Social Care Partnership Trust (KMPT)

1.3.2 A health overview report was also produced by NHS Kent and Medway. It included a chronology of GP involvement with the couple and it reviewed and evaluated the practice of KMPT, the GP and East Kent Hospitals University Foundation NHS Trust (EKHUFT) which provided treatment irrelevant to the review. As EKHUFT's involvement with B and S was brief and revealed no concerns about domestic abuse, an individual management report was not requested.

- 1.3.3 The GP practice where both B and S were patients had been requested to provide an individual management report but only provided a chronology about involvement with both parties. At the request of the review Chair, the author of the health overview report had two discussions with the GP practice, clarified their involvement with B and S and confirmed that no domestic abuse was disclosed. The chronology outlined the two contacts that the GP practice had with S and the one relevant contact with B. It also outlined the responses of the GPs to the presenting problems. These are described in paragraph 3.1. As the chronology revealed that the GP practice records contained no concerns about domestic abuse, the Chair of the review, together with the Panel, decided that it was not necessary to pursue a full individual management report.
- 1.3.4 KCA provided a brief summary of their single phone consultation with S. An individual management report was not requested as the contact was so limited and gave no indication of domestic abuse.
- 1.3.5 Both individual management reports and the health overview report were written by officers who had no previous involvement in the case. All authors based their reports on electronic and written records, and the police report also considered S's human resources record and material generated by the homicide investigation. The author of the police report interviewed 21 officers.
- 1.3.6 During the police investigation into B's murder, it was revealed that S had been a patient in a private recovery clinic between 15th and 21st March 2012 and that B had taken part in a conjoint meeting there on 18th March, when domestic abuse was discussed. The Panel became aware of this in January 2013. Therefore, in February 2013, the clinic was requested to provide a summary of its involvement with both parties. The summary was detailed and indicated some learning; hence an individual management report was not requested.

1.4 Family input into the review

- 1.4.1 Relatives of B were notified of the review by their police family liaison officer and offered the opportunity to meet with the overview report author after the conclusion of the criminal trial. B's father duly met with the author and gave a helpful perspective of the tragic events, which is outlined in section 2.6. Her mother chose not to meet with the author. B's father asked the author not to meet with B's friends, as he wished to limit involvement to close family members. The Chair of the review considered whether B's friend, V, should be contacted, but decided to respect her father's wishes. This was because B's father was also present with V at the incident in March 2012, so was able to describe the events that occurred when the police officers arrived. B's father, brother and sister in law met with the author after they had read the report. Their comments are in section 2.6.

1.5 The Review Panel

- 1.5.1 The review group membership was as follows:
- Helen Davies, Independent Chair and Overview Report Writer (an independent consultant)

- Andrew Coombe/Rosetta Lancaster, NHS Kent and Medway
- Tim England, Medway Community Safety
- Alison Gilmour, Kent and Medway Domestic Violence Coordinator
- Carol McKeough/Yvonne Phillips, Kent Families and Social Care
- Shafick Peerbux, Kent Community Safety
- Tim Smith/Andy Pritchard, Kent Police

1.5.2 Dates of review panels were:

- 4th July 2012
- 4th October 2012
- 18th December 2012
- 17th April 2013

1.5.3 The Chair of the Panel and author of the overview report has had no direct involvement with any of the professionals' work being reviewed. She is an Independent Children's Services Consultant, a qualified social worker who has worked in local authority children's social care for over 30 years, 13 of which were at assistant/deputy director level. She has worked as an independent consultant for two years and is Chair of a Local Safeguarding Children Board.

1.5.4 The overview report was based on information provided in the two IMRs, the health overview report, the two summary reports, information disclosed in a meeting the author had with the investigating police officers after the conclusion of the trial and the perspective of B's father.

2 The Facts

2.1 Circumstances of B's death

At 09:40 hours on Monday 30th April 2012, police were contacted by the ambulance service reporting that a woman had been stabbed. A number of medical personnel tried to resuscitate B but she was pronounced dead at her workplace. It was soon established that B's estranged husband S had entered the business and stabbed her several times with a knife and then left.

2.2 Police and Coroner's enquiries

Kent Police later arrested S at his home. He was charged with murder, to which he pleaded not guilty. He was remanded in custody pending trial and stood trial in December 2012/January 2013. On 11th January 2013 S was found guilty of B's murder and on 14th January 2013 he was sentenced to life imprisonment, with a recommendation that he serves a minimum of 28 years. There was no coroner's inquest as the crown court determined that B's death was unlawful killing. The Independent Police Complaints Commission (IPCC) requested a copy of the police IMR after the trial and it was provided. The case had not been referred to the IPCC because S was not a serving police officer at the time of the murder, having left the force two years earlier and no complaint

had been made to Kent Police. It was called in by the IPCC in February 2013, and the IPCC referred the matter back to Kent Police in August 2013.

2.3 Family structure

At the time of her death B, aged 33, had been living separately from S, aged 38, at her father's home since February 2012. S remained in the marital home. The couple had no children.

2.4 Family Background

2.4.1 S was born in the North of England. Between 1990 and 2003 he was employed in a number of unskilled jobs. In July 2003 S joined Kent Police and was posted to town A police station. He remained working in town A in a number of roles until he resigned in December 2009. In February 2008 S disclosed to his employer that he was struggling with alcohol and cocaine misuse. He disclosed historic misuse of cocaine and alcohol, stating that he first started taking cocaine in the mid 1990s when he lived in London. He stated that he had stopped taking drugs for a long period but had started again in October 2006 due to increased pressure at home, largely relating to finance and opening a business jointly with his wife. Kent Police's response was supportive and S was placed on duties which involved no contact with the public. In September 2008 he was judged by occupational health to be fit for return to full duties.

2.4.2 In January 2009 S was criticised by his supervisors for having controlled drugs, seized as part of his work, in his office desk drawer and a remedial action plan was drawn up, designed to improve his performance. In September 2009 S was placed on a management action plan following his failure to comply with written instructions. In October 2009 he ignored a warning for sending inappropriate emails at work. In November 2009 S was noted to be under the influence of alcohol in the police canteen. In a meeting with his superiors he said that he was of unstable mind and was considering resignation from the police. On 14th December 2009 he tendered his resignation from Kent Police following a dispute with his supervisors and he did not return to work. He formally left Kent Police on 13th January 2010. Thereafter, he was not in paid employment, although he attempted to become a football agent.

