Domestic Homicide Review
Louise
December 2020
Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 28 April 2023

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The following comments were made by Heidi on behalf of the whole family. The Chair of the Review Panel would like to place on record his thanks and admiration for all the family members for the considered and dignified way they have assisted this review process.

Following a difficult divorce, my lovely daughter reluctantly agreed to rescind custody of their children to her husband whom she loved till the bitter end, as he could provide for them in a manner she felt unable to. Louise had a breakdown and took to alcohol which in turn led to aggression as retaliation against me (her Mother).

Despite many attempts to get her help by all the family, we were consistently ignored as she was "over age", came under "non-disclosure policies" and told "patient confidentiality" applied. Her Father then died whom she was very close to and the family very sadly lost touch with her for several years, despite constant repeated efforts to trace her.

I did have a phone call late one night from the Police telling me "She is safe" but the officer would neither disclose who I was speaking to nor what she was safe from. I SO WRONGLY assumed she had been picked up as drunk and disorderly. I had no idea she had called the police as she was in danger. Which has since been disclosed.

Latterly during Covid we did have intermittent phone calls between us and at the end of 2020 these calls became more frequent and less hostile. Many were whispered conversations with an explanation that "others might hear" but no further discussions took place to identify the problems.

On one occasion a photo was sent asking whether I approved of her new hair cut which was appalling – my comment was I had seen better but no explanation was given, and I now realise this was because it had been hacked off by her partner. Never at any time did she blame him, explaining bruising and hospital visits for injuries which she told me about in the conversations as due to her own clumsiness.

By Christmas 2020 we were having regular WhatsApp/texts and phone calls. She was not under the influence of alcohol, and I was delightfully hopeful I was on the road to getting my daughter, who I loved so much, back again. On Christmas day we played games over the phone. On no occasion did my phone get taken for any investigation by the Police as evidence of our communications.

I hope reader, that you will comprehend that the devastating news 24 hours later of her murder was more than we could bear. My naivety and guilt as to not recognising coercive behaviour and brutality by a partner whom she evidently was trying very hard to get treatment for, will live with the whole family for ever. Despite her alcohol addiction, her Affairs were completely up to date, logically filed and as efficient as she always had been. Evidence in the flat showed at some point her partner had been added to her tenancy which I believe was coercion on his part and not checked by the Authority given he would not have qualified Other alarming evidence was a copy of her Will was openly out on the side in her flat and had been changed to favour her partner on her death, and both signed and witnessed by her partner. Thankfully illegally. There is evidence that she "cared" for him in some strange way, and that she sought help for him.

Despite her partner admitting Murder when taken into custody, as Covid had made Court proceedings impossible, and his Defence had requested medical interventions which shown some brain damage on his part (never explained as to whether this was alcohol related or from birth), we chose the easy option to accept his plea of Manslaughter in order to proceed so that we could all move forward in what was at the time the unknown Covid lockdown. This I now regret, I feel I have let my daughter down, and have grave concerns that the accused will be free to inflict his behaviour on others in the future.

I am unlikely to be alive when he is released but her children will, and they will have significant concerns too.

Nothing will ever bring her back and life must go on for all my dear family. Our complete jigsaw is now and always will be missing one vital piece. My sorrow as Mother, her sister's loss and the loss of a mother to her children cannot be replicated. There must be much improvement in the manner in which families are listened to when they reach out for help which is currently being ignored.

CONTENTS

1 Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and the support given to Louise, a resident of Kent, prior to her death in late 2020. Gary, her long standing partner, dialled 999 stating he had stabbed Louise following an argument.

1.2 Police attended the family home and found Louise suffering from multiple knife wounds. Paramedics responded and provided immediate medical aid but sadly life was declared extinct before Louise could be stabilised and conveyed to hospital.

1.3 Gary was arrested on suspicion of murder. Gary was intoxicated and made several significant statements to the arresting officers (admissions of guilt). Gary entered a guilty plea based on diminished responsibility. In the summer of 2022, Gary was sentenced to 16 years imprisonment with a further 4 years on Licence to run consecutively to reflect the Crown Court Judges concern Gary still represented a danger to others.

1.4 A post-mortem identified the cause of death as multiple stab wounds to the torso.

1.5 There was a history of alcohol dependence and domestic abuse involving Louise and Gary and an escalation of the latter in the months running up to the fateful morning when Louise was murdered.

1.6 This DHR examines the involvement that organisations had with Louise and Gary during 2020. (An explanation of the timeframe chosen for this review can be found in paragraphs 14.2 to 14.4).

1.7 The key reasons for conducting a Domestic Homicide Review are to:

a) establish what lessons can be learned from this domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims.

b) identify clearly what those lessons are both within and between organisations, how and within what timescales these will be acted on, and what is expected to change.

c) apply these lessons to service responses including changes to policies and procedures as appropriate.

d) prevent domestic violence and abuse and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working.

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

f) highlight good practice.

1.8 A referral was received from Kent Police in January 2021. This prompted the initial research and fact finding to allow the Kent Community Safety Partnership to understand if this case met the criteria for conducting a DHR.

1.9 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Group decision was made on 26 February 2021. This decision was made virtually by Core Group Panel Members due to COVID-19 and the pressure on agencies at the time. The Panel agreed the criteria for a multiagency review had been met and a review should be conducted using the current DHR methodology. This decision was ratified by the Chair of the Kent Community Safety Partnership and the Home Office were informed.

2 Confidentiality

2.1 The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

2.2 As recommended by the statutory guidance, pseudonyms have been used for the victim, offender and family members. Precise dates have been obscured to protect the identities of those involved.

2.3 The pseudonyms have been provided and agreed by the family of Louise.

2.4 The members of the DHR Panel are identified by their real names.

2.5 Dissemination is addressed in paragraph 11.3 below.

2.6 Details of the deceased and perpetrator:

Name (Pseudonym)	Gender	Age range	Relationship to deceased	Ethnicity
Louise	Female	40s	Deceased	White British
Gary	Male	50s	Partner/Perpetrator	White British

2.7 The family members who were known to the Review Panel have been given the following pseudonyms.

Pseudonym	Relation to deceased	Relation to perpetrator
Heidi	Mother	Not applicable
Frankie	Sister	Not applicable
Josie	Sister	Not applicable
Alice	Sister	Not applicable
Rose	Adult Daughter	Not applicable
Brian	Adult Son	Not applicable

3 Timescales

3.1 The panel met on four occasions during the review. The Independent Chair was appointed on 10 March 2021 and the Terms of Reference Meeting was held on 05 May 2021. The Independent Management Report (IMR) Review Panel Meeting was conducted on 15 September 2021, where IMRs were examined. The panel also met on two separate occasions to scrutinise the overview report and its recommendations. These dates were 24 November 2021 and 07 February 2022.

3.2 Final amendments were made to the report in response to CSP feedback during the sign-off process in September 2022. It was inevitable that some delays in the process occurred due to the COVID 19 restrictions that were in force at that time and the significant additional demand the pandemic generated for the participating agencies.

3.3 This review was originally scheduled to run in tandem with but not overtake the criminal prosecution. The trial was scheduled to start in August 2021 but was put back to early 2022 due to defence submissions to the trial Judge. A guilty plea was accepted by the Crown Prosecution Service (CPS) in December 2021.

4 Methodology

4.1 The detailed information in this report is based on Individual Management Reports (IMRs) completed by each organisation that had significant involvement with Louise and Gary. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

4.2 Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Louise and Gary during the period covered by the review.

4.3 There were no summary reports or additional information provided outside of the IMR process.

5 Terms of Reference

5.1 The Review Panel met on 05 May 2021 to consider the draft Terms of Reference (ToR), the scope of the DHR and those organisations whose involvement should be examined. The Terms of Reference were agreed subsequently by correspondence and are attached at Appendix A. The Terms of Reference have been anonymised.

5.2 At this meeting the following key lines of enquiry were set:

i. Both Louise and Gary were alcohol dependent (self-identified). Both had a history of domestic abuse recorded against each other. Both suffered from issues of their mental wellbeing. There were multiple engagements and/or referrals with/by/to various agencies during the relevant time of this review. How effective were these interactions and/or engagements in safeguarding or identifying possible risks to either Louise or Gary?

ii. How attuned were agencies to what was a deteriorating situation over a relatively short period of time? Was this recognised?

iii. When “urgent” referrals about safeguarding concerns are received from partner agencies, what should the response be? Does current policy or procedure recognise the inherent potential increased risk the term “urgent” presents?

iv. The link between alcohol dependence and domestic abuse is well established.[1/2] What steps or special measures were/could/should have been put in place by each organisation involved that recognised the significant risk this combination posed?

v. What was the impact of the COVID-19 restrictions on the mental and social wellbeing of Louise and Gary? Were these recognised as additional pressures? What was the impact of the same restrictions on the organisations providing their service? Did this have a pertinent bearing on the service provided?

5.3 The Focus of the DHR.

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

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

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

5.4 Specific Issues to be Addressed.

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

i. Were practitioners sensitive to the needs of Louise and Gary, knowledgeable about potential indicators of domestic violence and

[1] Alcohol and domestic abuse | Alcohol Change UK
[2] Alcohol, Aggression, and Violence: From Public Health to Neuroscience - PMC (nih.gov)

abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

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

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

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

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

vi. When, and in what way, were the victims wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

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

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

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for several years?

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

xiv. Are there lessons to be learned from this case relating to the way in which this 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?

xv. Did any staff make use of available training?

xvi. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Louise and Gary?

6 Involvement of Family Members and Friends

6.1 The Police Family Liaison Officer (FLO) was contacted on 01 April 2021 and advised of the intention to conduct a DHR. Details of the family members were requested to facilitate contact. The FLO updated the family, who indicated they did want to engage with the DHR process. The FLO also advised that Victim Support's Domestic Homicide National Support Team had been provided with the next of kin details. Two family members accepted advocacy from Victim Support. The Chair contacted the Victim Support Advocate and provided his contact details and rough timescales for the DHR process.

6.2 Formal introductions to each family member were sent on 17 May 2021. This included the Home Office DHR guidance leaflet. The letters had been held back and were not sent in April 2021 due to the COVID-19 restrictions in place for meetings at that time. (All family members plus the chair plus the FLO exceeded the permitted number of meeting participants).

6.3 The Chair and FLO met the family at the home of Heidi (mother) on 28 June 2021. All three sisters were present. Both adult children participated via Video Call. The advocacy service provided by Victim Support was discussed. Victim Support's offer had been declined by all but one of the family members. The Chair also signposted the family to AAFDA (Advocacy after Fatal Domestic Abuse) as an alternative.

6.4 A copy of the Terms of Reference was sent to each family member on 01 July 2021. Regrettably, it was discovered the family surname had been spelt incorrectly. This error was immediately rectified, and the Chair apologised unreservedly for this error.

6.5 It was agreed the FLO would maintain contact with the Family on the Chair's behalf and a rough timetable for the next stage of the process was outlined based on the anticipated trial date.

6.6 On 13 October 2021 the family were contacted and advised a copy of the chronology would be provided at the beginning of November and a meeting scheduled a week later to obtain their views and feedback. This was to enable the Chair to relay to the DHR Panel any views or questions the family had. The family made the following comments.

(i). They were disappointed by the apparent "professional indifference" displayed by the GP Practice in response to the various notifications by other agencies seeking the assistance of the GP to manage the challenges Gary faced with alcohol and mental health problems. They wanted to know what could be done to hold these professionals to account for what appeared to them to be a complete disregard of their duty of care to a patient.

(ii). They were troubled by the response provided by KMPT and their failure to act more resolutely to the voices Gary claimed he had heard. The family felt being alcohol dependent was inextricably linked to problems with mental health and to try and separate these two issues did not make any sense.

(iii). Finally, the family wanted to know who held Forward Trust to account for what appeared to them to be an inadequate service, recognising COVID-19 restrictions did have a detrimental impact on Forward Trust's ability to deliver a comprehensive service. The assessment that showed Gary had a low alcohol dependence demonstrated the lack of depth and vigour to their processes. They were also troubled there appeared to be no awareness of the risks Gary posed to Louise following his threats to cause Louise serious harm.

6.7 The DHR Panel met on 24 November 2021 to consider the Draft Overview Report. Several actions were generated for further work to be undertaken to provide a full response to the questions raised by the family.

6.8 The family were provided with the relevant parts of the draft Overview Report to specifically address the observations made at paragraph 6.6. The family spokesperson made the following comments in response.

(i). The family accept the GP did what was requested of them and made the relevant referrals for Gary, although they remained puzzled as to why the referral letter was not actioned until late December 2020. There was still a feeling the GP could and should have done more to help Louise. The view was expressed that this lack of intervention was more a product of the current structure of GP Practices and the patient load GPs were expected to manage. In fairness to the GP, Louise was never referred to the surgery by any other agency and they were unaware of the increase in domestic abuse incidents that Louise suffered.

(ii). The recognition by KMPT that action should have been taken to treat the voices Gary heard and that mental wellbeing and alcohol dependence should not be treated either separately or in isolation of each other, was welcomed.

(iii). The plans by Forward Trust to redesign their referral process to ensure they have the relevant information to make accurate risk assessments and treatment plans was also welcomed. There was a recognition COVID-19 restrictions did significantly impact on Forward Trust's ability to make effective interventions.

6.9 Gary was not interviewed as part of this DHR. A guilty plea on the grounds of diminished responsibility was accepted by the CPS. Some family members were distressed at the prospect of Gary having a voice in this

process when Louise could not. Given this concern and the fact the guilty plea was made on the grounds of mental incapacity, it was felt inappropriate to engage with Gary.

6.10 The police referred all family members to the Victim Support Homicide Support Team, who offer specialist advocacy support throughout the DHR process. One family member, Alice, engaged with a Homicide Case Worker. The Victim Support Homicide Service is highlighted within the Home Office Guidance as a specialist advocacy service. The Chair personally checked with the remaining family members if they wished any other advocacy support. This offer was declined.

6.11 A full copy of the draft report was provided in October 2022 and was discussed with members of the family on 29 March 2023. (Mum and all three sisters). Details can be found in the addendum on page 61.

7 Contributing Organisations

7.1 Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DHR Panel. None of the IMR authors or the senior managers had any involvement with Louise and Gary during the period covered by the review.

7.2 The following organisations contributed towards the review:

Agency/ Contributor	Nature of Contribution
Kent County Council (KCC) Adult Social Care	IMR
Kent & Medway Clinical Commissioning Group (CCG)	IMR
East Kent Hospitals University NHS Foundation Trust (EKHUFT)	IMR
Kent Police	IMR
South East Coast Ambulance Service (SECAmb)	IMR
Kent & Medway NHS and Social Care Partnership Trust (KMPT)	IMR
Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC) (Probation)	IMR

Forward Trust	IMR and Addiction Specialist
Clarion Housing	Domestic Abuse Specialist (IDVA)
Victim Support	Victim Advocacy

8 Review Panel Members

8.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had contact with Louise and/or Gary. None of the panel members had any previous direct contact with Louise and/or Gary, nor any supervisory responsibilities for the staff from their organisations who did have contact. The Panel included a senior member of the Kent Community Safety Team and an independent advisor from a Kent-based domestic abuse service. The Panel met on four occasions.