2.4.3 B lived all her life in and around town C. She had her own successful business, jointly owned with S. She was consistently described by her family and friends as a kind and caring person who was very private.

2.4.4 S and B met in 2002 and soon began living together. They married in October 2006. Up to this point there were no reports of domestic abuse incidents between the couple and there was nothing recorded to this effect on S's police personal file. However, during the murder investigation B's friends indicated that the relationship was marred by domestic abuse from early on. The couple separated in September 2011, when B went to stay with her brother and S remained at the marital home. B described their relationship as volatile to a police response officer on the 25th October 2011 and stated that S had assaulted her in the past, but she had not reported these attacks to the police. (There is no record of any reports of domestic abuse on S's police personal file

in the period before December 2009). The couple remained in contact during this period of separation and B returned to the marital home after 6 weeks. At the end of 2011 they went on a 'make or break' holiday together; after the holiday, during which S disclosed that he was using cocaine and having a sexual relationship with a man, the couple separated again in February 2012 when B went to live at her father's home. She remained there until her death.

2.5 Agencies' Involvement with the couple

- 2.5.1 The first significant contact with agencies was when S visited his GP in February 2008 reporting recreational drug use and high alcohol consumption. He stated that his employer was aware of this and that he had been put on restricted duties. The GP discussed counselling with S, who stated that there were difficulties in attending KCA due to the nature of his job. An appointment was made for the in-house counsellor but S did not attend in April 2008.
- 2.5.2 The first police involvement with the couple was on 14th December 2009, the day on which S had resigned as a police officer. Kent Police attended their home after an abandoned 999 call. They found B crying and distressed. S was present and it was established that a verbal altercation had taken place when S informed B of his resignation. During the altercation a banister had been broken and each party alleged the other had caused this damage. The attending police officer took B to her brother's house as she was intoxicated and distressed.
- 2.5.3 The police officers considered that no offences had been committed, as there were no injuries and the property damaged belonged to both parties. The incident was recorded as domestic abuse and a SPECCS (Separation, Pregnancy, Escalation, Cultural Issues, Children, Stalking, Sexual Assault and other aggravating factors) risk assessment was completed. This assessment was graded as 'standard' with risk factors identified as escalation, increased frequency, the involvement of drugs and alcohol, controlling behaviour and mental health issues in that S was described as suffering from depression. The officer recorded that B was not thought to be vulnerable or intimidated and, if required, B could access generic information about domestic abuse on line. The information was recorded on a secondary incident record (a document designed to record incidents which do not amount to substantive crimes). This document was then reviewed by a sergeant, who concluded that no further action was necessary. The matter was then filed.
- 2.5.4 On 25th October 2011 the second police involvement occurred. B went to the local police station and reported that she was experiencing unwanted contact from S. A police response officer was assigned to deal with B, she explained that she was separated from S and had refused to see him the previous weekend as she believed he was taking drugs. Since then he had been constantly phoning her and had made a threat to kill her, threatening to go to her brother's house (where she was staying) or to her workplace. She said that the volatility of their relationship had escalated since S's resignation from the police and that she had been assaulted in the past but had not reported these incidents to the police, although on one occasion she had been to her solicitor

in order to record an injury inflicted by S. Her only contact with the police had been in relation to the incident in December 2009. B also stated that in addition to violence, S had abused her emotionally, continually putting her and her family down and trying to make her feel useless. She had received texts of an upsetting nature from S informing her that he was engaged in a sexual relationship with a man and asking her to join them for a 'threesome'.

- 2.5.5 The police officer identified this incident as domestic abuse and therefore completed a Domestic Abuse Stalking and Harassment (DASH) assessment, which was classified as 'medium' risk. The risk factors identified included B being frightened and feeling isolated when she was with S, the pressure caused by separation, the frequent phone calls and text messages, S's controlling behaviour and his threats to harm or kill B. It was also mentioned that he had access to firearms and since his resignation from Kent Police he had been financially dependent on B.
- 2.5.6 The police officer gave B advice on how to deal with domestic abuse and suggested that she send S a text stating that all further contact should be made through her solicitor.
- 2.5.7 The police officer felt sufficiently concerned about B's report that she liaised with her supervisor, as she felt that a police visit to S was required. Later that day the supervisor went to S's home, S was aware that B had spoken to the police and apologised for sending the text messages, but said that B had provoked him into this situation and that she had been taking drugs all weekend. S was not arrested and it was decided that no recordable offences had taken place. Therefore, the events were recorded on a secondary incident report.
- 2.5.8 Following the submission of this report, several attempts were made between 31st October 2011 and 17th November 2011 by an officer from the police domestic abuse unit to contact B in order to advise her further on how to deal with any future incidents. Such contact did not take place and it appears that B was unwilling to engage further with the police at this stage.
- 2.5.9 A supervisor from the police public protection unit assessed and validated the incident as 'medium' risk. The supervisor recorded that he had concerns that the domestic abuse may escalate.
- 2.5.10 An entry was made on the secondary incident report requesting that the domestic abuse unit contact the Kent Police firearms unit regarding S's shotgun certificate.
- 2.5.11 Another supervising police officer reviewed the secondary incident report and recorded that there were no substantive offences or outstanding reasonable lines of enquiry. There was no further reference to S having a shotgun and it appears that the only action in relation to this entailed a report being made to the Kent Police firearms unit, which is responsible for security and certification of firearms.

2.5.12 On 16th November 2011 (around 3 weeks later) S was visited at home by a firearms officer, this was a direct result of the report emanating from the report of 25th October 2011. He agreed to surrender voluntarily his shotgun certificate and shotgun for six months or, until the situation with B had been resolved. He also stated that B had moved back into the marital home on 27th October 2011 and had been living there ever since.

2.5.13 The next contact between Kent Police and B was on 10th February 2012, when she contacted the force control centre and informed the operator that she had now left S and was living at her father's address. She said that S was threatening to visit her there which clearly concerned her. She said that she did not wish to see a police officer and merely wanted the information logged. The control centre operator identified this as an incident of domestic abuse and arranged for a police officer to see her; however, B cancelled this appointment saying that she was busy at work. Further efforts were made to contact B but she was adamant that she did not wish to see the police.

2.5.14 The following day (11th February 2012) B made an emergency call from her father's address to the force control centre stating that S was very depressed and was threatening to 'slit his throat'. She informed the control centre staff that S had no history of self-harm but when he went to her father's address the previous day he was carrying a knife. A police officer met B and her father outside S's address and went inside the house, where S was found unharmed but upset. He did not indicate to the officer that he wished to take his life but was very distressed, crying and intoxicated. The police officer was concerned for his wellbeing and considered he might need some medical help. She invited S to go with her to a psychiatric hospital to which he agreed. After leaving the house, the police officer formally detained S under section 136 of the Mental Health Act and he was taken to hospital for a mental health assessment.

2.5.15 On arrival at the hospital S was assessed at the section 136 suite in accordance with national and local guidance. A comprehensive assessment was completed by experienced practitioners. S disclosed that he had been feeling depressed but had not sought advice or support from his GP. S denied any active thoughts or plans to harm himself; therefore, he was not deemed to be detainable under the Mental Health Act. During the risk assessment S stated that he and B shared a business together; he admitted that he had sent abusive text messages to B but refused to elaborate on their content. He also stated that he had sent B text messages threatening to kill himself.

2.5.16 After the assessment S was discharged home with advice to contact his GP; his mother was apparently due to arrive the following day to provide support.

2.5.17 On 13th February 2012 B saw her GP and complained of mood swings and insomnia since separating from S. She gave no indication that S was abusive to her.

- 2.5.18 On 14th February 2012 S saw his GP who described him as ‘acutely stressed’. S reported that his wife had left him following marital problems during the past two years. He described the events of the previous weekend when he had been assessed under section 136 of the Mental Health Act. S said that he was not suicidal and that his stress was mainly due to relationship problems. He was advised to attend counselling with KCA and to use a self help NHS website on cognitive behavioural therapy. The GP agreed to review him as necessary. This was S’s last contact with his GP.
- 2.5.19 On 6th March 2012 S contacted KCA and had a phone consultation, the record of which states that he had a moderate level of psychological distress and he expressed an interest in couple therapy. There was no mention of domestic abuse. He was offered a follow up appointment on 20th March 2012, which he did not attend.
- 2.5.20 The last incident reported to Kent Police before B’s death was on the 13th March 2012. The force control centre was contacted at 20:33 by a male friend of B, who explained that he (V) and B were at her father’s house and that S was outside refusing to leave. He was banging on the door and being verbally abusive. B was in the background and the operator heard her shout “you are not allowed to come in, you tried to kill me”. The friend, V, informed the operator that the previous day S had gone to B’s workplace and assaulted her, placing his hands around her neck until she was unconscious. V stated that like other assaults, B had not reported it to the police because she was afraid to do so.
- 2.5.21 A response police officer went to the address one hour later; by this time the attendance criteria had been downgraded as S had left the premises. The police officer spoke briefly to V who was unhappy about the length of time police had taken to attend. V was not interviewed about his remarks to the control centre regarding the workplace assault. B’s father spoke with the police officer and was clearly very angry about S’s behaviour; he was not interviewed either. B was interviewed but refused to disclose information to the police officer regarding this incident, or any other incidents and she did not wish any action to be taken against S. The police officer saw no visible injuries on B and she signed his notebook confirming that she wished no further action to be taken. The police officer was not given details of the incident in the workplace the previous day when it is alleged that S tried to strangle B; he stated that this information was not passed to him by the control centre and he had not viewed the CAD (Computer Assisted Despatch).
- 2.5.22 This incident was recorded on a secondary incident report as a domestic abuse related event and a DASH risk assessment was completed. A number of risk factors were identified including the fearfulness and concern of B, issues around the separation, constant texting by S, escalation, threats to harm/kill, threats by S to take his own life. One of the comments S had made to B was ‘if she ever left him, she would be dead.’ The attending police officer initially classified this incident as ‘standard’ risk. However, the following day it was reviewed by a more senior officer, who re-classified it as ‘medium’ and

instructed that a safety plan be put in place but this officer was not aware of the information about strangulation on the CAD.

2.5.23 The police experienced some difficulty in contacting B but she was eventually seen on the 15th March 2012 by another police officer at her father's address, where she was provided with information giving details of the local domestic abuse One Stop Shop, a centre in town C that offers victims of domestic abuse free advice, information and support under one roof. She was also given information about NCDV, the National Centre for Domestic Violence, an organisation that specialises in providing legal assistance to victims of domestic abuse, particularly in obtaining injunctions. Operational information was also placed on her father's address and her workplace address.

2.5.24 This was the last contact that Kent Police had with B. The murder trial heard of subsequent threats to kill her made by S, escalating on the day before her murder. None of these were reported to the police.

2.5.25 S was admitted to a private recovery clinic on 15th March 2012 for the treatment of his alcohol and cocaine addiction. Initially, it was planned that he would stay for two weeks in order to get through the period of detoxification. B made one visit to the clinic on the 18th March 2012 to attend a conjoint meeting with S and a counsellor. During the session B spoke about S trying to strangle her to the point she passed out but appears to have minimised this incident. The counsellor recommended to B that she consider counselling and talking to the police. B said that she had contacted the police and that she had good family support. Apart from this occasion, S made no mention of any physical or emotional domestic abuse.

2.5.26 During the meeting B made it clear that the marriage was over. Thereafter, S wanted to leave the clinic, revealing that his decision to enter recovery was partly to secure B's return. He left on 21st March 2012 against the advice of staff at the clinic who were concerned that S had emotional issues that needed exploring and would lead to further alcohol and drug use. B and S's father were notified that S had left treatment early. Clinic staff made attempts to contact S by phone after he left but he never responded to messages.

2.6 Family Views

2.6.1 B's father praised the support he received from the police investigating officers and the family liaison officer. He appreciated their efforts to secure the murder conviction. He had been briefed by the senior investigating officer about the key findings of the police IMR. He was aware that the police officers who visited his home in March 2012 did not have all the information communicated to the force control centre, but he did not wish to apportion any blame to Kent Police, feeling very strongly that responsibility for his daughter's death rested with S. B's father did, however, think that the police officers who visited his home on 13th March 2012 should have interviewed him and B's friend, V, as they had relevant information about S's behaviour. The officers only interviewed B and asked him and V to leave the room.