8.2 The members of the panel were:

Name	Organisation	Job Title
David Pryde		Independent Chair
Shafick Peerbux	Kent County Council	Head of Community Safety
Sarah Carnell	Clarion Housing Group	IDVA Services Manager (Domestic Abuse Specialist)
Christopher Rabey	Kent Police	Detective Inspector
Catherine Collins	KCC Adult Social Care	Adult Strategic Safeguarding Manager
Lisa Lane	Kent and Medway CCG	Designated Nurse Safeguarding Adults
Carol Tilling	East Kent Hospitals University NHS Foundation Trust (EKHUFT)	Head of Safeguarding Children and Named Nurse
Auxilia Muganiwah	Kent & Medway NHS and Social Care Partnership Trust (KMPT)	Specialist Safeguarding Advisor (Children, Adults and MCA)
Jenny Churchyard	South East Coast Ambulance Service (SECAmb)	Specialist Safeguarding Practitioner

Tina Hughes	Probation Service	Deputy Head East Kent Probation Delivery Unit
Andy Jackson	Forward Trust	Service Manager
David Naylor	Victim Support	Area Manager

A brief resume of the panel members qualifications and experience is available at Appendix B.

9 Independent Chair and Author

9.1 The Independent Chair and the author of this Overview Report is a retired Assistant Chief Constable (Hampshire), who has no association with any of the organisations represented on the panel. The Chair has previously served with Kent Police but left the organisation on promotion in 2007.

9.2 The Independent Chair has a background in conducting Domestic Homicide Reviews and Adult Safeguarding Reviews. This experience has been enhanced with the Home Office feedback from previous reviews and assisted by the Home Office training courses aimed at Chairs and Report Writers for the DHR process.

9.3 The Chair spent nine years as the strategic police lead for Safeguarding, chairing multi agency Safeguarding Boards across two Counties. This included the role of Senior Responsible Officer for all police related Serious Case Reviews in these jurisdictions. The Chair commissioned and designed a new multi-agency safeguarding governance structure following the recommendations that were made by the Baby P review in 2010/12. This knowledge and experience demonstrate a good understanding of domestic abuse issues and the roles and responsibilities of organisations involved in a multi-agency response to safeguarding in a domestic abuse context.

9.4 The Independent Chair is the Safeguarding Advisor to the Bishop of Winchester and carries out the role of Independent Chair for the Winchester Diocese and Winchester Cathedral Safeguarding Boards. To support this role, the Chair is an associate member of the Social Care Institute of Excellence and has a post Graduate Diploma from Cambridge University in Criminology.

10 Other Reviews and Investigations

10.1 A Serious Further Offence (SFO) Review was commissioned by KSS CRC. This is a statutory requirement when an offender under supervision commits a further serious crime. The response provided by KSS CRC to this DHR is based on the SFO investigation and its findings.

10.2 The Head of Investigations within NHS England (South) reviewed the first draft of the overview report. A separate Independent Mental Health Homicide Review was not deemed necessary. This is not a statutory process and provided the DHR overview report explored any mental health issues and identified any good practice or lessons learned, there was no need to duplicate this work with the agencies involved or cause any further distress to family members going over the same ground. The report identified a current gap in practice where substance misuse and mental health support can and should be treated simultaneously.

10.3 The Coroner opened and adjourned the Inquest on 06 January 2021, pending the completion of the criminal trial. The Coroner subsequently concluded the cause of death was multiple stab wounds.

11 Publication

11.1 This Overview Report will be published on the websites of Kent and Medway Community Safety Partnership.

11.2 Family members will be provided with the website addresses and offered hard copies of the report.

11.3 Further dissemination will include:

- The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Clinical Commissioning Group and the Office of the Kent Police and Crime Commissioner.
- The Kent and Medway Safeguarding Adults Board.
- The Kent Safeguarding Children Multi-Agency Partnership
- Additional agencies and professionals identified who would benefit from having the learning shared with them.

12 Equality and Diversity

12.1 The Overview Report Panel gave due consideration to the nine protected characteristics under the Equality Act 2010. (Age, Disability including learning disability, Gender reassignment, Marriage and civil partnerships, Pregnancy and maternity, Race, Religion and belief, Ethnicity, Sex and sexual orientation).

12.2 This was benchmarked against the doctrine of intersectionality and that the Panel should consider "everything and anything" that can marginalise people.[3]

12.3 Louise was female, had an alcohol dependence, suffered from depression and was recorded as both a victim and perpetrator of domestic abuse involving Gary. Louise had a long history of depression and as such this would be considered a disability under the Equality Act.[4]

12.4 There are statistics that show around 57% of women killed knew their assailant, with them being most commonly a partner or former partner. A staggering 70% of women killed, are killed in their own home.[5] More recent research into DHRs has identified 80% of victims were female and 83% of perpetrators were male.[6] While these are very stark statistics in terms of risk, it is a fact most domestic abuse incidents do happen at home. Another factor that is relevant is the link between alcohol and domestic abuse. Research by Drinkaware highlights that woman are at a far higher risk of harm against them by male partner who has been drinking than vice versa.[7]

12.5 The Domestic Abuse Act 2021 does make provisions (and funding) for Local Authorities to support alternative accommodation for victims of domestic abuse which is a positive step forward in trying to mitigate this risk, where a disproportionate number of females are victims.

12.6 Gary was alcohol dependent (self-admitted), suffered from mental health issues (depression/auditory hallucinations) and was recorded as a victim and perpetrator of domestic abuse involving Louise.

12.7 Thus, both Louise and Gary were exposed to the cumulative risks posed by domestic abuse, mental health issues and substance misuse. This trio of vulnerabilities are normally used as a high-risk indicator to safeguard

[3] Intersectionality, explained: meet Kimberlé Crenshaw ... – Vox
[4] Equality Act 2010 - Disability discrimination

[5] https://www.femicidecensus.org
[6] Key findings from analysis of domestic homicide reviews - GOV.UK (www.gov.uk)
[7] Alcohol and aggression | Drinkaware

children, but they are equally applicable to vulnerable adults when it comes to assessing the potential risk of harm.[8] Several organisations did not pick up the significant increase of risk these three factors brought because there were no children in the household. It is proposed to review this current practice as part of Recommendation 8.

12.8 The Panel were very attuned to the possible disadvantages people who are alcohol dependent may suffer in terms of access to services or their delivery and did make the following observation.

12.9 Addiction is a disorder that is complex. Individuals experience compulsions for the addiction despite the serious health and/or social consequences this may bring. All agencies should be aware that individuals who are suffering from an addiction will not always act rationally and therefore special consideration should be given if it is suspected an addiction is likely to be present, even if it is denied.[9]

12.10 A panel member did make a comment that while unconscious bias training is undertaken, NHS clinicians do not always have the time to explore the underlying reasons for hospital attendance. The immediate medical need is treated, and the patient is moved on to allow the next patient to be dealt with. If a patient is identified as being a victim of domestic abuse, they can be referred to a hospital based Independent Domestic Violence Advisor (IDVA) where these are available.

12.11 The typologies of domestic abuse offenders were also considered. Research has identified many benefits in identifying the different types of domestic abuse offender but also where this approach may also be unhelpful and may contribute to an element of unconscious bias.[10] In this case the response by all agencies did not recognise both Louise and Gary were recorded as victims and perpetrators of domestic abuse. Each incident was treated in isolation and a holistic approach was not taken.

12.12 This is a complex subject. The response by all agencies was to identify who was the victim and who was the perpetrator at any given time. There was no recognition this was an ongoing process of cause and effect. In a detailed analysis of typology, neither Louise nor Gary could be completely categorised in any of the recognised definitions of domestic abuse offenders. (See Table 1 at the reference cited at paragraph 12.10).

[8] https://safelives.org.uk/sites/default/files/resources/Risk,%20threat%20and%20toxic%20trio.pdf
[9] Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews
[10] Domestic violence typologies: What value to practice?

12.13 The common factors that Louise and Gary shared were that they were alcohol dependent, and they both had a history of mental health issues. It was these factors that influenced their behaviour towards each other.

13 Background Information

13.1 Louise was brought up in a stable family home with three siblings (sisters). Louise was described by her family as very strong willed and a good mum before her marriage broke up in 2008. Custody of the children was awarded to dad and contact with the children, Rose and Brian, was infrequent. Louise moved to Cyprus and returned to Kent in 2010 with the assistance of her mother, Heidi.

13.2 Louise stayed at the parental home for a short period of time and then left, relying on a local homeless charity to provide alternative accommodation.

13.3 Her mother and siblings went to considerable effort to help Louise manage her depression and alcohol use. They made direct contact with her GP, mental health specialists and various hospitals to seek their assistance. The family felt their efforts to get Louise the support they believed she needed were impeded by issues of patient confidentiality and mental capacity.

13.4 The medical response was to comply with the wishes of Louise. The family held the view Louise was not well enough to be able to make informed decisions regarding the treatment she needed. You can understand the family frustration but also the difficulty this placed medical professionals in. Louise did have full mental capacity and any decisions regarding her treatment were hers to make and hers alone. What is clear is that the immediate family cared deeply for Louise and wanted to do everything they could to try and assist her.

13.5 Louise began a relationship with Gary sometime in 2013. By 2017 Gary was a co-tenant and lease holder on the property where they both lived. There were no other occupants in the house. Louise had no criminal history other than a conditional discharge for assaulting Gary in 2017. Louise re-established contact with Heidi in January 2020. During the COVID-19 restrictions, Louise had weekly telephone calls with Heidi and described the ups and downs of her relationship with Gary and managing some personal medical problems. Heidi had the impression Louise was more open to re-engaging with the wider family.

13.6 Gary has two estranged siblings, a brother, and a sister. Gary had regular contact with both his parents, who live locally. Gary was described as a troubled child who did not attend school and got involved in petty crime. Gary was difficult to engage with and slow to respond to questions put to him in general conversation. Neither parent can say when he became dependent on alcohol, but Gary was not allowed to visit or telephone when intoxicated.

13.7 Both Gary and Louise visited his parents' home weekly during 2019 because Louise enjoyed working in the garden. Neither were intoxicated when they visited, but on the few occasions when his parents visited Louise and Gary at a neutral venue near to their home, it was apparent they had both been drinking. They last saw Gary in December 2020 to drop off a food parcel for Christmas. They did not want to give Gary money because this would be used to buy alcohol rather than food. Gary was sober, although unkempt and scruffy. They did not see Louise.

13.8 Gary's parents were not spoken to directly. The above information was obtained from the police investigation as part of their antecedent history of Gary as an offender. Both parents were defence witnesses, and it would have been problematic to carry out an interview with them while the trial was pending.

13.9 Gary has one conviction for a serious offence in 1998 for which Gary served a term of imprisonment. The incident involved stabbing a stranger in the street following a verbal altercation.

14 Chronology

14.1 The time parameter for this DHR covered a substantial part of 2020. Both Louise and Gary had previous dealings with various statutory agencies prior to this date. The last recorded incident prior to the start of this review was in March 2019 (See paragraph 15.4.6) and prior to that April 2017 (see paragraph 15.4.5).

14.2 A decision was made to keep the time parameter short as there appeared to be a relatively rapid deterioration of the relationship between Gary and Louise over a period of months in 2020. The family members would have preferred the review to go back to the point of the marriage break up in 2008, when there were several family interventions to try and help Louise cope with her depression and alcohol misuse. However, the view was taken that the couple could demonstrate a significant period of stability without any statutory agency involvement from 2013 through to April 2017.

14.3 The police did acknowledge they could have done more with safeguarding referrals for the incidents recorded in 2017. However, from the original agency submissions it was only the police and the acute hospital that had any involvement with either Louise or Gary and it seemed unlikely there would any other organisational learning that had not already been identified that would surface.

14.4 There is a trade-off in reducing the administrative burden on Statutory Agencies trying to service the needs of the DHR process. While periods of review can be lengthy, relatively short periods can also meet the DHRs needs. In this case, what was significant was the impact of the COVID-19 restrictions. This did influence the time parameter set for this review, coupled with the multiple incidents in 2020 after a year of no contact with any statutory body. In any event all participating agencies were asked to include any pertinent information prior to 2020, which they did.

14.5 In March 2020 Louise called 999 in distress, alleging she had been assaulted by Gary. The call was described as very confusing. For example, Louise apologised for not washing up. After speaking to the call taker Louise stated it was not an emergency. The police attended the home address.

14.6 Louise stated to the attending police officers that Gary had hit her head on the wall and pulled her hair. Gary admitted doing this and was arrested. It was apparent that both Louise and Gary were intoxicated. Gary was seen by a Criminal Justice Liaison Diversionary Service (CJLDS) support worker whilst in police custody but declined to cooperate. Louise would not support a prosecution. Gary was cautioned and released.

14.7 In April 2020 Louise called the police stating she had been threatened by Gary. Louise had apparently emptied the bath when Gary was in it because Gary had damaged a radiator and Gary had threatened to drown himself. Police attended. No damage was found but both Louise and Gary admitted they were alcohol dependent, and that this was having an adverse effect on their mental wellbeing. The police submitted a referral to Adult Social Care.

14.8 Adult Social Care processed the police referral via the Area Referral Management Service (ARMS) who concluded the referral was appropriate, recognising the risks posed with alcohol dependency and the added strain of staying indoors due to the COVID-19 restrictions. ARMS sent a letter the following day advising both Louise and Gary to contact their GP and Forward Trust (alcohol support service).

14.9 In May 2020 Louise called the police stating she had been assaulted by Gary. The police attended. A counter allegation was made by Gary who claimed Louise had punched him first. Louise was arrested. The responses to the DARA (see glossary) risk assessment indicated coercive and controlling behaviours by Louise towards Gary.

14.10 Louise was seen by a CJLDS support worker whilst in police detention. Louise admitted she was alcohol dependent and under the care of her GP. Louise was bailed and no further action taken when Gary declined to support a prosecution.

14.11 In July 2020 an NHS 111 call operator contacted the police with concerns for Louise. It was reported that Louise had called 111 stating Gary was banging his head against a wall and was hearing voices telling Gary to self-harm and assault Louise.

14.12 Police attended to find Louise sitting outside and Gary inside, calm and uninjured. Both were described to have been drinking. Louise stated she had called 111 because she was worried about the mental health of Gary. Gary admitted he did hear voices but that was normal when drinking and Gary had no intention of self-harming.

14.13 The attending police officers provided the telephone number for the mental health Single Point of Access (SPoA) to Gary and encouraged him to make contact. Safeguarding advice was given to Louise.

14.14 SECAmb attended later the same evening and found Gary asleep in bed. Gary was woken up and he advised the paramedics that hearing voices was not unusual when he drank alcohol, and he did not require any further assistance from them.

14.15 Gary made a self-referral to the SPoA the following day. Gary disclosed suicidal ideation and auditory hallucinations, a problem he had been managing for six years. The disclosure was risk assessed and it was concluded there was no immediate risk of harm to either Gary or Louise. A follow up call by a community mental health nurse was arranged.

14.16 A follow up call was made but the call went to answerphone.

14.17 SPoA wrote to Gary's GP and reported the circumstances of the self-referral and requested the GP conduct a medication review and refer Gary to the Community Mental Health Team.

14.18 At the end of July 2020 Louise contacted the police stating she had been assaulted by Gary. Police responded and arrested Gary. Gary was released on conditional bail, which included staying away from the address where he and Louise lived.

14.19 Whilst in police custody, Gary was assessed by the CJLDS. Gary reported daily alcohol use but was engaging with Forward Trust. Gary advised he suffered from depression, had anxiety, and heard voices. CJLDS arranged to contact Gary when he was released from police custody to assist him obtaining a medication review. CJLDS wrote to his GP the following day.