- 2.6.2 B's father explained that B was reluctant to support a prosecution of S because she wanted to avoid him acquiring a criminal record. This was likely to impede his career ambitions and she wanted him to be successful in a new career, in the hope that this would enable him to move on from their marriage, thereby freeing her to build a new life. B's father did not believe that S's former employment as a police officer had any bearing on B's reluctance to disclose to the police the full extent of the domestic abuse she had suffered. He considered that the only relevance of S's former employment was that it could have assisted him when interviewed by police officers.
- 2.6.3 B's father confirmed that he was not aware of all the abuse that his daughter had experienced. She was a very private person and revealed only a little to family members and friends.
- 2.6.4 B's father, brother and sister in law read this report and met with the author to discuss it. They were content with its conclusions. They were concerned that the police investigation in March 2012 was insufficiently thorough, as the investigating officers were not aware of all the circumstances (notably the information on the CAD) and did not interview B's father or her friend, V. B's family hope that lessons will be learned from this missed opportunity, especially the importance of interviewing family members/friends, as they might have information which a victim of domestic abuse is reluctant to disclose.

3 Analysis

- 3.1 There was limited involvement of health agencies with this couple. B saw her GP on a few occasions for minor complaints. The only significant contact was in February 2012 when B visited her GP complaining of insomnia, anxiety and mood swings following separation from S. She was prescribed sleeping tablets. S had contact with his GP in 2008 when he described his cocaine use and high alcohol consumption; he did not follow up the recommended counselling. He next saw his GP in February 2012 following his assessment under the Mental Health Act the previous weekend and described 'acute stress' following the breakdown of his marriage. He was advised to contact KCA which he duly did in March 2012 for a phone consultation. He did not attend the appointment offered by KCA later in March 2012. There is no evidence that either the GPs or KCA were aware of domestic abuse. However, the response of S's GP in February 2012 could have been more assertive, given his apparent distress, that there had been sufficient concern to admit him to hospital for a mental health assessment and he had revealed cocaine use and heavy alcohol consumption in the past.
- 3.2 KMPT had no involvement with B and had one involvement with S on the evening of 11th February 2012 when he was assessed in hospital under section 136 of the Mental Health Act. The assessment focussed on whether he was a risk to himself and although S indicated during the assessment that he had sent abusive text messages to B, the content of these messages was not explored.

- 3.3 The recovery clinic had one contact with B and S remained there for 6 days. It became clear that S was never committed to recovery; it was a means to manipulate B to return to him. Staff at the clinic were aware of the attempted strangulation in March 2012 but were reassured by B's statement that she had told the police. While they could have checked with Kent Police, it is understandable that they accepted B's version of events.
- 3.4 The only significant agency contact with the couple was by Kent Police, both as S's employer until January 2010 and in response to B contacting them on five occasions between December 2009 and March 2012. Therefore, most of the following analysis relates to Kent Police's responses to B's concerns. It is also necessary to touch on S's record while serving in Kent Police between July 2003 and January 2010 and comment on the response of the police to his problems. However, it must be remembered that this review is primarily concerned with domestic abuse and is not a scrutiny of S's police service record.
- 3.5 Were practitioners knowledgeable about potential indicators of domestic abuse and aware what to do if they had concerns about a victim or perpetrator?**
- 3.5.1 Kent Police has for many years had domestic abuse training embedded at all levels of police training. At the time of the case and to date, domestic abuse training is delivered to new recruits, detective training courses, sergeant and inspector courses, senior detective officer courses, front line response staff and force control room staff. There is also enhanced single agency and multi-agency training for specialist officers within public protection and family liaison officers. As a result of the recommendations in this case, Kent Police has refreshed DASH training for all front line response officers. This was delivered in July 2013 and will be part of a rolling training programme. This training should assist officers in dealing with calls from the public but also in identifying domestic abuse within their own working environment.
- 3.5.2 S's colleagues, including his supervisors, did not identify domestic abuse while he was a serving officer and there is no evidence to suggest that he or B disclosed domestic abuse during this period. The police officers who responded to B's reported concerns revealed that they were knowledgeable about indicators, as they identified that the reported incidents constituted domestic abuse (apart from the incident on 11th February 2012) and all incidents were reviewed by a more senior officer.
- 3.5.3 In KMPT practitioners are informed through mandatory adult and child protection training how to respond if there are concerns about domestic abuse. The risk assessment process ensures that all practitioners ask about violence, aggression and abuse to family members. This question was asked of S but his revelation that he sent abusive texts to B was not pursued. Subsequently, staff have learned from domestic homicide reviews that text messages can be a form of domestic abuse and are now expected to challenge a client who made a disclosure.

3.5.4 The recovery clinic states that staff have in the past liaised with both police and social care services when domestic abuse is apparent and the victim is ready to disclose the abuse. In this case, they relied on B's reassurances.

3.6 Did agencies have effective policies and procedures for (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have effective policies and procedures in place for dealing with concerns about domestic abuse? Was the victim subject to a Multi Agency Risk Assessment Conference (MARAC)?

3.6.1 Kent Police has a robust policy on domestic abuse which is regularly updated, as is the risk assessment process. Some of the main features relevant to this case include:

- Where an offence has been committed, an arrest will normally be necessary to protect a vulnerable person to prevent the suspect causing injury, and allows for a prompt and effective investigation of the offence.
- Officers should consider the victim as a whole and not just the oral or written evidence of the victim. Officers should focus on gathering information in order to charge and build a prosecution phase that does not rely entirely on the victim's evidence.

3.6.2 The policy includes use of the DASH model to assess risk. This checklist has replaced the SPECSS model in use in December 2009 when the first reported incident of domestic abuse occurred. The policy states that the DASH process involves asking a series of pre-set question and at its conclusion, the risk category of 'standard', 'medium' or 'high' will be identified. The policy also states that the DASH risk assessment will be based on the circumstances of the incident and information known to the police, which includes previous crime reports, secondary incident reports and previous convictions. Using the DASH model assists in making a structured assessment of risk but this case highlights how classification of risk is subject to interpretation. In the first instance, in December 2009, the risk was graded as 'standard' by the attending officer and confirmed as such by two sergeants; this was a reasonable assessment in the circumstances. The second reported incident in October 2011, when B visited town C police station, was graded as 'medium' risk by the police officer that interviewed B and was confirmed as such by a sergeant in the public protection unit. B's report to the force control centre on 10th February 2012 of continued harassment by S via texts was not risk assessed, as she merely wished it to be logged and refused to be interviewed by a police officer. The force control centre operator took her concerns seriously but was unable to persuade B to speak with a police officer.

3.6.3 The incident of 11th February 2012, when B expressed concern about the risks S might pose to himself, was not judged to constitute domestic abuse, even though she described him visiting her father's home the previous day with a knife and the threats of self harm could have been construed as a means of S continuing to control and harass her. The incident on 13th March 2012 was assessed as 'standard' risk by the attending police officer but upgraded to

'medium' by a sergeant in the central referral unit (which had taken over responsibility for oversight of DASH assessments from the public protection unit). The sergeant did not see the CAD completed by the force control centre which contained information given by B's friend (V) about the alleged strangulation of B by S the previous day at her workplace when she had lost consciousness. If this information had been available to the sergeant, it is very likely that the risk would have been assessed as 'high' leading to a multi-agency risk assessment conference (MARAC) and a comprehensive safety plan for B. Despite the 'medium' grading, the sergeant instructed that a safety plan should be put in place.

- 3.6.4 In Kent, generally, only classifications of 'high' risk will result in a MARAC referral. In this case, the grading was never above 'medium' so a MARAC referral was not made. Kent Police policy means that only high risk cases involve any form of continued interaction with the victim, and contact with domestic abuse specialists will be restricted to high risk cases.
- 3.6.5 Kent Police also has in place a policy for dealing with reports of domestic abuse involving serving officers. This entails notification to the Professional Standards Department and to the 'Proactive Scanning Group' which was set up following a previous domestic homicide by a serving police officer. The Group, chaired by the Head of Human Resources and attended by senior managers, ensures that information is shared and that the resources of the force work together to seek positive outcomes in the management of acutely vulnerable employees, including police officers who are suffering or perpetrating domestic abuse. There were no reports that S was involved in domestic abuse before 14th December 2009, the day on which he resigned from the force.
- 3.6.6 The first reported incident was on that day and although S never returned to work, he was technically a police officer until 13th January 2010. The two police officers that attended the marital home on 14th December were unaware of the policy, but in any case, understood that S was no longer employed by Kent Police. The sergeant who decided that no further action was necessary was aware of the policy but did not realise that S was a police officer (S worked in town A and lived in town C). Had the policy been implemented, the incident would have been considered by the Proactive Scanning Group on 16th December when they were scheduled to discuss S's difficulties. However, it is unlikely that it would have made any difference, as he was due to leave Kent Police on 13th January and was not at work.
- 3.6.7 KMPT has a strategy for domestic abuse. Since February 2012, a specific member of the safeguarding team has been in post to address issues relating to clients who are either victims or perpetrators of abuse. KMPT uses the DASH risk assessment when indicated. It was not considered necessary in this case, as the staff undertaking the mental health assessment did not identify domestic abuse.

3.7 Did agencies comply with domestic abuse protocols agreed with other agencies, including information sharing protocols?

3.7.1 The only instance of inter-agency working in this case was when Kent Police took S to hospital for an assessment. Its purpose was to assess his mental health and he was not considered at that time to be a risk to himself or his victim. There is no evidence that his disclosure of sending abusive texts to B was shared with safeguarding leads within KMPT or with Kent Police.

3.8 What were the key points or opportunities for assessment and decision making in this case?

3.8.1 When B attended town C police station in October 2011 and reported the receipt of threatening phone calls and text messages, including threat to kill, alongside historic assaults, this was not recorded as a crime and submitted for investigation. This was a lost opportunity, as S could have been arrested for sending malicious communications, or he could have been issued with a Harassment Warning. Either way, this incident should have resulted in a more robust response.

3.8.2 When B contacted the force control centre on the 11th February to report her concerns for S's welfare, she reported that he had been carrying a knife when he went to her father's address the previous day. More information should have been recorded; this would have resulted in further investigation into an offence of possession of an offensive weapon.

3.8.3 The incident reported by V in March 2012 should have prompted a more robust investigation. There were two aspects; firstly, the attending police officer was not told by the force control centre of the CAD, which recorded V's account of the strangulation at B's workplace the previous day and B's shouting that S had tried to kill her. Therefore, he did not interview V and B did not report it to him. Secondly, the incident on that day when S turned up at B's father's house was not investigated fully. Although B did not wish the matter to be pursued, this should not have prevented S being interviewed, as B had described a threat to kill. As indicated in paragraph 3.6.1 Kent Police policy is that officers should not rely wholly on the evidence of the victim when building a case for prosecution. Had the full information been available to the attending officer and to the sergeant in the central referral unit who reviewed the DASH assessment, it should have been clear that a crime investigation was necessary, entailing interviews with staff at B's workplace and the arrest and interview of S.

3.8.4 The mental health assessment in February 2012 was another key point. It concluded that S was not a suicide risk or a risk to others. This was a reasonable assessment based on the information available. However, further exploration of the nature of S's threatening texts would have been advisable.

3.8.5 The disclosure by B of attempted strangulation during the conjoint meeting at the recovery clinic on 18th March 2012 was another key point. The staff's failure to pass this information on to the police was a missed opportunity as S had acknowledged his violence, but it is understandable that B's assurance that she had already notified the police was accepted.

3.9 Was the quality of assessments undertaken adequate? And were the decisions and actions that followed appropriate?

3.9.1 The quality of SPECES/DASH assessments by Kent Police was variable. The first assessment in December 2009 was recorded on a secondary incident report as the attending officers judged that no crime had been committed. The standard list of questions was put to B, but it is possible that some of the answers were not accurate (e.g. no disclosure of past abuse) and, with hindsight, they might have been challenged. The quality was adequate in that appropriate questions were asked, but the officer completing the assessment would have no knowledge of the background and would not be an expert in domestic abuse. It is understandable that the assessment was 'standard' risk as it was the first report of domestic abuse involving this couple and there were no injuries. B was protected by being escorted to her brother's home and the secondary incident report ensured that there was a record of the domestic abuse incident on the police information system. The only omission was failure to comprehend that S remained a serving police officer for another month following his resignation on that day, which meant that the guidance on domestic abuse involving serving police officers was not complied with. However, it is unlikely that this omission would have made any difference to subsequent events.