14.20 CJLDS contacted Gary when he was released from police detention. Gary advised he was going to get in touch with his GP and his Forward Trust support worker. Gary did not want any further assistance. CJLDS took no further action on this basis. (Gary did not contact the GP or Forward Trust).

14.21 The GP was advised that a telephone appointment had been arranged for Gary with the Community Mental Health Team for the beginning of September 2020 following the GP's referral for Gary to them. (See paragraph 14.17) Gary did not keep this appointment. The GP did not follow up on the non-attendance.

14.22 In September 2020 Gary was charged with assault on Louise and bailed to court. (For the offence at paragraph 14.18). Louise stated the only reason she had supported a prosecution was to ensure Gary received mental health help.

14.23 In October 2020 Louise dialled 999 stating she believed she had suffered a stroke. SECAmb attended. On arrival it was apparent Louise had been drinking. Louise advised she now felt much better and did not need any medical assistance.

14.24 Later the same day Louise called the police stating Gary was angry and had injured her arm. Gary could be heard in the background and sounded intoxicated. Police attended. It transpired Louise had caused a facial injury to Gary. Gary complained that Louise had been pushing him around all week and there were indications of coercive and controlling behaviour by Louise in the DARA risk assessment.

14.25 Louise was arrested and kept in custody overnight before being released without charge. Louise was seen by the CJLDS support worker and advised them that she did not wish to take part in a vulnerability screening process, which she was entitled to do.

14.26 The following day Gary appeared at Magistrates' Court. Gary entered a guilty plea to common assault and was sentenced to a Community Order with a 9-month Alcohol Treatment Requirement (ATR) and a 20-day Rehabilitation Activity Requirement (RAR). Whilst at court Gary was seen by a CJLDS support worker. Gary advised he did not need CJLDS assistance to contact his GP or Forward Trust. The case was discharged, and a letter sent to the GP Practice to advise them of this intervention.

14.27 The day after his court appearance, Louise called the police alleging Gary had been verbally abusive. Police attended. Both Louise and Gary had been drinking and neither made any substantive complaint. Safeguarding advice was given, and both were signposted to alcohol support services and advised to contact their GP.

14.28 Sometime after the police had left Louise telephoned 999 and asked for an ambulance, stating Gary could not walk. A clinical call back by SECAmb established Louise was concerned about the mental health problems Gary had. Gary was spoken to. Gary stated he was well and did not need an ambulance. Both Louise and Gary had slurred speech.

14.29 Later that evening Gary telephoned SPoA and complained of depression and hearing voices. Gary explained he was alcohol dependent and looked after a partner who was also alcohol dependent. Gary was advised to self-refer to Forward Trust (Substance misuse support service).

14.30 The National Probation Service (NPS) allocated Gary to the Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC) to manage the court orders. (See paragraph 14.26).

14.31 Gary completed the induction assessment with his KSS CRC Responsible Officer (RO). On the same day, the Forward Trust support worker tried to contact Gary, but the call went straight to answerphone.

14.32 In early November 2020 a Forward Trust worker completed the initial assessment with Gary and a plan was put in place to manage the court order.

14.33 On the same day the UK went into the second lock down due to the COVID-19 pandemic, which was in force until 02 December 2020. This impacted on the ability to have face to face encounters with Gary for several agencies.

14.34 Gary kept two scheduled telephone contacts with Forward Trust to comply with the Alcohol Treatment Requirement (ATR).

14.35 At the beginning of December 2020, the KSS CRC Responsible Officer contacted Gary by telephone. It was immediately obvious Gary was intoxicated. Gary admitted he had been drinking and arguing with Louise for the last six days. Gary was advised to stop drinking and leave the house.

14.36 The KSS CRC Responsible Officer contacted the police and expressed their concerns about safeguarding Louise. Police attended and spoke to both Louise and Gary. No offences were disclosed. The police conveyed Gary to the home of a friend to comply with the instruction from KSS CRC. Gary later returned home.

14.37 Gary kept his next telephone appointment with Forward Trust.

14.38 Gary missed his scheduled telephone appointment with KSS CRC. (It is not entirely clear if this was missed, or the records are inaccurate).

14.39 In mid-December 2020 Louise called the police stating Gary "had gone into one" about not having the TV remote. Police attended. Louise disclosed Gary had said "the voices" were telling Gary to kill Louise and the couple's pet duck. Gary was arrested. Whilst in custody Gary was seen by the CJLDS support worker. Gary admitted he had a problem with alcohol, but he was actively engaged with Forward Trust and under the care of his GP for depression. CJLDS concluded there was nothing more they could offer.

14.40 Gary denied he had made any threats to cause harm to either Louise or their pet duck during his police interview. Louise declined to support a prosecution and stated she never believed any threats Gary made, but Gary did need help with his mental health issues. The Police Investigating Officer, in response to the plea from Louise for help, sought and obtained Gary's permission to submit an "urgent" mental health referral on his behalf to the Kent and Medway NHS Partnership Trust (KMPT). KMPT are the specialist mental health provider for Kent.

14.41 Gary kept his next telephone appointment with Forward Trust. Gary did disclose his recent arrest to the support worker.

14.42 A week later Gary kept his telephone appointment with Forward Trust. Gary advised the support worker he had obtained non-alcoholic drinks to celebrate Christmas with Louise.

14.43 On the same day Gary did not keep a face-to-face appointment with the KSS CRC Responsible Officer (RO). A telephone appointment was made instead. Gary advised there was no alcohol in the house, and he had

spoken to Forward Trust earlier to discuss how he would manage the festive season without alcohol. The RO advised Gary they would make a home visit after Christmas.

14.44 On the same day, the KMPT SPoA received the urgent police mental health referral that had been raised a week earlier. (See paragraph 14.40). This urgent referral was assessed as an amber risk. An amber risk does not require an immediate intervention but does require contact with the subject of the referral within 72 hours.

14.45 Five days later, the SPoA made two attempts to contact Gary by telephone. This was in breach of the 72-hour deadline. Unable to make contact, the matter was referred to the local Community Mental Health Team (CMHT) to make an urgent follow up with Gary.

14.46 The CMHT reviewed the referral made by SPoA the next day and concluded Gary posed no risk and discharged the case. It was recommended Gary was referred to Adult Social Care and Gary should make a self-referral to Forward Trust.

14.47 Gary was arrested for the murder of Louise the same day.

15 Overview

15.1 KCC Adult Social Care

15.1.1 Kent County Council (KCC) has a statutory responsibility for safeguarding as defined by The Care Act 2014. The Act requires KCC to make enquiries or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

15.1.2 The Care and Support Statutory Guidance includes the concept of 'Making Safeguarding Personal'. This requires any intervention to be person led and outcome focused. The process should engage the person in a conversation about how to respond to their safeguarding situation in a way that enhances their involvement, choice and control.

15.1.3 In October 2018 Mental Health Social Workers transferred back to KCC line management from the Kent and Medway NHS and Social Care Partnership Trust (KMPT). KMPT provide specialist mental health services across the whole of Kent and the Unitary Authority and remain a separate organisation. The Mental Health Social Workers now work in geographically located Mental Health Social Care Teams.

15.1.4 Adult Social Care via the Area Management Referral Service (ARMS) received a copy of a Kent Police Crime Report in April 2020 which detailed an incident between Louise and Gary. (See paragraph 14.7). The reason for the referral was both Louise and Gary had stated they wanted help with their mental health and alcohol dependency.

15.1.5 ARMS triaged the referral and sent Louise and Gary a letter advising them they should contact their GP and self-refer to alcohol support services. Contact details of the 24-hour mental health helpline were included. The referral was closed.

15.1.6 The next and final contact with Louise was the referral from the police via KMPT after Christmas 2020 (See paragraph 14.46). This referral was risk assessed. Safeguarding and mental health concerns were identified. Louise was offered a home assessment appointment scheduled for February 2021 by letter in mid-January 2021.

15.2 **Kent and Medway CCG**

15.2.1 Louise and Gary were patients at a local GP practice. This is a practice that provides care for 5250 patients. There are two GP Partners, one salaried GP, two nurses and two healthcare assistants. The Care Quality Commission (CQC) inspection in 2016 rated the practice as good in all areas.

15.2.2 Louise had one contact with the practice for a Flu vaccination in November 2020. The records noted Louise had alcohol dependence but nothing about being a victim of domestic abuse.

15.2.3 Gary had no contact with the practice during the period under review and would have appeared to have had no contact in the preceding six years. Gary self-referred to the KMPT Single Point of Access (SPoA) complaining of auditory hallucinations. This generated a request from SPoA to the GP Practice to refer Gary to the Community Mental Health Team (also part of KMPT) and to carry out a medication review.

15.2.4 In August 2020 the GP Practice were advised there was a telephone appointment for Gary with the Community Mental Health Team (CMHT) in September 2020, in response to the referral the GP Practice had made.

15.2.5 In October 2020 a letter from the Criminal Justice Liaison and Diversion Service (CJLDS) was sent to the GP Practice. The letter stated Gary was hearing voices directing him to hurt people, had declined a referral to the CMHT and had been advised to contact his GP to seek help.

15.2.6 Gary did not contact the GP Practice nor did the GP Practice follow this letter up until a text was sent to Gary after Christmas asking him to make a non-urgent appointment.

15.2.7 The practice did not know Louise and Gary were victims and perpetrators of domestic abuse towards each other.

15.3 **EKHUFT (Acute Hospital)**

15.3.1 Gary attended the Acute Hospital in March 2020 presenting with an injured hand. The explanation provided by Gary was that he often injured himself when drunk but could not provide any details as to how the current injury had occurred. Gary was intoxicated when examined.

15.3.2 Louise was known to the hospital under two different names. Records indicated Louise had a history dating back to 2013 of alcohol excess, anxiety and depression.

15.4 **Kent Police**

15.4.1 Prior to the period under review the police first became aware of Gary and Louise as a couple in April 2017. Louise called the police following an argument. Gary was drinking and Louise had tried to stop this. When it became apparent that Gary was going to be arrested Louise became visibly upset. Gary was arrested and subsequently released with no further action taken. The DASH assessment was graded as standard.

15.4.2 In August 2017 the police received a call from SECAmb – they had been contacted by Gary who stated he had been stabbed in the stomach by Louise. SECAmb and the police attended. The wound was assessed as minor. Both Gary and Louise were described as intoxicated.

15.4.3 Louise was arrested. Gary declined to prosecute. Louise admitted the offence and was subsequently charged with assault despite the lack of support from Gary. Louise was given conditional bail and appeared to be committed to adhering to this, making plans for alternative accommodation. Gary was adamant that he wanted Louise back at home. The DASH assessment was graded as medium.

15.4.4 Louise received a conditional discharge at Magistrates' Court.

15.4.5 In October 2017 Gary telephoned the police four times during the early hours of the morning complaining there were suspicious noises/persons outside the property. Police attended and could see no suspicious activity or people in the vicinity of the house. Louise advised the police Gary was suffering from hallucinations due to undertaking detox.

15.4.6 In March 2019 Louise contacted police to report Gary had hit her on the head. Louise was described as crying hysterically. SECAmb gave a 3-hour ETA. Due to this delay police officers attended and took Louise to hospital. Louise stated that she had woken up Gary and Gary had panicked and accidently struck out hitting her head. Both were intoxicated. The hospital noted Louise was behaving strangely and arranged for a mental health assessment to be carried out at another specialist hospital. Before Louise could be assessed, Louise left the hospital. No further action was taken regarding the alleged assault on Louise.

15.4.7 The Chronology details subsequent police engagement with Louise and Gary. In summary, the police were aware Louise and Gary were alcohol dependent, were both recorded as victims and perpetrators of domestic abuse and were both subject to coercive and controlling behaviour. It is possible both Louise and Gary were in a relationship that could have been categorised as "situational couple violence." When this type of pattern occurs, arguments escalate to minor violence, but one partner isn't constantly trying to control the other.[11]

15.4.8 In all their encounters with Gary and Louise, the risk assessments (DASH or DARA) were never graded "High" and no referral to MARAC was ever made.

15.5 **South East Coast Ambulance Service**

15.5.1 SECAmb had multiple engagements with both Louise and Gary during the period under review. These were predominately in conjunction with the police.

15.5.2 On all but one occasion both Louise and Gary declined to engage with, or follow the advice of clinicians, regarding treatment.

15.6 **Kent and Medway NHS Partnership Trust (KMPT)**

15.6.1 Louise and Gary were in contact with different KMPT providers during the period under review. These included the services listed below.

[11] What is Situational Couple Violence? - UF/IFAS Family, Youth and ...

15.6.2 Single Point of Access (SPoA) is a telephone-based service offering a mental health telephone triage to provide advice and guidance for the public alongside accepting professional referrals from GPs and other health providers. The service was changed to be a public facing telephone crisis line in April 2020 in response to COVID-19. It does not offer face to face contact.

15.6.3 The Criminal Justice Liaison and Diversion Service (CJLDS**)** model went live on 01 April 2019, screening people going through the criminal justice system for any vulnerabilities. The service is designed to find people living with mental health and learning disabilities to ensure the right support is provided. The CJLDS is staffed by unqualified support workers and qualified mental health practitioners.

15.6.4 Support Workers are staff without a professional registration who conduct screening/triage assessments for people in police custody or attending court. This is not a mental health assessment.

15.6.5 When the screening identifies an acute mental health need, a referral is made to a Specialist Liaison and Diversion Practitioner (SLDP) to carry out a further assessment.

15.6.6 Specialist Liaison and Diversion Practitioners are staff with a professional registration who conduct specialist assessments in custody and provide a service to the courts. This process includes an assessment of a person's mental health.

15.6.7 Community Mental Health Teams (CMHT) are geographically based and provide support and treatment in the community to adults between the ages of 18-65 who are experiencing a mental illness. The teams include psychiatrists, community mental health nurses, occupational therapists, psychological services, and support staff. The teams work in close partnership with Adult Social Care, who line manage Mental Health Social Workers.

15.6.8 Louise was under the care of the CMHT from September 2014 until May 2015 and received a short intervention to support her low mood and social circumstances which related to gaining access to her children. Louise was also engaged with Turning Point (Alcohol Support Service).

15.6.9 A Psychological diagnosis to provide the right support was one of the outcomes the initial assessment carried out on Louise wanted to achieve. However, due to Louise missing appointments and continuing to consume alcohol, Louise was discharged by CMHT back to her GP without a psychological assessment ever being carried out.

15.6.10 In March 2019 Louise attended the minor injuries department where it was reported Louise was intoxicated, agitated, and acting strangely. Louise was referred to the psychiatry liaison service at another specialist hospital and taken there accompanied by Heidi (mum) and Frankie (sister), but Louise left the hospital before specialist support could be provided.

15.6.11 In May 2020 Louise was seen by a CJLDS Practitioner in custody. This highlighted alcohol dependency, but Louise advised she did not want to stop drinking and her GP was aware.

15.6.12 In October 2020 Louise was seen by a CJLDS Practitioner whilst in custody. Louise declined to engage with the vulnerabilities screening process.

15.6.13 This was the last contact Louise had with KMPT services.

15.6.14 Gary had no contact with KMPT services prior to March 2020, when Gary was in police custody and was seen by a CJLDS support worker. Gary did not engage with the support worker.