3.9.2 The next incident in October 2011 resulted in a 'medium' assessment of risk and another secondary incident report. This was a DASH risk assessment and the standard questions were asked and recorded. Replies were short but indicative of escalation of risk. B was described as frightened and in fear of violence and injury; hence the elevation from 'standard' to 'medium' risk. This was a reasonable assessment. However, the police officer that interviewed B was sufficiently concerned that she alerted a supervising officer who visited S at home later that day. S apologised for the texts and no action was taken. This response was not robust enough as outlined in paragraph 3.8.1 and was a missed opportunity.

3.9.3 In her interview, B mentioned that S had a shotgun but the supervising officer who visited S in October was unaware of it, so he did not address or assess its implications. The police domestic abuse unit duly reported this to the firearms unit and three weeks later S was visited by an officer from the firearms unit and agreed to surrender his shotgun and licence. This was good practice but the visit should have occurred much sooner.

3.9.4 The incident on 10th February 2012, when B merely wished unwanted contact from S to be logged, was taken seriously by the force control centre operator who persisted in trying to persuade B to speak with a police officer but she declined.

- 3.9.5 The incident the next day involving S threatening suicide was dealt with promptly by Kent Police and the attending officer ensured that he was assessed in hospital under the Mental Health Act. Although S agreed to the assessment, the officer had concerns for S and the safety of others and decided to formalise his attendance at hospital by detaining him under section 136 of the Mental Health Act.
- 3.9.6 This incident should have been subject to a DASH risk assessment, as S had taken a knife to B's father's address the previous day and it was a continuation of the pattern of abuse, as described in paragraph 3.6.3. It should also have been recorded on a secondary incident report to ensure that there was a record on the information system as cumulative evidence. As indicated in paragraph 3.8.2, it should also have resulted in investigation into the offence of possession of an offensive weapon.
- 3.9.7 The assessment and actions that followed the incident reported to the police on 13th March 2012 were not adequate for the reasons outlined in paragraphs 3.6.3 and 3.8.3. The DASH risk assessment identified a number of high risk factors, not least of which were threats to harm or kill B. The initial decision by the attending officer to classify this as 'standard' risk was clearly flawed. It was elevated to 'medium' risk by a supervising officer, but she was unaware of the alleged strangulation. If the DASH risk assessment had taken account of all the available evidence, it should have been classified as 'high' risk resulting in a MARAC. This conference would have put in place an action plan to reduce risk, addressing a proactive approach to the safety of B and interventions with S. Also, the alleged crime at B's workplace the previous day should have been investigated. The outcome was that the sergeant who confirmed the DASH assessment as 'medium' instructed that a safety plan be put in place for B. She avoided contact with the police as they tried to put this plan in place but did see a police patrol officer. He provided her with advice at her father's home a few days later and operational markers were put on B's workplace and her father's address.
- 3.9.8 The KMPT assessment of S under section 136 of the Mental Health Act was a comprehensive assessment in accordance with national Guidance and was undertaken by suitably qualified practitioners. However, as indicated above, it did not pursue the comments made by S about abusive text messages. The action that followed was advice to S to contact his GP (which he duly did a few days later). There was no written communication from the assessing psychiatrist to S's GP. The health overview report identifies that there is no automatic written information sent to an individual's GP following a section 136 assessment, a judgment is made on a case by case basis depending on the nature of the assessed risks. In this case, S was not deemed to be a risk to himself or to others, so no information was supplied to his GP. However, had the abusive texts been investigated, it is possible that cumulative risk might have been identified, increasing the likelihood of a notification to S's GP.

3.10 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?

3.10.1 After the first reported incident in December 2009 there was no follow up by the police as B was not thought to be vulnerable or intimidated. At B's second contact with Kent Police in October 2011, she was given advice on how to deal with domestic abuse by the response officer who interviewed her. Subsequently, the police domestic abuse unit staff made several unsuccessful attempts over a three week period to contact B in order to advise her further on how to deal with any future incidents. It appears that B was reluctant to engage with the domestic abuse unit staff, so she did not receive any further advice in line with Kent Police policy on safety plans for medium risks cases.

3.10.2 When B contacted the force control centre on 10th February 2012, the operator tried to persuade her to speak with a police officer and made an appointment but B cancelled it. After the incident on 13th March 2012 there was follow up with B, she was seen at her father's address by a police officer a few days later and given details of a domestic abuse One Stop Shop and NCDV. Operational information was placed on her father's address and on her workplace. Other interventions might have been helpful; for example, contact with the domestic abuse unit and encouragement to involve family, friends and colleagues in a safety plan. However, by this stage, the situation should have been recognised as high risk and a MARAC referral and multi-agency safety plan put in place.

3.10.3 S was advised by his GP to refer himself for counselling because of his substance misuse in 2008 but he did not take it up. He was advised by his GP to refer himself to KCA in February 2012 but only pursued a phone consultation. He did not attend an offered appointment in March 2012. He entered a private recovery clinic for six days in March 2012 but discharged himself against advice, when he realised that completion of the programme would not save his marriage.

3.11 In what ways were the victim's wishes and feelings ascertained and considered? Was she informed of options/choices to make informed decisions? Was she signposted to other agencies?

3.11.1 Kent Police made several attempts to engage with B, as indicated in paragraph 3.10 and to signpost her to relevant services. However, she appeared reluctant to engage with the police or with any specialist domestic abuse service. In all B's contacts with Kent Police the officers made efforts to ascertain her wishes. At the first contact they took her to her brother's house for the night; at the second contact in October 2011, B gave a detailed account of her experiences of domestic abuse which was taken seriously by the interviewing officer, who felt so concerned that she reported it to a more senior officer. It appears that B was not seeking advice or positive action from the police at this time.

3.11.2 When B made contact with Kent Police for the third time on 10th February, she was adamant that she did not want to see a police officer; she merely wished to report threatening text messages. Correctly, the force control centre operator

tried to persuade her to see an officer but B refused. The next day, B's concerns for S's wellbeing were taken very seriously by Kent Police. At the time of the last reported incident in March 2012, B was reluctant to provide the attending police officer with information about the incident on that day or about any previous assaults, and she refused to support any notion of a prosecution, signing the attending officer's notebook to this effect.

3.12 Is there evidence to suggest that the victim's decision to engage with services was affected by the perpetrator's former employment?

3.12.1 B's family believe that she did not wish to engage with services because she was a very private person. They do not believe that she anticipated an unfavourable response from Kent Police because of S's former employment with the force. Her motivation was to avoid S obtaining a criminal record because she feared this would harm his future employment prospects. She wished him to be successful in his quest to become a football agent, hoping that he would feel able to move on and leave her alone. Although not relevant in B's case, when an alleged perpetrator of domestic abuse is a serving or former police officer, great care should be taken by the police in reassuring the victim that a fair and impartial investigation will ensue. There is no evidence to suggest that S's former employment had any bearing on the way in which Kent Police handled this case; indeed, the officers dealing with S did not know him (the force is a very large organisation). It is however possible, that S used his knowledge of the criminal justice system to minimise the risks he posed to B when visited by the police in October and November 2011.

3.13 What was known about the perpetrator?

3.13.1 S began working for Kent Police in 2003 at the age of 29, having undertaken a range of unskilled jobs since leaving school. Before moving to Kent he lived in London in the 1990s when he developed a cocaine habit (this was not known to Kent Police until 2008). He met B in 2002 and they began living together soon after they met. S worked as a police constable in a number of roles in town A. His record included some good conduct, punctuated with a number of adverse reports and appraisals, at the centre of which was his self disclosure in 2008 that he had a problem with cocaine and alcohol. Following concerns about his performance, he resigned from Kent Police in December 2009 and his employment formally ended in January 2010. There is no evidence of any reported incidents of domestic abuse before the date of his resignation and no evidence that any of S's former colleagues or supervisors knew of abuse in his marriage.

3.13.2 S and B married in October 2006 and jointly set up a business in town C in 2008 where B worked. Following his resignation from the police, S did not work and was financially dependent on B and the business. He tried to become a football agent. It seems that from 2008 onwards S became increasingly troubled. He took cocaine and drank heavily but there is no evidence that he was dependent on these substances. He described himself as depressed and stressed. The marital relationship became more volatile and S said that he had engaged in a sexual relationship with a male friend. It appears that he did not

accept that the marriage was over; he was seeking couple therapy in March 2012 and entered a recovery clinic later in March, hoping that B would return to him if he entered treatment for his alcohol and cocaine use. He was abusive, threatening and controlling towards B. He was excessively jealous and, after their separation, harassed B through persistent phone calls, texts and visits.

3.14 Were there any indicators of abusive behaviours or risk factors identified that could have mitigated future risks?

3.14.1 The factors identified in the above paragraph were indicators of escalating risk and if they had been analysed alongside the alleged incident of attempted strangulation in March 2012, there should have been an assessment that the risk posed to B was high, resulting in a MARAC, a comprehensive safety plan for B and a criminal investigation of S's behaviour.

3.15 Was race, religion, language, culture or disability a factor in this case? And was it considered fully and acted on if required?

3.15.1 S was of mixed black and white origin. His father is black and from Trinidad, while his mother is white British. There is no indication from police records or from interviews conducted by the police IMR writer that this had any bearing on either his life at work, or in his home environment.

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

3.16.1 During S's police career senior managers were involved as appropriate in response to his disclosure of cocaine use and subsequent events. None of them were aware of domestic abuse. With regard to the incidents reported by B, supervisory input was at an appropriate level and all the assessments were scrutinised by a more senior officer. However, the incident on the day of S's resignation should have been reported to an inspector, as he was still a serving officer and the inspector should have informed the Professional Standards Department.

3.16.2 It was appropriate that S's mental health was assessed in February 2012 and staff at the requisite level were involved in completing the assessment.

3.16.3 Had S been arrested for assault following his alleged strangulation of B in March 2012, this would have provided further opportunities for assessment of his mental health and his substance misuse.

3.17 Did resources/workload/staff supervision and support have any impact on agencies' practice in this case?

3.17.1 Within KMPT there is no evidence to indicate that they had any impact on the outcome of this case.

3.17.2 Within Kent Police, by the time of the incident in March 2012, the Central Referral Unit (CRU) had been introduced and supervisors within this department were trying to assess all crime reports and secondary incidents relating to domestic abuse. Originally, 'standard' risk cases were not assessed by the CRU, but poor completion of the DASH questions, particularly in relation to children, resulted in CRU supervisors trying to view all cases in order to validate the risks, because they knew there was not an appropriate level of supervision being applied by the frontline officers' supervisors. The assessment of 'standard' risk cases was not factored into the workloads of the CRU; plans are now in place to refresh the training of frontline supervisors to ensure that they conduct the supervision of DASH risk assessments in line with their role description.

3.17.3 For practical reasons, largely relating to resources, only high risk domestic abuse cases result in a MARAC referral and only high risk cases will involve any continued interaction with the victim by Kent Police. Likewise, domestic abuse specialists are restricted to high risk cases.

3.18 Are there any examples of good practice?

3.18.1 There were several examples of good practice by Kent Police:

- When B made an emergency call to the force control centre in December 2009, distressed and in tears, she cleared the line before giving her details, but the call was immediately traced and a patrol car was quickly dispatched to the address.
- Taking B to her brother's home in December 2009 to avoid escalation of the incident.
- Removing his shotgun and licence from S in November 2011.
- Officers from the domestic abuse unit persisting in their attempts to see B in October and November 2011.
- The force control centre operator persisting in making an appointment for B to see a police officer in February 2012.
- A police patrol officer persisting in seeing B in March 2012 to give her information about specialist services.

3.19 To what degree could the homicide have been accurately predicted and prevented?

3.19.1 By March 2012, there was evidence of a number of risk factors in S's circumstances and behaviour as set out in paragraph 3.13.2. It was also known that he had made threats to kill B, that he had been to B's father's address carrying a knife in February and it was alleged, that in March he had strangled B until she lost consciousness. Unfortunately, all this information was not collated, as the alleged strangulation was not known to the police officer who investigated the incident at B's father's address on 13th March; nor was the CAD, which contained this information, entered on the crime report and examined alongside the report of the incident at B's father's home by the supervisor at the police CRU. Had all the information been collated, it is likely that the DASH assessment in March would have been graded 'high' risk, a multi-agency risk assessment conference would have been convened to

assess all the risks and devise a multi-agency safety plan for B. It is also likely that the incident at B's workplace would have been investigated by Kent Police.