15.6.15 The next contact with KMPT was in July 2020. Gary contacted the Single Point of Access (SPoA). This was a self-referral on the advice of the police. Gary disclosed he had suicidal thoughts and was hearing voices. This disclosure was assessed as Amber – not an immediate risk of self-harm but one that required further contact within 72 hours.

15.6.16 Gary was contacted the following day. Gary disclosed he was drinking large quantities of vodka most days and did not want to stop. Gary denied any plans or intentions to self-harm. The action plan following this assessment was for Gary to self-refer to Forward Trust (Alcohol Support Service) and for a note to be sent to the GP to review his medication and make a referral to the CMHT, who support GPs with mental health issues. The case was closed.

15.6.17 In July 2020, Gary was seen by CJLDS whilst in custody following an allegation of assault (against Louise).

15.6.18 Gary denied any current thoughts, plans or intent to harm himself or others. Gary was referred to a CJLDS outreach support worker to encourage Gary to contact his GP for a medication review. The case was closed after Gary declined any further assistance from the outreach worker.

15.6.19 In October 2020 Gary attended Magistrates' Court. The Probation Service referred Gary to the CJLDS court-based practitioner following a disclosure

by Gary to them that the voices were telling him to hurt others. Gary agreed to engage with the CJLDS Vulnerability Screening Assessment. The CJLDS support worker concluded Gary did not appear to have any acute mental health needs nor did he require a diversion from the criminal justice system.

15.6.20 In December 2020 Gary was seen by a CJLDS support worker whilst in custody at a police station. Gary engaged with the assessment process. The support worker concluded Gary did not require any further intervention from Mental Health Services. The case was closed.

15.6.21 After the above assessment, the SPoA received an urgent referral from the police, stating that Gary was a perpetrator of domestic abuse, he was making threats to hurt his partner, he was hearing voices and was alcohol dependent. The SPoA assessed the referral as Amber- meaning there was no immediate risk to self or others and contact would be made within 72 hours.

15.6.22 The SPoA telephoned Gary in the morning and again in the afternoon some 5 days after the referral had been assessed. The telephone calls went unanswered. Policy directs after two attempts to contact a client are unsuccessful, the case should be referred to the most appropriate service, which in this case was the local CMHT.

15.6.23 The referral from SPoA was discussed the day after it was received by the CMHT at their morning screening meeting. They noted the recent contact with CJLDS and that CJLDS had not referred Gary to their service. (See paragraph 15.6.20). The Team concluded Gary did not have any mental health needs and a referral should be made to Adult Social Care and Gary advised to make a self-referral to Forward Trust. The case was closed.

15.6.24 All subsequent dealings with Gary followed the death of Louise.

15.7 **KSS CRC**

15.7.1 In October 2020 Gary appeared at Magistrates' Court. Prior to sentence, the Court can ask the National Probation Service (NPS) to interview the person and write a pre-sentence report (PSR). A PSR provides an insight into a defendant's circumstances, analyses any risks, and advises on an appropriate sentence.

15.7.2 It is good practice for the Court to request a PSR, given the history of domestic abuse and alcohol misuse.

15.7.3 A programme of work specifically designed to help Gary change his abusive behaviour towards Louise was not proposed on the basis the PSR writer felt it would be “unworkable”. The Building Better Relationships (BBR) domestic abuse programme was specifically noted and dismissed by the PSR writer because Gary was still drinking to excess.

15.7.4 It was evident Gary had consumed alcohol prior to the PSR interview. Gary disclosed he needed to drink to avoid shaking, which indicates a physical dependence on alcohol. The Probation Officer was sufficiently concerned about his mental health that they referred Gary to the court based CJLDS practitioner to seek their advice prior to completing the PSR.

15.7.5 Following the CJLDS assessment, the PSR author recommended a Rehabilitation Activity Requirement (RAR) which would allow work to be completed on domestic abuse and encourage Gary to engage with his GP and/or mental health provider to manage his depression. An Alcohol Treatment Requirement (ATR) was proposed to complement the RAR days, with the aim of getting Gary to reduce his excessive levels of alcohol consumption.

15.7.6 The Court imposed a Community Order with a RAR order for 20 days and ATR order for 9 months.

15.7.7 When a defendant is sentenced at Court, the NPS decide whether the Community Orders imposed by the Court are managed by the NPS or a Community Rehabilitation Company. This decision is informed by an assessment tool called the Risk of Serious Recidivism Score (RSR). If a RSR score is high the NPS take the case because the person is likely to pose a high risk of serious harm to others. People who are assessed as posing a low or medium risk of serious harm, are managed by KSS CRC. Gary was allocated to KSS CRC.

15.7.8 After a person is allocated to KSS CRC, a risk assessment is carried out and a decision made as to what level of risk the person may pose of further offending. This is known as a RAG (Red/Amber/Green) level. The level a person is on dictates the level of engagement with KSS CRC. Gary was assessed as Red. This meant Gary had to see his Responsible Officer (RO) weekly and the RO had to be a qualified Probation Officer.

15.7.9 After the court appearance the Responsible Officer (RO) had an induction appointment with Gary. The Community Order was explained, expectations discussed, and further appointments made.

15.7.10 The RO recognised that Gary posed a high risk of further offending, had mental health issues (depression), alcohol misuse and a history of domestic abuse. The RO was also aware Gary lived with Louise, who was a vulnerable person and had been a victim of domestic abuse by Gary.

15.8 Forward Trust

15.8.1 Forward Trust are a national charity and have been contracted to provide a Drug and Alcohol Support Service to a large part of Kent since May 2017.

15.8.2 Gary was assessed in November 2020. An Alcohol Use Disorder Identification Test (AUDIT) was completed. This highlighted Gary consumed alcohol considered to be at a hazardous level and above the recommended guidelines. The AUDIT is a ten-point questionnaire approved by the World Health Organisation to screen patients for hazardous and harmful alcohol consumption. A Severity of Alcohol Dependency Questionnaire (SADQ) was completed. This indicated Gary had a low dependence to alcohol.

15.8.3 Forward Trust were aware Gary lived with Louise and this presented a higher risk of domestic abuse, but they were unsighted on the true level of alcohol misuse by Gary and probably Louise.

16 Analysis

16.1 KCC Adult Social Care

16.1.1 The Area Referral Management Service (ARMS) triages all new referrals of individuals who are not already known to Adult Social Care. Triage can result in the person being referred to the appropriate division in Adult Social Care, signposted to other services or closed. Most ARMS staff are not registered practitioners.

16.1.2 ARMS are not the formal front door for mental health referrals. However, ARMS will sometimes receive mental health referrals, as was the case with Louise. This demonstrates a degree of confusion amongst other partner agencies about where a referral should be directed. (See Recommendation 1).

16.1.3 When ARMS receive a Mental Health related referral, they will either forward it to the Single Point of Access (SPoA)[12], the individual's GP or to a Mental Health Social Care Team if the referral appears to relate to social care issues and the individual is under 65 years old.

16.1.4 The first referral in the form of a police crime report ARMS received was in April 2020. ARMS sent Louise and Gary a letter providing details of relevant alcohol and mental health services and then closed the referral to Adult Social Care. ARMS did respond promptly, processing the referral and the resolution within 24 hours.

16.1.5 KCC Assessment Policy and Practice Guidance states "ARMS will discuss the reasons for the referral and the outcomes the person wishes to achieve." In this instance, there is no evidence of any contact by ARMS with Louise or Gary being attempted prior to the letter being sent. This protocol had only recently been introduced but it was still a missed opportunity albeit one that did have the mitigating factor that this was a new practice.

16.1.6 Despite the lack of contact in line with the policy above, the ARMS referral closure was authorised by a Senior Contact Assessment Officer. The Supervisory safety net therefore did not work. This represents a further missed opportunity.

16.1.7 The triage process within ARMS has changed. ARMS now have access to Practice Advisors who are Registered Social Workers and are available to provide advice as and when required. This commenced in July 2020.

16.1.8 ARMS have undertaken additional domestic abuse training for their Senior Contact Assessment Officers. This was completed in June 2020.

16.1.9 Further analysis of the information provided by the police crime report does raise the issue why this referral was not flagged as a domestic abuse concern by ARMS, given the crime report stated Gary was threatening Louise.

16.1.10 The crime report notes a DARA (Domestic Abuse Risk Assessment) was graded a Medium Risk as information provided by Louise could be construed as possible controlling and coercive behaviour. Gary was threatening to self-harm, doing things deliberately to annoy Louise and making specific threats against Louise.

[12] SPoA: - A KMPT structure managing mental health referrals.

16.1.11 When Gary and Louise were spoken to by the police at the time, they did not make any further domestic abuse allegations. There was no indication of any previous domestic abuse history. The referral stated Louise and Gary were asking for help with their mental health and alcohol dependency. This may explain why ARMS did not pick up that this was a domestic abuse concern, and why it was triaged as information and guidance.

16.1.12 As safeguarding concerns were not identified by ARMS, the crime report was not forwarded to the Central Referral Unit (CRU) for any safeguarding enquiries to be carried out. (CRU is where safeguarding concerns for individuals not known to Adult Social Care were sent for an initial safeguarding assessment and a determination if a Care Act Section 42 Safeguarding enquiry is required. The CRU has since been disbanded and these assessments and enquiries are now carried out by locally based Safeguarding Teams).

16.1.13 The crime report contained the wording “Adult Protection Referral”. Contextually, prior to the police sending crime reports as referrals, they would complete the KCC Vulnerable Adult referral form when notifying Adult Social Care (ASC), that they had safeguarding concerns. Sending a copy of the crime report rather than completing a bespoke form is a more expeditious way for the police to pass on information, it does come at a potential cost in terms of clarity and ASC understanding what the police are trying to flag up as a risk.

16.1.14 ASC would assert the police should be more explicit in what they are requesting ASC to do. The police would submit it is not their role to task ASC directly, but to highlight the potential risks for ASC to consider. Both views have merit for different reasons.

16.1.15 There were several indicators that a letter to Louise and Gary providing advice on who to contact was not an appropriate way to close this referral. ARMS now make a direct referral for mental health issues to the KMPT SPoA, instead of advising the person to make the contact themselves.

16.1.16 It is acknowledged that there may not have been sufficient detail to clearly identify the concerns the police had on the crime report. However, had contact been made with Louise (and Gary) in line with their policy, the uncertainty of what the true risk posed was and what was required to manage this risk, could have been explored.

16.1.17 This interaction would have closed this information gap. The current process, if policy is followed, should work. Simply put, the police flag up a person at risk by sharing the crime report. ASC follow their current policy and investigate exactly what that risk is with the person concerned and what they, the victim, would like to happen.

16.1.18 In any event this issue of inter-agency notification has been identified as problematic in other reviews and there is currently work in progress with the Kent and Medway Safeguarding Adults Board to agree a way forward that meets the needs of both organisations in terms of effective information exchange.

16.1.19 In respect of the second referral which was received by ASC in late December, this was dealt with on the same day it was received. The referral consisted of the police crime report and supporting notes following the arrest of Gary in December. By this time, this information was two weeks out of date. Crucially it stated Gary was in custody and therefore the focus of the ASC response was on Louise and not Gary. It does illustrate the ASC view that a crime report may not be the best way to share information.

16.1.20 The referral was correctly assessed as Red on the RAG assessment and safeguarding concerns identified in respect of Louise. However, due to inexperienced staff being unfamiliar with the triage system for red referrals, the referral was not prioritised and remained pending until the middle of January 2021.

16.1.21 The referral was not flagged to the Mental Health Safeguarding Team which was also probably a product of the referral not being prioritised correctly.

16.1.22 It is little consolation that even if action had been taken immediately, this would not have safeguarded Louise. Sending a letter to Louise in January 2021 was unfortunate. The death of Louise would have been known to other parts of ASC and it is a gap in internal communication this information did not filter down to the relevant division.

16.1.23 There needs to be more recognition that people who are alcohol dependent present a greater risk than people who regularly abuse alcohol. This is even more relevant if both the victim and perpetrator are alcohol dependent. Couple this with mental health concerns and the risk becomes even greater. Had ARMS followed their procedures, this joint risk would have perhaps become more evident, and a different approach taken.

16.1.24 If the same circumstances were presented to ARMS today, the referral made in April 2020 would not be closed without contact being made with Louise and Gary to establish if this needed to be forwarded on to the local safeguarding team for further enquiries to be carried out.

16.1.25 Since completion of this report, Adult Social Care has gone through significant change and this has resulted in a review of the ARMS function and an improvement project has been undertaken leading to development of the Area Referral Service (ARS). The Area Referral Service (ARS), now contains registered practitioners and will triage new referrals into Adult Social Care, as part of a new Integrated Triage. The aim of the integrated triage discussion is to review what support the person requires, ensure the right person with the right skills is working with the individual and determine how urgent their needs are as well as agreeing what service is the right one to support the individual. Additionally, these changes have resulted in the Mental Health Social Care Teams and Local Safeguarding Teams being incorporated into the creation of 24 new Community Locality Teams, these Teams are multi skilled and cover all adult groups.

16.2 **Kent and Medway CCG**

16.2.1 Louise attended the practice on one occasion for a flu jab in November 2020. Gary had no contact during the period under review.

16.2.2 The GP Practice were aware of the various referrals made to them by organisations such as CJLDS in respect of Gary and did action the requests for a medication review and a referral to the CMHT.

16.2.3 The letter from the CJLDS sent in October 2020 was actioned by the GP sending a text to Gary in December 2020, asking Gary to make a non-urgent appointment. The surgery state they received CJLDS letter in December 2020 and they actioned it the same day. CJLDS cannot say exactly when the letter was sent. All they can say it was created in October 2020, approved by a manager the next working day and would have been sent the same day. It may be a mere coincidence that the GP did receive a referral from KMPT SPoA about Gary that identified for the first time there was an issue of domestic abuse in December 2020. It has been clarified with the surgery this was not what prompted the text to Gary. (See Recommendation 2).

16.2.4 It is unfortunate it cannot be established exactly when the letter was sent to the GP Surgery. Just to complicate matters the premises is used by two separate GP Practices. Without a named Doctor on the correspondence,

the letter could have arrived earlier than December 2020 and been with the other GP Practice before being forwarded on to the GP Practice that looked after Gary.

16.2.5 Many of the organisations who tried to help Gary took at face value his assertion he was currently under the care of his GP. Given the multiple letters the practice received the Surgery could have flagged up that they had not seen Gary for some time. While they are not obligated to do so, information sharing is a two-way process and this lack of engagement by Gary with the GP would have been very useful information for other partners to have known.

16.2.6 A new IT system is about to be introduced that will allow Social Care and all Health Professionals to access a single patient record for people living in Kent and Medway. This has the potential to significantly improve inter agency communication.

16.3 **EKHUFT (Acute Hospital)**

16.3.1 Gary attended the hospital in an ambulance called by Louise in March 2020. It was recorded that his right hand was swollen and bruised. Old superficial injuries were noted on his forehead. When asked about this Gary replied these were carpet burns which occurred when his partner had dragged him across the floor when he had passed out. Gary was intoxicated when examined and this explanation was not explored further. Gary did not visit the hospital again.

16.3.2 Louise was known to the hospital when she was treated for anxiety, depression and alcohol excess in 2013. Louise was on a waiting list for a surgical operation for a long-standing medical complaint. A decision was made in August 2020 that the operation would be postponed due to the risks posed by the COVID-19 pandemic. This was a telephone consultation and Louise had no further contact with the hospital.

16.3.3 The hospital has sophisticated measures in place to identify and manage any patients who may be suffering domestic abuse. This includes a hospital based IDVA. Given his intoxicated state at the time of his treatment and in the absence of any complaint about the superficial injuries, it is understandable why attending medical staff did not feel the need to raise a safeguarding concern nor flag Gary as a potential victim of domestic abuse.

16.4 **Kent Police**

16.4.1 Other than the incident in July 2020 each investigation following arrest was managed by the Vulnerable Investigation Team (VIT). This is a team that provide a specialist investigative response to allegations of domestic abuse and victims who are deemed to be vulnerable. The incident in July was dealt with by an officer on a criminal investigation attachment due to VIT investigators being unavailable. This was the incident that resulted in Gary being charged with common assault. When Gary was charged and bailed to Court, this should have been on conditional bail, but no conditions were put in place. This was an oversight by the Investigating Officer and has been a learning point for them.

16.4.2 On each occasion of arrest alternative outcomes were considered in the absence of sufficient evidence to charge either Louise or Gary. However, due to each being very vocal as to their desire to have their partner return to the home, the protection provided by a Domestic Violence Protection Order (DVPO) was not considered appropriate. Whilst victimless prosecutions were considered, this was not possible due to the lack of any compelling corroborating or independent evidence.

16.4.3 On two occasions both Louise and Gary were subject to conditional bail. This ordinarily provides the victim with 'breathing space' to consider their ability to break ties with their partner, but this did not happen with this couple. On every occasion of being separated, irrespective of who at that time was the suspect and who was the victim, both were voracious in their need to have the removed partner return home.

16.4.4 Gary's claims to have been subject to coercive and controlling behaviours were recognised in the DARA risk assessments. The allegations of coercive and controlling behaviour were denied by Louise and the refusal by Gary to support any prosecution meant these allegations could not be pursued.

16.4.5 Not all police interactions with Louise and Gary were linked to domestic abuse. The incidents in 2017 should have prompted a mental health referral when Gary was suffering from hallucinations. There are some practical considerations however that can prevent this taking place. If the person involved does not want a referral made and is judged to have mental capacity, the circumstances would have to be sufficiently serious in terms of risk to go against the persons wishes. This was not the case with this incident.

16.4.6 The Police Central Referral Unit (CRU) do not routinely assess and review all reports of domestic violence. It is the responsibility of the Investigating Officer to highlight to CRU vulnerable adults, alcohol/substance misuse and Mental Health concerns that would benefit from this information being shared with partners through Domestic Abuse Notifications and Safeguarding Referrals. It is acknowledged while this did occur on some occasions and health care professionals were involved (CJLDS), there could have been more referrals submitted due to the aggravating factors of mental health concerns, co-dependency, and alcohol misuse.

16.4.7 Following the arrest of Gary in December 2020 the Investigating Officer submitted a mental health referral with the consent of Gary. This was flagged to the Police CRU as "urgent". Unfortunately, the CRU had a backlog of cases and because the DARA risk assessment was not assessed as High, the CRU did not pick up on this referral for seven days. The referral was therefore not sent to the SPoA promptly. (See Recommendation 3).

16.4.8 The view of the Kent Police IMR is if this was urgent, the risk assessment should have been flagged as a high risk and not a medium risk. That misses the point. What was "urgent" was the provision of mental health support, not a MARAC referral that would have been automatically generated by submitting a high-risk DARA assessment.

16.4.9 The delay in sending on the urgent referral did start a chain of events that could be considered as a collective missed opportunity. A referral marked urgent that is not processed quickly does lose its legitimacy as being a priority action. Kent Police need to revisit their current processes to ensure they are satisfied they can process an urgent mental health referral when it does not have an accompanying DARA risk assessment graded as high risk. (See Recommendation 3).

16.4.10 Each incident in 2020 was assessed as a medium risk with previous incidents and the prevalence of alcohol acknowledged. The police are satisfied a medium risk was appropriate based upon the circumstances disclosed by both Louise and Gary and measured against the high-risk criteria set in guidance and policy. There is an issue of the frequency of the incidents over a relatively short period of time. This is a theme that has surfaced in other Kent DHRs. (See Ann/2018).

16.4.11 There are conflicting views on how much weight should be placed on this factor. The police view is the frequency of incidents should not influence the determination of risk. SafeLives, a national domestic abuse charity, believe any more than three DASH assessments in a year should prompt a MARAC referral.[13]

16.4.12 The work the police have in hand in the proposed new perpetrator management strategy will revisit this point.

16.5 **SECAmb**

16.5.1 With one exception when Gary was taken to hospital on in March 2020, neither Gary nor Louise engaged with attending clinicians or followed their medical advice about receiving treatment. SECAmb were present with the police when responding to alleged assaults and there was no need for them to submit their own safeguarding referral forms.

16.5.2 There is a system in place where SECAmb can notify a GP of their attendance to one of their patients and the patient declines medical assistance and/or refuses to go to hospital. SECAmb propose to revisit the threshold for GP summary referrals.

16.5.3 In this case, eight attendances in as many months would have alerted the GP to the ongoing domestic abuse between both parties and the influence alcohol had on their respective behaviours. This was a gap in this case as the GP was not aware of the ongoing domestic abuse, despite several referrals by other health agencies who raised mental health concerns but not domestic abuse. (See Recommendation 4).

16.6 **KMPT**

16.6.1 Louise was seen by CJLDS practitioners twice in the time frame set out in the Terms of Reference. CJLDS are a sign posting service and any engagement requires the consent of the person involved. In the first contact, Louise engaged in the Vulnerability Screening. Louise disclosed she was alcohol dependent but did not want to stop drinking. No mental health needs were identified. Louise declined referrals to Forward Trust and stated her GP was aware of her alcohol use. Louise did not discuss or disclose any concerns regarding domestic abuse.

[13] SafeLives Dash risk checklist for the identification of high risk ...

16.6.2 The screening tool has a section that addresses domestic abuse. It includes a prompt for the practitioner to consider whether they have reason to believe the individual is in an abusive relationship, even if they have denied this. Given Louise was in custody for assaulting her partner, it is odd domestic abuse was not considered. The explanation provided for this gap was the practitioner did not know who the victim was and didn't ask. This is a learning point for the individual concerned.

16.6.3 In the second encounter Louise did not wish to engage with the support worker. Louise was provided leaflets explaining what CJLDS could do if she wanted further support with her alcohol dependency.

16.6.4 Gary was seen on five occasions by CJLDS. The first intervention was in March 2020. Gary declined to engage with the Practitioner. The second contact was in July 2020. Gary revealed daily alcohol use, reported having depression, anxiety, and hearing voices. Gary explained the voices were internal and reflective of his own personal insecurities and he was on prescription medication for depression. When asked about thoughts or plans to self-harm or hurt others, Gary stated he had no such thoughts. Gary requested a medication review. The CJLDS practitioner was responsive to this request and arranged a CJLDS Support Worker to contact Gary when released to assist with the GP appointment. A letter was sent to the GP.

16.6.5 While the CJLDS did take active steps to assist with a medication review, no action was taken about the disclosed auditory hallucination. This was a missed opportunity. The practitioner should have referred this to a qualified mental health worker for advice. The referral to the GP did note Gary was hearing voices, but this presupposed Gary would visit his GP. The Support Worker who contacted Gary post release closed the case on the reassurance from Gary he would get in touch with his GP. Gary never did get in touch.

16.6.6 Gary was seen again in October 2020 at the Magistrates' Court. Gary disclosed excessive alcohol use as well as hearing voices. The outcome of this screening was Gary did not appear to have acute mental health needs and did not require a diversion from the criminal justice system. The practitioner, however, did recognise hearing voices needed to be explored further and offered to refer Gary to CMHT for further help. Gary declined this support, as well as support from the outreach team to contact his GP.

A letter was sent to the GP advising them of the Vulnerability Screening Assessment and that Gary was hearing voices. The letter advised Gary had declined a referral to the CMHT and wanted to be seen by his GP about his auditory hallucinations. (This was the letter that prompted contact by the GP to Gary in late December 2020).

16.6.7 Gary had two contacts with the Single Point of Access (SPoA). The first contact was self-initiated, in July 2020. Gary referred himself claiming suicidal ideations and auditory hallucination. Gary also disclosed an alcohol dependence, depression, a desire to have a medication review and that he was the primary carer for his partner, who was also alcohol dependent.

16.6.8 The SPoA practitioner recommended Gary self-refer to Forward Trust and to contact his GP for a medication review and a referral to the CMHT. No action was taken regarding the auditory hallucinations, nor further probing about his role as a primary carer. There was no consideration given to what the state of his relationship was, and no questions were asked about domestic abuse. This was a missed opportunity. Given Gary had declared he was a carer and the problems he had disclosed, this should have prompted some consideration about offering a carer's assessment.

16.6.9 The second contact followed the urgent referral made by the police in December 2020. This was initially assessed as an amber risk, meaning while important, contact could be made over the next 72 hours. The IMR has identified this grading should have been red risk. It concluded sufficient weight had not been given to the combined impact of the information disclosed which included alcohol dependency, recent domestic abuse and voices that were now suggesting Gary should cause serious harm to Louise. A red risk grading requires an immediate intervention or contact.

16.6.10 CJLDS had seen Gary the day before the police made their referral and had not made a mental health referral. The police "urgent" referral had taken 7 days to arrive, so how urgent was it? The assessment to grade as an Amber risk was probably influenced by these two factors.

16.6.11 Attempts to contact Gary were made 5 days after the referral was received. The delay in not meeting the 72-hour contact deadline was due to the impact of the COVID-19 pandemic. The SPoA service had by this time moved into a crisis model with the SPoA role expanded to be a public

facing contact line offering immediate advice and guidance to people seeking help. By way of illustration, a week in December 2019 SPoA dealt with 150 referrals. For the same dates and time in 2020, 558 referrals were made.

16.6.12 SPoA in line with their protocol made two attempts to contact Gary before sending the referral to the local CMHT. The referral should also have been brought to the attention of the Safeguarding Team, but this was not done. There was no explanation provided as to why this did not happen.

16.6.13 CMHT discussed the referral at their morning screening meeting the day after it was received. A decision to discharge the case back to Adult Social Care was made. The rationale for this decision was based on his alcohol dependency but CMHT were also influenced by the SPoA initial assessment. CMHT also concluded CJLDS had seen Gary two weeks previously and they had not referred Gary to their service, indicating his mental health needs were not immediate. The delay in the police referral getting to them also cast some doubt on how urgent this was.

16.6.14 There were two errors in this approach by SPoA and/or CMHT. It was assumed CJLDS had carried out a mental health assessment and a qualified practitioner had decided not to make a referral. The second error was SPoA and CMHT were not aware the police referral to SPoA had been inadvertently delayed by a backlog in the police processes.

16.6.15 This confusion about what CJLDS do with people in police custody is a legacy of the old system. The majority of CJLDS staff in police custody suites are not qualified practitioners. In the past people in police custody would have been given a full mental health assessment. A vulnerabilities screening assessment is not a mental health assessment. However, just to add further confusion, some CJLDS staff are qualified practitioners and can carry out a full mental health screening. What this DHR has highlighted is a gap in the understanding of what different departments in the same organisation now do.

16.6.16 CJLDS have since delivered a training and awareness programme internally highlighting what the CJLDS role now is.

16.6.17 CMHT have offered a view that despite this misunderstanding of roles, their decision would still have been the same. Their view was the alcohol dependency Gary had was the primary driver of his problems, and this needed to be dealt with first before a successful mental health intervention could be made.

16.6.18 The IMR noted however, that CMHT did not mention any auditory hallucination or domestic abuse concerns in their decision-making process. There was also no mention of a multi or dual diagnosis. If these issues were considered or discussed, they were not recorded in the case notes.

16.6.19 The Amber grading has since been viewed as inappropriate and full consideration should have been given to the facts presented as a whole. To take a balanced view, it probably did not help that the referral was delayed by a week and that must have influenced the decision maker that this was not as urgent as it seemed. Had SPoA contacted the police CRU for clarification, they would have been told the risk assessment was graded as medium and therefore this referral was not urgent. This is an anomaly in the police process and is addressed in the recommendations. (See Recommendation 3).

16.6.20 Gary's mental health did appear to be deteriorating. Gary had reported hearing voices on many occasions, but the referral made in December 2020 was the first time the voices were telling Gary to cause injury or serious harm to Louise. The escalation of the voices from being relatively benign to ones making specific threats of violence towards Louise was not acted upon. (See Recommendation 5).

16.6.21 CJLDS made several interventions with Gary, including writing twice to his GP advising them of their recent contact. This is good practice. While well intentioned and in keeping with the wishes of Gary, the advice to contact his GP and self-refer to Forward Trust was not acted upon by him. The challenge a CJLDS practitioner faces is this is a consensual process and therefore this is advice rather than a direction or requirement. However, it does pose the question whether there should have been some fact checking on the information Gary had provided. There would have been notes on the CJLDS case management system of the recent encounters with KMPT and the previous undertakings he had made to contact his GP.

16.7 **KSS CRC**

16.7.1 A Serious Further Offence (SFO) Review was commissioned by KSS CRC. This is a statutory requirement in these circumstances. Thirteen areas for improvement were identified and incorporated into an Action Plan. This Action Plan was completed on 23 June 2021 and signed off as such by the Ministry of Justice.

16.7.2 The responses provided in the KSS CRC IMR were based on the SFO Review. It was apparent the review was thorough, detailed, and transparent, highlighting good practice and gaps in policy, compliance and the quality of record keeping.

16.7.3 The thirteen areas of improvement focussed on individual learning points for the Responsible Officer, their immediate supervisors, some organisational learning, and changes to operating practices that were in force at that time.

16.7.4 KSS CRC no longer exist. The organisation has been combined with the National Probation Service to create a new organisation called The Probation Service. Many of the staff remain and some operational practices and procedures have changed.

16.7.5 There seems little value in dissecting the findings of the SFO Review in this report when the action plan to close the identified gaps in process, practice and procedure have been completed and signed off.

16.7.6 The Probation Service have an ongoing transition plan that focusses on realigning existing resources against demand, ensuring qualified staff are in place to carry out the role they are being asked to undertake and ensuring supervision levels and scrutiny processes are in line with the Probation Service's Target Operating Model. Tackling these issues complement the gaps identified in the SFO Review.

16.7.7 What is relevant for this process is an opinion on whether the identified gaps were a significant factor in the events leading up to the death of Louise.

16.7.8 The COVID-19 restrictions did impact on the ability of KSS CRC to deliver an effective service. The Exceptional Delivery Model (EDM) changed the contact for Red RAG status cases from weekly face-to-face meetings to once a month. Doorstep visits went from monthly to quarterly visits. There were also issues with staff working remotely and the challenges that brought accessing IT systems.

16.7.9 Gary did miss a telephone appointment in December 2020. It was rearranged promptly two days later. When Gary was arrested by the police in December 2020, Gary was sent a travel warrant and an appointment for a face-to-face meeting for a week's time. Gary telephoned on the day of the meeting advising he had only just got the letter and he could not

physically attend. The meeting was switched to a telephone encounter. While technically this could have been a final warning letter for non-compliance, this would not have meant Gary was in breach of his Community Order.

16.7.10 There were gaps in applying policy and procedure, but these were not significant omissions that would have influenced the conduct and actions of Gary, on the immediate run up to the death of Louise. Credit should also be given to the RO who took resolute action to protect Louise when they contacted Gary and suspected he had been drinking during their telephone appointment in early December. (See paragraph 14.35).