3.19.2 However, it is not possible to conclude that the above actions would have prevented B's death. Nevertheless, they might have provided an opportunity for specialist domestic abuse services to work with B to devise a safety plan, which included her family and friends. Likewise, they might have resulted in services for S to address his abusive behaviour. Investigation of the alleged strangulation might have resulted in S being prosecuted and receiving a custodial sentence, thereby affording protection to B.

4 Lessons learned from the review

- 4.1 The quality of DASH assessments completed by frontline police officers was variable, so it is important that supervisors scrutinising them have the capacity to collate all relevant background information to inform their decisions about level of risk.
- 4.2 When victims of domestic abuse are reluctant to engage with the police and support a prosecution, police officers should, nevertheless, investigate incidents fully and consider the full range of options at their disposal, both criminal and civil, to try to prevent further abuse.
- 4.3 There are particular sensitivities when a perpetrator of domestic abuse is a serving or former police officer. There is variable knowledge among the police about the required actions to be taken within the police force. Also, there may be difficulties for victims in engaging with the police, so options such as the involvement of independent domestic violence advisers should be considered to facilitate their engagement.
- 4.4 Mental health practitioners were not alert to the indicator of possible domestic abuse and did not enquire in depth about the potential for domestic abuse when assessing risk to others.
- 4.5 It is difficult to engage GPs in domestic homicide reviews, their involvement in this case being limited to factual information with no reflection on lessons learned.
- 4.6 Police investigations following B's murder revealed that several friends and family members had information about the escalating domestic abuse she suffered over many years, but no one had the full picture.
- 4.7 This case confirms research evidence (*Wilson, M, and Daly, M (1993). Spousal homicide, risk and estrangement Violence and Victims, 8,3-16 and Campbell, J (1995). Prediction of homicide of and by battered women in JC Campbell (ed), Assessing Dangerousness; Violence by the sexual offenders, batterers and child abusers, London: Sage*) that the most dangerous time for a female victim of domestic abuse is when she ends the relationship. Once S realised that their marriage was over, he exerted his control over B for a final time by killing her.

5 Conclusions

- 5.1 This review has identified ways in which practice could be improved within Kent Police and KMPT. It has focused on domestic abuse, so it has not focused in depth on Kent Police's management of the perpetrator's difficulties in the last two years of his service. There is no evidence that anyone in Kent Police had information that the perpetrator was involved in domestic abuse until the day of his resignation. However, Kent Police in its own independent management report has made a recommendation about reviewing its policy for self disclosed drug taking by police officers or staff.
- 5.2 There is no evidence that S's former employment as a police officer in Kent had any bearing on the handling of this case by Kent Police, or that it deterred B from reporting abuse to them. It appears that her reason for not wishing to support prosecution was to avoid S acquiring a criminal record.
- 5.3 There was evidence of escalating abuse towards B in the six months before her death and of risk factors in S's behaviour. The incidents in March 2012 should have been investigated more fully, despite B's reluctance. They should also have resulted in a MARAC and a robust safety plan to reduce the risks to B.
- 5.4 Although mental health practitioners did not follow up an indicator of possible domestic abuse when making their assessment of S, there is no reason to conclude that this had any impact on the tragic outcome, as the police were already aware that S was sending B abusive and threatening text messages.
- 5.5 The recovery clinic staff reasonably accepted B's account that she had notified the police of S's assault on her in March 2012. However, it was a missed opportunity to provide the police with more evidence of S's abuse.
- 5.6 The overview recommendations are designed to ensure that the lessons learned are addressed.

6 Recommendations

- 6.1 When police officers are dealing with reports of domestic abuse, all relevant information must be recorded on the crime or secondary incident report, which will assist in ensuring a proper risk assessment is made. In particular, relevant information from the Computer Assisted Dispatch (CAD) should also be included on the crime or secondary incident report.
- 6.2 When a person, other than the victim, makes an allegation of domestic abuse to the police, then officers must make contact with not only the victim, but also the individual making the allegation to develop the whole picture. Officers should be reminded of their responsibility to achieve a proper standard of investigation and to ensure that appropriate evidence is captured from key witnesses, paying particular attention to interviewing family and friends.

- 6.3 Police officers and staff should be reminded that, following a report of domestic abuse involving a member of Kent Police (either as a perpetrator or victim), the Professional Standards Department should be informed, usually via a locally based supervisor of the rank of inspector or above.
- 6.4 Kent Police policy to be amended to direct that officers taking reports of domestic abuse perpetrated by a serving police officer/staff, or retired police officer/staff, should consider referring the victim to an independent domestic violence adviser (IDVA) or domestic abuse support worker.
- 6.5 When an alleged perpetrator of domestic abuse is also the holder of a shotgun or firearms certificate, Kent Police should ensure that a risk assessment in relation to the possession of firearms by suspected perpetrators takes place, and, in such cases, consideration should be given to removal of any firearms as a matter of urgency.
- 6.6 The planned review by Kent Police of the police central referral unit (CRU) should consider the capacity of the unit to carry out effective assessments of crime and secondary incident reports of domestic abuse graded as 'standard' risk. The review should also consider whether the assessment of such cases should be the responsibility of divisional supervisors rather than the CRU.
- 6.7 When a person is detained under section 136 of the Mental Health Act resulting from circumstances which may directly or indirectly relate to domestic abuse, Kent Police should record the details on a secondary incident form.
- 6.8 When KMPT staff receive information that could indicate that a patient is a possible perpetrator of domestic abuse, they should seek further specialist advice about the most appropriate action to take. Evidence of this consultation and decision making must be recorded.
- 6.9 When KMPT frontline practitioners identify that a client may be a perpetrator of domestic abuse, they will ensure that this is clearly identified on the KMPT risk assessment. Concerns will be discussed within supervision and multi-disciplinary team meetings.
- 6.10 Following detention and assessment under section 136 of the Mental Health Act, when any indication of domestic abuse is identified by completing KMPT's risk assessment process, a detailed letter should be sent to the client's GP advising follow up.
- 6.11 Domestic abuse training is to be provided for GP surgeries, including competencies for all staff. Once the core competencies have been identified, training will be rolled out to all surgery and primary health care staff.
- 6.12 Domestic abuse training is to be delivered to all Clinical Commissioning Group (CCG) Board members, including required assurances, governance arrangements and domestic homicide review responsibilities.

6.13 CCGs to expedite the appointment of a named GP for adult safeguarding; the postholder would complete individual management reports on GPs' practice for domestic homicide reviews.

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