16.8 **Forward Trust**

16.8.1 Forward Trust followed national guidance and suspended face to face contact with service users and carried out telephone interventions when the COVID-19 restrictions were in place. All interactions between the case worker and Gary were conducted by telephone. There were six telephone contacts between November and December 2020.

16.8.2 Forward Trust are very reliant on the information provided by service users. While they conduct risk assessments, these are limited in value, as they do not know what the service user is not disclosing. Forward Trust did not know Gary was complaining about hearing voices and these voices were now telling Gary to cause serious harm to Louise. Gary did not disclose this information following his arrest in December 2020 during the next scheduled telephone contact.

16.8.3 The IMR identified that there may be gaps in the current referral pathway where insufficient information was either not provided or collected from Criminal Justice and Health Care Partners before the Community Order was started. An action is in place to rectify this.

16.8.4 The assessment that Gary had a low dependence on alcohol is not consistent with the plethora of evidence available to other organisations. It is acknowledged that Forward Trust have a difficult balance to strike trying to encourage service users to change their behaviour and challenging the information they have provided, while maintaining an effective working relationship. It is also difficult to assess accurately if a service user is drinking regularly when contact is limited to prearranged telephone calls.

16.8.5 Forward Trust need an effective information exchange in order that they can determine the appropriate level of treatment. They also have a crucial role to play in providing additional safeguarding support to the service user's immediate family members and on that basis every effort should be made to provide this organisation with the information they need to carry out this role effectively.

16.8.6 It would be helpful when Health and Criminal Justice agencies recommend a person should self-refer to Forward Trust, they should provide the background information as to why they have made this recommendation to Forward Trust. This should be part of the broader discussion involving the information exchange protocol that is being developed.

16.8.7 Gary stated he had taken active steps to have an alcohol-free Christmas break and Forward Trust had no reason to believe otherwise. Other organisations had information to the contrary, but this was not shared.

17 Conclusions

17.1 This DHR is predominantly about safeguarding alcohol dependent people who commit domestic abuse against each other. It also involves mental health and the difficulty that seems to pose when mental health issues are combined with alcohol dependency. This is recognised as a dual diagnosis issue by mental health experts, but it is not a practice that is widely adopted.

17.2 There is a key distinction to be made. People who are alcohol dependent and commit domestic abuse pose a different risk to people who drink to excess and then engage in domestic abuse. In a recent Alcohol Change UK publication it notes people who live vulnerable and chaotic lives, often with no regard for their general wellbeing, can still be assessed as having the mental capacity to make choices.[14] (This view resonates with the views expressed by the family at paragraphs 13.3 and 13.4). The issue of choice was something the Review Panel did highlight very early on as problematic. The Panel felt the ideas and suggestions in this publication did merit some further work on a multi-agency basis. (Recommendation 8).

17.3 It also seems to be conventional thinking that a person with an alcohol dependency and mental health issues, must deal with the alcohol problem first before they can successfully tackle any mental health issues. This was the consistent response by "front line" mental health professionals.

[14] "Dying with their rights on" | Alcohol Change UK

17.4 This response has been raised with the Clinical Director at KMPT. It was acknowledged there is a reluctance to adopt a dual diagnosis approach which was highlighted in the IMR. This is not just a local issue; it is a national problem, and this is reflected in the work currently being undertaken to remove barriers to access support for people with alcohol and mental health challenges. This work is referred to as the Community Mental Health Transformation Framework and has a focus on addressing needs irrespective of primary and secondary support.[15]

17.5 Work is in hand locally to encourage practitioners to recognise people can access mental health services and support when they are alcohol dependent, even if they are not involved with an alcohol support service. This cultural change also involves moving away from separating primary and specialist care providers where too often a person seeking help can be referred to several different organisations and end up getting no help at all. The experience of Gary in December 2020 demonstrates how this can happen. (See Recommendation 7).

17.6 This should address the gaps in the current system which this DHR has exposed as overly complicated and compartmentalised. Ideally Mental Health and Alcohol Support Services should work in tandem, but this must be client led. Mental Health cannot refer anyone to alcohol support without their consent. It is however a significant leap forward that mental health practitioners now recognise alcohol dependency is not a bar to mental health support and taking it a step further, there are other legal options to manage alcohol dependency as the Alcohol Change UK report suggests. This should be explored at a multi-agency seminar. (Recommendations 7/8).

17.7 Advising a vulnerable person to self-refer to their GP or seek help from an alcohol support service such as Forward Trust may tick the box in terms of safeguarding advice, but it does not add any real value if this does not actually happen. In this DHR both Louise and Gary regularly claimed they were under the care of their GP for alcohol misuse and/or depression. The only contact either of them had with their GP for the entire period of this review was when Louise visited the surgery for a flu jab.

17.8 No agency checked if this advice was taken up although to the credit of CJLDS they did regularly update the GP. This highlighted a gap in effective information exchanges between various organisations and was compounded by a reference by Adult Social Care that their Mental Health Teams had limited access to the records held by the KMPT Mental Health Teams.

[15] Community mental health services - NHS England

17.9 Fortunately, this disconnect is in the process of being resolved. A new IT system is being developed called the Kent and Medway Care Record System[16]. This will allow all Health and Social Care Professionals access to a patient's/client's single record making communication between different organisations much easier, quicker, and more efficient. This system has seen some technical slippage, and it will not now be introduced until late 2023, which is disappointing. In the interim ASC now have access to relevant parts of the KMPT record management system. While this is not ideal, it does close some information gaps between both organisations.

17.10 Information gaps were also a major feature of the Forward Trust response. There was a significant amount of information available that they were not aware of. It is a good outcome that Forward Trust have recognised this gap and are actively seeking to close it. I would encourage all Statutory Agencies to assist in any way they can. It is to the benefit of all for Forward Trust to succeed. (Recommendation 6).

17.11 Had a MARAC referral been made, this information would have been shared with Forward Trust as a core panel member but in this instance, there was no MARAC in place. There were different views expressed on whether this was the correct approach. Some felt this case should have been referred to a MARAC while others felt the threshold had not been met.

17.12 There was an interesting discussion on the risk assessment process, driven in the main by the fact the police now use the DARA risk assessment tool, while all the other agencies continue to use the more established DASH risk assessment process. The switch to DARA followed a College of Policing two-year study to identify more effective ways of identifying coercive control and to be less reliant on reaching a score that automatically mandated a MARAC referral.[17]

17.13 Both processes have their benefits and disbenefits. It is probably something that needs to be revisited at some stage. It does seem slightly anomalous that safeguarding agencies are now using similar but different risk assessment processes to manage or mitigate the same risks.

17.14 What is probably more important is the outcome either of the two risk assessment processes seeks to achieve in identifying high risk incidents.

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[16] Kent and Medway Care Record
As of the time of publication the KMCR is still in development. It is operational but currently not accessible to Adult Social Care staff.

[17] http://whatworks.college.police.uk/Research/Pages/Published.aspx.

17.15 The MARAC process is currently under review following recommendations from other Kent DHRs, SARs (Safeguarding Adult Reviews) and SCRs (Serious Case Reviews). This remains an issue of resource and funding and where to draw the line on the threshold that automatically triggers a MARAC process. There are two distinct views. One side advocates an expansion of the number of cases managed by MARAC, while the other, because of resources and capability, wants the numbers reduced. A cogent case can be made for both viewpoints. It is not a matter for this DHR to favour either viewpoint. It is pertinent however to encourage the MARAC review should be progressed without further delay.

17.16 The police proposal to implement a perpetrator focused strategy may be a way of supplementing a multi-agency problem solving approach that does not impact on the MARAC structure and the resources available. This is tackling the same risk from a different direction and given the current tensions in MARAC capability, a very positive development. The focus on perpetrators will be managed by a process called Multi-Agency Task and Co-ordination (MATAC). This new approach is being trialled in one policing area from June 2022.

17.17 There are still numerous examples of policies and procedures not being followed. Where this was an issue of resource, additional resources have been added. Where this was due to a lack of training or experience, additional training has been provided and more experienced professionals made available to provide the appropriate guidance. This is a positive step forward. (See paragraphs 16.1.7 and 16.7.6).

17.18 Responding to the Terms of Reference the following observations can be made.

17.19 *Both Louise and Gary were alcohol dependent (self-identified). Both had a history of domestic abuse recorded against each other. Both suffered from issues of their mental wellbeing. There were multiple engagements and/or referrals with/by/to various agencies during the relevant time of this review. How effective were these interactions and/or engagements in safeguarding or identifying possible risks to either Louise or Gary?*

17.19.1 There would appear to be limited weight applied by all agencies in terms of assessing future risk to the trio of vulnerabilities identified as alcohol dependence, mental health issues and domestic abuse. This is a well-versed risk parameter when children are in the household, but because there were no children involved, this was not considered.

17.19.2 When referrals were made, the triage process at Adult Social Care did not pick up on the issue of domestic abuse. This gap has since been closed with additional domestic abuse training for contact staff and from July 2020, the provision of Practice Advisors who are Registered Social Workers to provide advice as and when required.

17.19.3 Gary was signposted to support agencies by several organisations on the presumption he would self-refer. The reality was Gary did not engage with his GP nor KMPT, therefore this was not an effective strategy to reduce the risk of future harm. Adult Social Care no longer invite clients to contact KMPT to seek mental health support, they now make a direct referral to this organisation. This still requires the person being referred to engage with KMPT or their GP for support, but it does mean the onus is not on the person seeking help to take the first step.

17.19.4 Forward Trust are working on their information sharing agreement with statutory agencies that will enable these organisations to share information about individuals they have signposted to this substance misuse support service.

17.20 *How attuned were agencies to what was a deteriorating situation over a relatively short period of time? Was this recognised?*

17.20.1 The RO acted promptly when they discovered Gary had been drinking and arguing with Louise in early December 2020 and contacted the police. This demonstrated an appreciation Gary did pose a risk to Louise.

17.20.2 Gary disclosed he was hearing voices on several occasions, which were assessed as being benign in terms of a risk of harm to himself or others. When Louise disclosed these voices were now telling him to kill her, he was arrested, but Louise did not want to pursue a prosecution. What Louise wanted was Gary to get some mental health support. Gary gave his consent for a mental health referral, which the police actioned as an 'urgent referral' to KMPT. This did reflect a recognition of the potential risk these auditory hallucinations posed to Louise.

17.20.3 It is not known if the police ever disclosed to Louise Gary's previous conviction history, which could have been a consideration under Clare's law.[18] Louise stated she never believed any threats Gary made, but that may or may not have been based on her knowledge of Gary's time in prison. On the basis the IMR made no mention of this, the presumption must be

[18] What's Clare's Law? How is it Requested/Applied? Data & ...

the police did not make Gary's conviction for a serious violent offence known to Louise. However, it should be noted that in relation to DHR Kitty, the police have been implementing recommendation 9 which is in relation to raising awareness and use of Claire's Law / DVDS Kitty-2020-Overview-Report.pdf (kent.gov.uk)

17.20.4 The test that was applied at the time would have been a judgement on whether a disclosure would have been reasonable and proportionate. Proportionality would have been benchmarked against the level of violence alleged. In hindsight, there probably would have been sufficient grounds to share this information with Louise when Gary made threats to kill her, and Louise stated she did not believe any threats he made.

17.20.5 The urgent police referral was delayed and then assessed as a mental health issue that did not require specialist support from KMPT. There were various reasons why this assessment was made. (Paragraphs 16.6.13 -14). KMPT practitioners have asserted that despite the circumstances outlined in the analysis, their decision to discharge Gary would not have changed. However, the contemporaneous records did not reference auditory hallucinations nor a history of domestic abuse as part of the decision-making considerations to discharge Gary.

17.20.6 It is reasonable to conclude the assessment process did not recognise the potential risk Gary posed. This view is supported by the IMR writer who concluded the decision to grade the urgent referral as amber should have been graded as red, which requires an immediate intervention or contact.

17.21 *When "urgent" referrals about safeguarding concerns are received from partner agencies, what should the response be? Does current policy or procedure recognise the inherent potential increased risk the term "urgent" presents?*

17.21.1 For various reasons previously outlined (Paragraphs 16.4.7 - 9) the benefit of highlighting a mental health referral as "urgent" was lost. A recommendation of this DHR is for the police to revisit their processes and procedures to ensure an "urgent" referral is not missed. Part of this will include agreeing with partner agencies what their response should be. As a rule of thumb, it should be a professional courtesy to take due regard to another professional's judgement that this is an urgent matter. Where this judgement is likely to be challenged, contact should be made to gather further information and explain why this assessment of urgency is not being supported. (Recommendation 3).

17.22 *The link between alcohol dependence and domestic abuse is well established. What steps or special measures were/could/should have been put in place by each organisation involved that recognised the significant risk this combination posed?*

17.22.1 For clarity, not everyone who commits domestic abuse is alcohol dependent or consumes alcohol. But the link between alcohol and violence in terms of impairing people's judgement is well known.

17.22.2 The response of agencies was to address Gary's dependence on alcohol. This was reflected in the subsequent court orders, that required rather than requested him to undertake alcohol misuse support. The key gap however was the combination of alcohol dependence, mental health well-being and domestic abuse.

17.22.3 There was a collective missed opportunity for agencies to respond to these three separate but intertwined factors. The police identified the risk with their urgent referral to KMPT. A DVPO could have been put in place but that would have been at odds with what Louise wanted and history demonstrated it did cause them both considerable distress when they were physically separated. There was no indication Louise wanted to terminate the relationship. On the contrary, her motive for supporting a prosecution was to not to punish Gary, but to ensure he got the mental health support he needed.

17.22.4 A court imposed Mental Health Treatment Requirement Order could have been applied for when Gary was sentenced to the ATR, but this requires Gary to consent to this process. When Gary was seen by the CJLDS worker at Magistrates Court prior to sentencing he declined any mental health support, which accounts for why this option was not progressed.[19]

17.22.5 The level of violence used by Gary against Louise up to the point of Louise's murder did not indicate an escalation in terms of the severity of injury, but it was significant the voices Gary was hearing did say he should kill Louise. It is this change in what the voices were telling Gary to do that most agencies underestimated the significance of in terms of future risk.

19
Introduction to the courts and mental health

17.23 *What was the impact of the COVID-19 restrictions on the mental and social wellbeing of Louise and Gary? Were these recognised as additional pressures? What was the impact of the same restrictions on the organisations providing their service? Did this have a pertinent bearing on the service provided?*

17.23.1 Lockdown and social isolation would have had an impact on Louise and Gary. This was recognised by several agencies, but it did not alter what their response was on the basis the Covid restrictions did not allow them to do so.

17.23.2 The COVID-19 restrictions and the national guidance did impact negatively on most organisations and compounded the issues faced by Louise and Gary. This was particularly the case with organisations that had relied previously on face-to-face interventions. Telephone conversations were never going to be as effective, when trying to assess potential risk.

17.23.3 The demand on many organisations rose exponentially with a corresponding reduction of available staff resources through home working, self-isolation and new operating practices. These new operating practices did not have the supervision or IT infrastructure in place to provide the necessary support to function efficiently. It is relevant to comment the most organisations have had the opportunity to reflect on what their initial response was to Covid 19 and have concluded that, what they did then, is not what they would do now.

18 Lessons to be Learnt

18.1 A different approach should be taken when dealing with alcohol dependent victims and perpetrators of domestic abuse, especially if they also have more complex needs such as mental health issues, general health issues or homelessness.

18.2 The current position of deferring to alcohol first in terms of treatment does not have a high success rate.

18.3 A good way forward will be a multi-agency seminar with key partners to discuss and explore alternative strategies and best practice to tackle this relatively small cohort of hard-to-reach people. The new police perpetrators strategy may complement and support this approach. The lesson learned is the recognition something must change in terms of current practice.

18.4 Maintaining accurate and current records of information and intelligence is essential to inform decision making and to produce realistic risk assessments that deliver effective safeguarding measures. A few organisations have acknowledged this is a gap for them in this DHR and they have either put in place or are in the process of putting in place new procedures to achieve this.

18.5 This DHR has also put the spotlight on a few organisations not following their own policy and procedures. Organisations need to ensure policy does lead practice. This will ensure a consistent approach in service delivery and that past poor practice is not repeated.

18.6 If policy and procedures are not complied with, the reasons for this should be documented. There will be occasions when such a course of action is both proportionate and necessary and can reflect an agile response to areas of uncertainty, which in this DHR was created by the pandemic. However, it needs to be recorded why policies and procedures were not followed to provide transparency and accountability.

18.7 The example in this DHR where additional resources and training has been invested in ARMS, reflects good practice and organisations should resource their teams accordingly and invest in their workforce skills and development to ensure they can effectively manage the demands made on them.

18.8 The lessons learned have been kept at a high level and they do not apply to every organisation. Good practice has been referenced to demonstrate there is innovation and a desire to deliver a good service. Where specific gaps remain, it is hoped that they are closed in the next section by the action plans the recommendations generate.

19 Recommendations

19.1 The Review Panel make the following recommendations from this DHR:

	Paragraph	Recommendation	Organisation
1.	16.1.2	Agencies should be aware which “Front Door” Service should be their first point of contact. ARMS and SPoA need to circulate their referral criteria.	KCC ASC KMPT

2.	16.2.3 16.2.5	GPs practices need to have robust processes in place to ensure that when information from other agencies directs an action for primary care that these requests can be promptly actioned. This should include the acknowledgment to referring agencies when a requested action cannot be met due to non-engagement.	Kent and Medway CCG
3.	16.4.6 16.4.7	The police CRU should review their current procedures for facilitating Safeguarding Referrals to Health Care Professionals where these have not been assessed as High Risk in a DARA Risk Assessment.	Kent Police
4.	16.5.3	The threshold for GP summary referrals should be reviewed and due consideration given to including attendance at domestic abuse and/or alcohol dependent patients.	SECAmb
5.	16.6.5 16.6.20	CJLDS practitioners should be encouraged to refer disclosures of auditory hallucination to Registered Practitioners or at least consult with them to get the necessary professional advice.	CJLDS (KMPT)
6.	16.8.3 16.8.5	The current referral pathway for Alcohol Treatment Requirement/Drug Rehabilitation Requirement needs to be reviewed. This will include Information Sharing Agreements with key Statutory Partners to obtain information and intelligence to manage	Forward Trust

		risk assessments and facilitate Safeguarding protection for service users' families.	
7.	17.4 17.5	The Dual Diagnosis assessment process should be reviewed, and a Multi-Agency Pathway developed (in conjunction with substance abuse experts).	KMPT Forward Trust
8.	18.3	More effective multiagency working through stronger risk assessments and training for practitioners will identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm. This can be achieved by a multi-agency seminar with key partners to discuss and explore alternative strategies and best practice to tackle this relatively small cohort of hard-to-reach people.	KCC Public Health
9.	16.4.11	KCSP to ensure the MARAC Hub Manager is provided with this DHR, with a request it be considered during the development and implementation of new MARAC procedures	KCST

Addendum

The full report was discussed with members of the family on 29 March 2023. (Mum and all three sisters). A full copy of the draft report had been provided in October 2022. The feedback process was delayed by a bereavement in November 2022 and the unavailability of the police FLO until this date. The family had built up a close rapport and requested the FLO was present during the feedback process. The Chair felt this was a reasonable request.

The family repeated their frustration (as outlined in paragraphs 13.4 and 13.5) that more weight should be placed on the views of a supportive family network who are trying to help and assist a loved one suffering mental health episodes and/or addictions.

The family illustrated this with their experience trying to secure residential hospital care for Louise in March 2019, when she was taken to the local hospital by the police and subsequently transferred to another hospital in the early hours of the morning to be psychiatrically assessed. Members of the family (Heidi and Frankie) who attended both hospitals were disappointed this assessment was not progressed promptly and Louise was allowed to leave the hospital premises by both medical staff and the police. The family did make repeated requests for a Deprivation of Liberty application to be made, but this was not pursued by medical staff, pending a psychiatric assessment.

When it comes to people suffering from mental health and addictions a view was expressed that professionals need to be more robust and less risk adverse when considering the provisions of the Mental Health Act.

The family were pleased to note that the practice asking vulnerable people to self-refer to other organisations such as the GP and addiction support services had been discontinued but commented that while a referral is now made direct to these support services, there is no guarantee that this offer of help will be taken up. This returned the discussion to the point made above and those professionals had to be braver in their interventions. It was pointed out that professionals were bound by legal and ethical constraints and such a course of action was not always possible.

The family were interested in what had now changed and how the lessons learned from Louise's death would be used in the future. They asked if these lessons went beyond the boundaries of Kent and how others may benefit. The role of the Home Office Quality Assurance Panel was explained, and best practice and lessons learned would be available to other organisations. The family were reassured that inroads had been made with dual diagnosis in Kent and hoped that would be replicated in other parts of the country.

The family felt it was now time to bring closure to this process but did want to be updated with any comments the Home Office Panel may make, which the Chair undertook to do.

Appendix A

Kent & Medway Domestic Homicide Review

Victim – Louise

Terms of Reference (Anonymised) - Part 1

1. Background

1.1 In late 2020 Gary called 999 stating he had stabbed his partner, Louise. The police responded to the home address and found Louise suffering from multiple stab wounds to her front and rear torso.

1.2 Paramedics attended and administered full life support. Life was declared extinct before Louise could be conveyed to hospital. Gary was arrested on suspicion of murder. At the time of his arrest, he was intoxicated and made several significant statements (admissions of guilt) to the arresting officers.

1.3 There is a history of alcohol dependance and domestic abuse involving both parties and a clear escalation of the later in the months running up to the fateful morning, when Louise was murdered.

1.4 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel virtual decision was made on 26 February 2021, and it confirmed that the criteria for a DHR had been met.

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

2. The Purpose of DHR

2.1 The purpose of this review is to:

i. establish what lessons are to be learned from the domestic homicide of Louise regarding the way in which local professionals and organisations work individually and together to safeguard victims,

ii. 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,

iii. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate,

iv. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

v. contribute to a better understanding of the nature of domestic abuse and

vi. highlight good practice.

3. The Focus of DHR

3.1 This review has established whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Louise.

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

3.3 This review focuses on whether each agency response to Louise and/or Gary was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. In particular, the review examines the methods used to identify risk and the action plan put in place to reduce that risk. This review also considers current legislation and good practice. The review examines how patterns of domestic abuse were recorded and what information was shared with other agencies.

4. DHR Methodology

4.1 Independent Management Reviews (IMRs) were submitted using the templates current at the time of completion.

4.2 This review is based on IMRs provided by the agencies that were notified of, or had contact with, Louise and Gary, in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse,

e.g., alcohol or substance misuse. Each IMR was prepared by an appropriately skilled person who has not any direct involvement with Louise and/or Gary, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.3 Each IMR included a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR highlights both good and poor practice, and makes recommendations for the individual agency and, where relevant, for multi-agency working. The IMR includes issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR included all information held about Louise and Gary for a ten-month period in 2020. (The specific dates have been removed to facilitate anonymity). If any information relating to Louise as the victim, or Gary as being a perpetrator, or vice versa, or domestic abuse before this time frame comes to light, careful consideration should be given as to whether this should be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must have been included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Louise and Gary. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g., In 2010, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, i.e., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation were identified. If none are relevant, a statement to the effect that these have been considered was included.

4.7 IMRs submitted by each relevant agency were considered at a meeting of the DHR Panel and an overview report was then drafted by the Independent Chair of the panel. The draft overview report was considered at further meetings of the DHR Panel, until a final, agreed version was submitted to the Chair of Kent CSP.

5. Specific Issues to be Addressed

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

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

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

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

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

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

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

vi. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

vii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

viii. Was this information recorded and shared, where appropriate?

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

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

xi. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for several years?

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

xiii. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Louise and promote her welfare, or the way it identified, assessed, and managed the risks posed by Gary or vice versa? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?

xiv. Did any staff make use of available training?

xv. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xvi. How accessible were the services to Louise and Gary?

Appendix B

DHR Panel Member Brief Resumes

Catherine Collins, KCC Adults

Catherine Collins is a Social Worker with over 30 years' experience working with adults within health settings and the community. Catherine has also worked as both a practitioner and a manager in adult mental health teams and as a specialist practitioner in an older person mental health team. Catherine is currently a Strategic Safeguarding Manager, and a Best Interests Assessor completing assessments in relation to Deprivation of Liberty applications for people in care homes and hospitals. Catherine also has experience of working as a panel member for several DHRs and SARs.

Christopher Rabey, Kent Police

Christopher Rabey has been a Police Officer for fourteen years and has worked within dedicated vulnerability focused roles for the past five years. Chris has experience of managing investigations of serious and complex crime, including domestic abuse, serious sexual offences, child protection and adult protection. Chris is also a nationally accredited Detective Inspector and currently works in the Protecting Vulnerable People Command for Kent Police.

Jenny Churchyard, SECAmb

Jenny Churchyard has been in the ambulance service since 1997 and has been a HCPC registered Paramedic since 2001. Jenny has been in her current role, as Specialist Safeguarding Practitioner for three and a half years. Jenny has completed Safeguarding Adults and Children to Level 4, and covers Kent, Medway and East Sussex, for both adults and children within the ambulance service, supporting the Safeguarding Lead.

Lisa Lane, K&M CCG

Lisa Lane is a Registered Mental Health Nurse (RMN) with 24 years' experience working in the NHS. Lisa has worked within psychiatric intensive care services for 16 years, supporting individuals with acute and chronic mental health presentations before taking the specialist route into Adult Safeguarding in 2014. Lisa's initial role within Adult Safeguarding was as a Safeguarding Adult and Mental Capacity Act Lead within a large Mental Health Trust, before moving to the Clinical Commissioning Group in 2018, firstly as a Deputy Designate Nurse before progressing to her current Designate Nurse post. Lisa has contributed as a panel member to numerous statutory safeguarding reviews since 2014 and regularly provides safeguarding expertise into the health focused Serious Incident panels.

Qualifications:

- Higher National Diploma in Mental Health Nursing (RMN) 1995 - 1998
- Interprofessional Practice BSc 2014 -2017
- Leading Culture Change in Safeguarding PG Cert – current

David Naylor, Victim Support

David joined Victim Support in 2015 and is responsible for the strategic development and operation of the local service. Since 2016 the local Victim Support service has been part of the Kent Integrated Domestic Abuse Service (KIDAS) commissioned by Kent County Council and David sits as part of the Partnership Group within this.

Before joining Victim Support, David was a Director in a charity addressing Equality and Diversity where he was part of the Pan-London HIV Prevention Programme and managed services addressing drug and alcohol use by adults and young people.

Auxilia Muganiwah, KMPT

Auxilia Muganiwah is currently a Specialist Safeguarding Advisor for Children and Adults, delivering training to health clinicians on safeguarding and MCA matters. Auxilia trained as a Registered Nurse for people with a Learning Disability (RNLD) and worked as a nurse for four years. Then, she was a Care Manager for 17 and a half years, working for Adult Social Services in an integrated team for adults with a learning disability. Auxilia also trained as a Best Interests Assessor (Mental Capacity Act 2005) and has worked as a DoLS (Deprivation of Liberty Safeguarding) assessor, and Specialist Mental Capacity assessor.

Carol Tilling, EKHUFT

Carol Tilling qualified as an Adult Nurse in 1986 and a Children's Nurse in 2004. Carol worked as a School Nurse for 6 years, before moving into Safeguarding at an acute hospital trust in 2010. Carol's primary role has been in Safeguarding Children; however, for the previous 18 months the emphasis has been shifting to a 'safeguarding for all age' approach.

Shafick Peerbux, Kent County Council, Community Safety

Shafick Peerbux has worked in Community Safety for 17 years and currently serves as the Head of the Community Safety Unit at KCC. Prior to joining KCC, Shafick worked for Kent Police for four years, in a couple of roles, most notably as a researcher, focussing on victims of various crimes including those who had suffered domestic abuse. Shafick has been involved in the Domestic Homicide Review process since the legislation was introduced in 2011 and has been an active panel member in many reviews since that date. Shafick has overall responsibility for the Kent and Medway DHR process on behalf of the Community Safety Partnerships. Shafick has a master's degree in forensic psychology and is a White Ribbon Ambassador.

Andy Jackson, Forward Trust

Andy Jackson is a Care Quality Commission (CQC) Registered Service Manager. Andy has been employed with Forward Trust for 4 years and has been in the current role for 2 years. To be successful in his role he had to pass a fitness to practice interview with the CQC to display knowledge and skills to deliver treatment of disease, disorder or injury. Andy is responsible for the compliance and day to day operational management of the community service and has previous experience of working with children and adults that have alcohol and substance dependency. Andy also has a leadership and management qualification, along with a Level 4 substance abuse counselling diploma.

Sarah Carnell, Clarion Housing Group

Sarah Carnell is a IDVA Service Manager for the Clarion Housing Group. Sarah has worked with survivors of domestic and sexual abuse since 1996 across a range of services in a variety of roles. These roles have included rape crisis, refuge, IDVA, Senior IDVA, Adult Service Manager; currently IDVA & HIDVA service manager across north and south Kent.

Sarah has worked collaboratively with other services to bring about positive change for survivors of domestic abuse. In 2018 Sarah initiated the first hospital IDVA service in Kent. Sarah delivers training to a range of professionals about domestic abuse, including how to spot the signs of domestic abuse, how to ask safely about domestic abuse, how to respond to disclosure and how to complete the DASH (accredited Laura Richards DASH trainer).

Relevant Qualifications:

- Independent Domestic Violence Advisor (IDVA)
- Independent Sexual Violence Advisor (ISVA)
- Domestic Abuse Service Manager

Tina Hughes, Probation Service

Tina Hughes is a qualified Probation Officer with 27 years' experience working across Kent. Tina is currently the Deputy Head of Service in East Kent Probation Delivery Unit (PDU). In her current role, she is responsible for all operational sentence management delivery, the line management of all Senior Probation Officers in both sentence management and custody and manages a dedicated co-located Safeguarding Team. Tina leads on East Kent PDU investigations and complaints and is the lead Senior Manager for Kent & Medway Integrated Offender Management.

GLOSSARY

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the Overview Report are listed in the order that they first appear.

Abbreviation/Acronym	Expansion
AAFDA	Advocacy After Fatal Domestic Abuse
ARMS	Area Referral Management Service
ASC	Adult Social Care (KCC)
ATR	Alcohol Treatment Requirement
AUDIT	Alcohol Use Disorder Identification Test
CCG	Clinical Commissioning Group
CJLDS	Criminal Justice Liaison and Diversion Service
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CRU	Central Referral Unit
CSP	Community Safety Partnership
DA	Domestic Abuse
DARA	Domestic Abuse Risk Assessment
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
DVPN	Domestic Violence Protection Notices
DVPO	Domestic Violence Protection Orders
EKHUFT	East Kent Hospitals University NHS Foundation Trust
FLO	Family Liaison Officer
GP	General Practitioner
IMR	Independent Management Review
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KSS CRC	Kent Surrey Sussex Community Rehabilitation Company
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MATAC	Multi-Agency Task and Co-ordination

NHS	National Health Service
NPS	National Probation Service
PSR	Pre-Sentence Report
SECAmb	South East Coast Ambulance Service
SFO	Serious Further Offence
SLDP	Specialist Liaison and Diversion Practitioner
SPoA	(KMPT) Single Point of Access
RAR	Rehabilitation Activity Requirement
RO	Responsible Officer
ToR	Terms of Reference
VIT	Vulnerable Investigation Team

Domestic Abuse Risk Assessment (DARA)

See - **DOMESTIC ABUSE RISK ASSESSMENT**

Domestic, Abuse, Stalking & Harassment (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model was agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of 29 pre-set questions will be asked of anyone reporting being a victim of domestic abuse, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

Standard Current evidence does not indicate the likelihood of causing serious harm.

Medium There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.

High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

In addition, the DASH includes additional question, asking the victim if the perpetrator constantly texts, calls, contacts, follows, stalks or harasses them. If the answer to this question is yes, further questions are asked about the nature of this.
A copy of the DASH questionnaire can be viewed here.

Domestic Abuse (Definition)

The definition of domestic violence and abuse states:

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

Controlling behaviour is:

> *a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

Coercive behaviour is:

> *an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

Multi-Agency Risk Assessment Conference (MARAC)

A MARAC is a meeting where information is shared between representations of relevant statutory and voluntary sector organisations about victims of domestic abuse who are at the greatest risk. Victims do not attend MARAC meetings; they are represented by their Independent Domestic Violence Advisor (IDVA).

There are thirteen established MARACs across the whole County which are facilitated by MARAC Coordinators employed by Kent Police. Kent Police also employ a MARAC Central Coordinator, who is responsible for ensuring that the MARACs provide a consistent level of support to high-risk domestic abuse victims. The Central Coordinator deputises for absent Administrators at MARAC meetings.

The Central Coordinator is also responsible for ensuring that the Kent and Medway MARAC Operating Protocol and Guidelines (OPG) are updated, and that each MARAC adheres to them. A further responsibility of the Central Coordinator is to provide training for MARAC members and chairpersons.

Criminal Justice Liaison and Diversion Service (CJLDS)

CJLDS provides early identification and screening of vulnerable people of all ages within the criminal justice system. The team adopts a multi-disciplinary approach consisting of nurses, social workers, a youth specialist, a speech and language therapist, consultants, psychology and support workers. The service screens for all health and social vulnerabilities that may be contributing to increased contact with the criminal justice system. The team, where appropriate, will support individuals through the criminal justice system and where eligible, provide follow up in the community to support access to services and resources to meet their identified needs. The team will make referrals to appropriate care providers when necessary and link in with existing care providers to ensure clear pathways for follow up.

Based on screening/assessment, CJLDS practitioners offer advice and guidance to police officers, Magistrates and other colleagues within the criminal justice system, to help determine the most appropriate level of support and outcome for each person.

Domestic Violence Protection Notice (DVPN)

A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency.

Appendix C

The action plan is a live document and subject to change as outcomes are delivered.

Master Action Plan

DHR:

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
1. Agencies should be aware which "Front Door" Service should be their first point of contact. Both ARMS and SPoA need to circulate their referral criteria.	KCC ASC to publicise to partner agencies how to make a referral using the Referral Process document for Safeguarding referrals which highlights pathway for all referrals.	**KCC ASC -SSU**	Oct-22	Discussion for inclusion of referral pathway in revised KMSAB PPG document accessible to all partner agencies. The safeguarding concern form went to an online version on 4th April 2022, to accompany these changes a flow chart was created explaining the referral pathways into ASCH. The Corporate Director for ASCH shared this with partner agency leads and it continues to be used as a helpful explanation for referral processes within ASCH.	**Green**	Ensure Referral pathway document shared with partner agencies to assist with making to ASC. Since April 2022 there has been a referral pathway flowchart. This pathway has been directly forwarded by KCC ASCH to leaders in partner agencies and continues to be used, for example, at a recent Registered Managers Conference for Providers the referral process was used in discussions with colleagues.
	KMPT SPoA Managers and Comms team to ensure criteria and role of the service is shared.	**KMPT, Service Managers and Comms Team**	Complete.	In May 2022 KMPT's "front door" has been transformed and renamed , it is now called The Mental Health Urgent Helpline, information and referral criteria where circulated internally and externally.	**Green**	The outcome would be that appropriate referrals are received- referrals are aware of the role and criteria for the service. Audits to be used as a toll for measuring.

2. GP practices should ensure they have robust processes in place to ensure that when information from other agencies directs an action for primary care that these requests can be promptly actioned. This should include the acknowledgement to referring agencies when a requested action cannot be met due to non-engagement	KMICB will seek confirmation such measures are in place by the completion of the Primary Care safeguarding benchmarking tool.	**NHS Kent & Medway ICB**	Dec-22	Note has been made through out this action plan to change KMCCG to KMICB in line with new organisational name change following implementation of the Health and Care Act 2022). The bench marking toolkit sent to practice for completion. The completed bench marking toolkit was shared with the ICB on 19/12/2022 .	**Green**	A completed benchmarking toolkit that provides assurance of the practice safeguarding processes is shared with KMCCG designates for review update Novemeber 2022: The practice have been provided with the benchmarking toolkit and are currently undertaking completion. Offer of support has been provided by the ICB safeguarding team. The request to complete this was shared within a reflective session presentation which is shared below. Update May 2023 . The completed bench marking toolkit was shared with the ICB on 19/12/2022 the self assessment set out processes the practice undertake to address the statutory safeguarding responsibilities for primary care including information sharing.
	KMICB will provide a reflective session to the named GP practice in this review including management of referral processes	**NHS Kent & Medway ICB**	Jan-23	To be produced and sent out via the September comms update.	**Green**	Provision of a reflective session to the practice evidence provided via slides or available minutes. : Update Novemeber 2022 : a pre meet was arranged to discuss the delivery of a reflective session with the practice manager and this was held on the 27/9/2022 , with the reflective session being held at the practice on the 6/10/2022 - presentation provided as supported documentation.
	KMICB will provide information in the primary care bulletin around the need for practices to have robust processes in place for managing information from other agencies which directs an action for primary care and the need to inform referring agencies when a requested action can not meet due to non engagement	**NHS Kent & Medway ICB**	Jan-23	Primary care bulletin provided in January 2023 which covered a training offer to primary care which included effective communication and active signposting as well as long-term conditions patient recall.	**Green**	Provision of the primary care bulletin. November update : due to flow of information from reviews this message has been delayed and will be provided in January 2023 and further shared a training film for healthcare professionals working in primary care to recognise when a patient in their care has a common mental health problem, and to know what to do next http://www.southeastclinicalnetworks.nhs.uk/common-mental-health-problems/

3. The police CRU should review their current procedures for facilitating Safeguarding Referrals to Health Care Professionals where these have not been assessed as 'High Risk' in a DARA Risk Assessment	CRU will work with internal partners (ITF) to conduct a review on the current process for officers making referrals for vulnerable adults.	**Kent Police**	Sep-22	Review to be completed.	**Green**	Kent Police following consultation with partners have developed a new referral process. Following the successful pilot and full evaluation this will now golive on 09/01/2023.
	CRU team and ITF as part of the above will create a process and staff training to ensure cases are able to be prioritised in an efficient manner.	**Kent Police**	Dec-22	1) Process to be developed. 2) Training to be designed. 3) Training to be delivered. 4) Process to go live.	**Green**	Training has commenced with all frontline staff through live training sessions with the project lead. 14 sessions through November and a further session in December will capture all LPT officers during their designated training sessions as well as other divisional staff. This is a comprehensive training package focussing on why it is so important to capture the detail and ensure this is recorded particularly around the AWARE principles. Porfessional curiosity training will be provided separately through January to enhance the principles and understanding further. The process will be launched 9th January 2023. There is further guidance a support through training guides and SPOC's as well as Q &A sessions that will be available through December and January. For those officers unable to attend the live sessions. Develop Me package is also being developed for new officers, refresher training purposes etc.
4. The threshold for GP summary referrals should be reviewed and due consideration given to including attendance at domestic abuse and/or alcohol dependent patients.	SECAmb does not have a documented inclusion and exclusion criteria set out for cases where a GP summary must be completed. GP summaries are completed based on individual clinician's assessment of a patient on a case by case basis. Please note, a GP summary is simply for passing on helpful information when a clinician wishes a surgery to be aware of a situation. It is not a formal referral process that includes transfer of care. To be included in the regular learning update disseminated Trustwide: Following a recommendation from a recent Domestic Homicide Review, please can we encourage all clinicians to maintain a low threshold for making a GP summary, particularly when attending a patient who lives with alcohol dependence and/or may be a victim of Domestic Violence and Abuse. This cohort of patients are often vulnerable and may not be engaging	**SECAmb**	31/03/2022	Completed	**Green**	Learning disseminated across the Trust via email to network of Safeguarding Advocates for sharing with staff and added to noticeboards

5. CJLDS practitioners should be encouraged to refer disclosures of auditory hallucination to Registered Practitioners or at least consult with them to get the necessary professional advice	CJLDS Managers to provide training sessions to staff not registered and unregistered practioners on procedures to take when patients disclose auditory hallucination. Training to emphasis on unregistered staff to consult /refer on to registered staff, and registered staff to sign post to services who can address the need. Training to be formal as well as on going in team meetings and supervision.	**CJLDS management (KMPT)**	30/09/2021	Training was offered to SPoA and CMHT and extended to other staff who expressed interest when training sessions were advertised.	**Green**	CJLDS managers delivered training trust wide in 2021. Sessions were offered over a 6 month period (June to November) – 6 sessions – 2 hours in length was offered. The average attendance per session was 60%, with one session being over booked. Each session could have maximum 30 people. Safeguarding Champions also had a training sessions. The approximate total number of staff trained were about 150. A varied range of staff attended - from support staff (Health care assistants etc), allied professionals, psychologist, doctors, training and other support management staff. Staff were from in patient as well as community teams an support ancillary teams. Feedback included staff acknowledging that the training was informative and enabled them to understand roles and responsibilities of CJLDS staff as well as the difference between Mental health assessments and the vulnerability screening assessments/ tools used by the CJLDS practitioners. Plans for more training sessions to be offered in the future- no time specified yet.
6. The current referral pathway for Alcohol Treatment Requirement/Drug Rehabilitation Requirement needs to be reviewed. This will include Information Sharing Agreements with key Statutory Partners to obtain information and intelligence to manage risk assessments and facilitate Safeguarding protection for service users' families.	The Forward Trust to implement a digital organisational referral form which can be accessed by The Forward Trust website.	**The Forward Trust**	13/06/2022	Development of a digital referral form. Communication to Administration teams on how to process digital referrals. Implementation of digital referral form on organisation website. Communication to Probation Services on completing new referral pathway.	**Green**	Increase in risk management information being received from Probation services due to digital referral form requiring information to be submitted before being able to proceed to the next stage of the referral form.

7. The Dual Diagnosis assessment process should be reviewed, and a Multi-Agency Pathway developed (in conjunction with substance abuse experts)	Multiagency pathway to be developed for co-occurring conditions. Joint working with substance misuse services to develop a county wide protocol. Flow chart to be included within the protocol to support clinical staff with their decision making	**KMPT- Head of Service –Community Recovery Specialist Services (Rehabilitation, EIP, Specialist PD Service & Hospital Liaison)**	30/09/2021	Link for Joint Working Protocol for Co-occurring Mental Health and Substance Misuse Disorders. (including flow chart) - http://i-connect.kmpt.nhs.uk/document-library/joint-working-protocol-for-co-occurring-mental-health-and-substance-misuse-disorders/284	**Green**	Circulation to staff members and partnering agencies. JointWorkingProtocolCooccuringCond
	The Forward Trust in Canterbury to established a co-occurring conditions pathway with KMPT to offer joint clinical appointments to service users who present with substance misuse and mental health complexities to ensure a joint care coordination. The Forward Trust engage with KMPT through weekly screening meetings to ensure a wraparound of support is provided at the earliest opportunity. Joint clinical appointments are provided by a Forward Trust psychologist consultant, recovery worker and KMPT Community Psychiatric Nurse.	**The Forward Trust**	Complete.		**Green**	
8. More effective multiagency working through stronger risk assessments and training for practitioners will identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm. This can be achieved by a multi-agency seminar with key partners to discuss and explore alternative strategies and best practice to tackle this relatively small cohort of hard-to-reach people.	Programme of work to embed joint working co-occurring conditions protocol into practice	**KCC Public Health**	Sep-23	Alcohol Change UK working with us to develop a mental health intervention for all front line workers in substance misuse and mental health. We have had extensive round of training happening for front line workers for legal literacy for cognitive impairment as a result of co-occurring conditions.	**Amber**	
	A seminar to be delivered to support joint working co-occurring conditions protocol	**KCC Public Health**	TBC/Dec-23	New staff member leading on seminar is to start in post from 10th April.	**Red**	

Home Office

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Cllr Michael Hill OBE,
Kent County Council
Sessions House
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Maidstone
ME14 1XQ

27 November 2023

Dear Cllr Michael Hill,

Thank you for submitting the Domestic Homicide Review (DHR) report (Louise) for Kent and Medway Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25th October 2023. I apologise for the delay in responding to you.

The QA Panel finds that the review feels honest and transparent, with the family's contributions providing an insight into the victim as a person and giving her a voice. The review displays a good level of understanding of domestic abuse and coercive and controlling behaviour, and the impacts of alcohol and mental health issues within an abusive relationship.

The QA Panel found that the review has identified relevant learning and made some useful recommendations. The review has identified some important learning and has identified specific areas for agencies to improve, for example in Section 18, where it mentions identifying a few organisations that have not been following their own policy and procedures. The Panel commended the use of research to support the analysis.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- There are some suggestions of victim-blaming in places. For example, in section 14, where the report states that the victim did not want further help. The term 'toxic trio' is also used in the report which is not appropriate as the term is outdated.

- There do not appear to be any recommendations regarding Clare's Law and multi-agency risk assessment conferences (MARAC) for Kent Police.

- The analysis in section 16 does not specifically address the Terms of Reference and is set out per agency. This makes it repetitive and unnecessarily lengthy.

- The front title page needs to show the month as well as the year of death.

- There is no preface to the report.

- The sentencing date in section 1 should be removed to preserve anonymity.

- Section 5 identifies the link between alcohol dependence and domestic abuse and that it is well established. It would be helpful if more research to support this could be included.

- GP practices should need robust processes in place to ensure that when information from other agencies directs an action for primary care that these requests can be promptly actioned. This should include the acknowledgment to referring agencies when a requested action cannot be met due to non-engagement.

- There is no mention of the independence of Panel members.

- The report needs to be more specific in identifying which protective characteristics are relevant to the case.

- It is unclear why a Mental Health Homicide Review was not conducted. it would have been helpful to understand the decision making regarding this.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel