Domestic Homicide Review

George

September 2019

Overview Report

Author: David Pryde

Commissioned by: Kent Community Safety Partnership

Medway Community Safety Partnership

Review completed: 1st November 2022

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CONTENTS

1 Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and the support given to George, a resident of Kent, prior to his death.

1.2 In September 2019 the police were advised of a disturbance involving members of the homeless community in a town in Kent. Due to limited emergency response resources and other urgent outstanding calls, the police did not attend.

1.3 Early the next morning the police were contacted by a member of the public reporting the body of a male lying motionless on the ground. The police attended and located the body of George. It was evident he had suffered severe trauma injuries to the head, back and chest. George was pronounced dead at the scene.

1.4 Mary (a former partner of George) and Andy (a known associate) were also at this location. Both were arrested and subsequently charged with murder. They were found guilty at Crown Court, and each sentenced to 19 years imprisonment.

1.5 This DHR examines the involvement that organisations had between February 2018 and September 2019 with:

Name (Pseudonym)	Gender	Relationship to deceased	Age Range	Ethnicity
George	Male	Deceased	50-55	White other
Mary	Female	Perpetrator	45-50	White British
Andy	Male	Perpetrator	30-35	White British

1.6 The rationale for this timeframe can be found in paragraph 12.1.

1.7 The key reasons for conducting a Domestic Homicide Review (DHR) 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 these lessons are within and between organisations, how and in what timescales will these 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.

f) Highlight good practice.

1.8 This review began on the 05 November 2019, following a decision by the Kent Community Safety Partnership that the case met the criteria for conducting a DHR.

1.9 The review has been delayed by the disruption caused by the COVID-19 pandemic. Specifically, the Crown Court trial did not commence until January 2021. However, the DHR process was conducted promptly, and any immediate learning points were actioned by the relevant organisations. The circulation of the draft Overview Report was held back until after the criminal trial had concluded.

1.10 This report has been anonymised and the personal names contained within it are pseudonyms which were agreed by George's mother. This does not include the names of the DHR Panel.

2. Terms of Reference

2.1 The Review Panel first met on 11 December 2019 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined.

2.2 The Terms of Reference (anonymised) can be viewed at Appendix A of this report.

2.3 The following key issues were identified as being relevant to this DHR.

(i) All three subjects of this case had significant engagement with professionals over a relatively short period of time. All three at some stage seemed to have fallen off the radar as professionals found it difficult to effectively engage with them and provide any help. There is a

theme that as the subjects disengaged, a common response was to simply close the case. What rationale or risk assessment was used to support such a decision and were any additional measures considered or taken for people who are active rough sleepers?

(ii) The deceased and one of the perpetrators were the subjects of multiple Multi Agency Risk Assessment Conferences (MARACs) throughout 2019. This process will require careful review.

(iii) The deceased was a European national whose first language was not English. Both the perpetrator and victim were often drunk and uncommunicative. Was effective communication with all concerned a barrier to positive interventions by statutory agencies?

(iv) The location of this offence was spare ground in a residential area, where several homeless people had effectively become resident by pitching tents. What action did any agency take to effectively manage this situation and seek more suitable accommodation?

(iv) The police were alerted to a disturbance at the same location the deceased was subsequently found. They did not attend. Was there any form of unconscious organisational bias displayed due to the location of the disturbance and the background of the persons likely to be involved i.e. rough sleepers with a known background of alcohol abuse?

3. Confidentiality/Methodology

3.1 The findings of the Domestic Homicide Review are confidential. At the beginning of the meetings of the review panel, attendees were reminded of the confidentiality agreement. All panel meetings took place over Microsoft Teams due to the COVID-19 Pandemic. The information supplied throughout the review process was only available to those participating in the review and their line managers. The DHR report remained confidential until approved by the Home Office Quality Assurance Panel and their permission to publish was received. Dissemination is addressed in section 9 below.

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

3.3 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 George, Mary or Andy during the period covered by the review.

3.4 Each IMR was reviewed by all members of the DHR Panel and the opportunity to clarify or seek further information was taken at an IMR Review Panel Meeting held on 04 November 2020.

4. Involvement of Family

4.1 George came to this country from Eastern Europe to seek employment as a qualified tradesman. George and an older brother established a successful business in the Midlands, but when the business faltered during the 2008 recession, this partnership dissolved, and George relocated to Kent. His brother left the UK. George was divorced and has two adult children, neither of whom are resident in this country. George's mother resides in Europe and does not speak English. George was not in contact with his ex-wife or children but did stay in touch by telephone with his mother.

4.2 Contact with George's mother was made via the police Family Liaison Officer (FLO) and a letter of introduction, and the Home Office DHR explanatory leaflets, translated into the appropriate language were supplied. The availability of the Independent Advocacy Service AAFDA (Advocacy After Fatal Domestic Abuse) was included in the information provided, along with an expression of condolence and a recognition of the impact of George's untimely death.

4.3 George's mother did not respond to the offer to take part in the process. The FLO advised this was because she was an elderly lady, who travelled extensively throughout Europe and the impracticalities of engaging with the process from abroad. It was agreed the FLO would maintain regular contact on behalf of the DHR Panel while Mary and Andy were in custody awaiting trial.

4.4 There were no other family or friends, who had any recent contact with George, that the DHR process could approach. George's immediate associates were the two perpetrators and other members of the homeless community, who were all prosecution witnesses. This community were not approached at the request of the police while the trial was pending. When a guilty verdict was given, this coincided with the COVID-19 restrictions that were in place at that time and prevented any effective engagement. The

Panel were satisfied that the Homeless Charity Representatives were able to accurately reflect any issues a homeless person had regarding the challenges of rough sleeping in general and the impact this had on accessing support services.

4.5 At the conclusion of the review, George's mother was contacted again. The FLO, having considered and contributed to several drafts of a closing letter, advised no matter how skillfully the letter was written, the content would cause more upset and grief than was necessary. The FLO believed offering a copy of the overview report would be too much detail to digest and the content would only result in adding additional distress. They recommended this needed 'a light touch' and by someone, a frail, elderly lady already knew and had built a relationship with. The FLO volunteered to be this conduit.

4.6 This advice and offer of help was accepted. George's mother was provided with a very brief update by the FLO via bi-lingual family friends. These friends supported the view providing a copy of the report would be upsetting. They explained George's mother was fully aware of the circumstances George had been in and was saddened by this.

4.7 A check was made that the proposed pseudonym of George would not cause any unintended offence. George's mother agreed this was a suitable name to use.

4.8 A letter of thanks was sent to the police Senior Investigating Officer (SIO) to acknowledge the significant contribution and assistance their FLO had provided the Panel and Chair.

4.9 Consideration was given as to whether contact should be made with Andy and/or Mary and what possible benefit this could bring to this review process. It was concluded this would not be appropriate in the circumstances. Both were still blaming each other and had made no admission of guilt or statement of regret.

4.10 Following feedback from the Home Office Quality Assurance Panel, contact was made with the Prison Service to ascertain if Mary or Andy would be prepared to help with this DHR. This was to seek their views on what could have been reasonably done or what action should be taken in the future to prevent this happening again. Unfortunately, contact was not possible at the time.

5. Contributing Organisations

5.1 The following organisations were asked to prepare and submit of an IMR:

- Kent and Medway NHS Clinical Commissioning Group (CCG) **Now the Integrated Care Board (ICB)**
- East Kent Hospital University Foundation Trust (EKHUFT)
- Kent Surrey Sussex Community Rehabilitation Company (KSS CRC)
- Kent Police
- Kent County Council (KCC) Adult Safeguarding
- Criminal Justice Liaison and Diversion Service (CJLDS) and Kent and Medway NHS and Social Care Partnership Trust (KMPT)
- District Council
- Porchlight
- Oasis

5.2 In addition to the IMRs, Victim Support and the MARAC Central Co-ordinator provided updates of information held by them on George, Mary, and Andy.

6. Review Panel Members

6.1 The Review Panel was made up of an Independent Chair and representatives of the organisations identified at paragraph 5.1 above. It also included a member of the Kent County Council Community Safety Team and a Domestic Abuse Specialist.

Panel Members	**Job title**	**Representing Organisation**
Kirsty Edgson	Designated Nurse for Safeguarding Children	NHS Clinical Commissioning Group (CCG) - **Now the Integrated Care Board (ICB)**
Sally Hyde	Safeguarding Lead	East Kent University Hospital Foundation Trust (EKHUFT)
Emma Vecchiolla	Assistant Chief Probation Officer	National Probation Service and Kent, Surrey and Sussex Community Rehabilitation Company
Eleanor Miller	Detective Inspector	Kent Police

Catherine Collins	Adult Strategic Safeguarding Manager	Kent Adult Social Care
Zoe Baird	Specialist Advisor for Safeguarding Adults & Domestic Abuse Lead	Kent and Medway NHS and Social Care Partnership Trust (KMPT)
Kayleigh Jones	Community Development Officer/Domestic Abuse Lead	District Council
Charlie Grundon	Safeguarding Lead	Porchlight (Homeless Support)
Tina Alexander	Head of Operations	Oasis (Domestic Abuse Service)
David Naylor	Area Manager	Victim Support
Honey-Leigh Topley	Community Safety Officer	Kent County Council (KCC)
David Pryde		Independent Chair

6.2 The panel members hold senior positions in their organisations and have not had any contact or previous involvement with George, Mary or Andy, nor did they have any direct supervisory or managerial responsibility for members of staff from their organisations who did. The panel met on 11 December 2019, 04 November 2020, 28 April 2021, and 27 May 2021. All subsequent amendments to the Overview Report were agreed by email correspondence up until August 2021. There were delays during parts of the DHR process due to the COVID-19 pandemic.

6.3 The final Overview Report was completed in September 2021 and subsequently underwent a quality assurance process within the Kent Community Safety Partnership. At the same time, the Action Plan was being developed and in response to the quality assurance process, further amendments to the Overview Report were undertaken during 2022 in preparation for submission to the Home Office.

6.4 The original Panel was configured to deal with and explore the issue of rough sleeping, initially believed to be a key consideration for this review. Many of the panel members, through their primary roles, have considerable

experience and knowledge of alcohol dependence and the challenges this presents to individuals who are in this situation. This can be evidenced by the statements made in paragraph 11.7 of this report.

6.5 For completeness, whilst not members of the DHR Panel, the report was reviewed and critiqued by a KCC Public Health Commissioner responsible for commissioning Drug and Alcohol Treatment Services in Kent. A former core member[1] of Bradford Central Eastern European Migrants Forum was asked to review the report as a cultural advisor to ensure issues that arose because George came from Eastern Europe had been considered. The comments and observations made by these two "Critical Friends" have been incorporated throughout this report where appropriate.

6.6 The report was recirculated to the Panel in August 2022 to seek ratification of the comments and observations added following this consultation and quality assurance process. The amended report was further shared for quality assurance within the Kent Community Safety Partnership, with final additions to the report and the action plan made in Spring 2023.

7. Author of Overview Report

7.1 The Independent Chair and 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.

7.2 The Independent Chair spent 10 years as the strategic police lead for Safeguarding, chairing multi agency Safeguarding Boards across two Counties. This included the role of Senior Reporting Officer for all police related Serious Case Reviews in these jurisdictions. The Independent Chair commissioned and designed a new multi-agency safeguarding governance structure following the recommendations that were made by the Baby P review in 2010.

7.3 The Independent Chair has experience conducting Domestic Homicide Reviews and Adult Safeguarding Reviews, with knowledge of domestic abuse issues and a thorough understanding of the roles and responsibilities of organisations involved in a multi-agency response to safeguarding. 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.

[1] The cultural advisor has not been identified to preserve the anonymity of George.

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

8. Parallel Reviews/Investigations

8.1 Kent Police made a self-referral to the Independent Office for Police Conduct (IOPC). This organisation concluded no action was required by them or Kent Police in relation to the decision made not to respond to the report of a disturbance involving rough sleepers in September 2019.

8.2 HM Coroner recorded the cause of death as blunt force trauma to the head and neck.

8.3 The National Probation Service commissioned a Serious Further Offences Review (SFOR) following the murder of George. The findings of this internal review form the basis of the submissions made by the KSS CRC in their IMR response to this DHR.

9. Publication

9.1 This Overview Report and accompanying documents will be made publicly available on the Kent County Council website and a link to this page will be available on the Medway Council websites.

9.2 Due to circumstances outlined in Section 4 (Involvement of Family Members and Friends), the Panel with advice from the FLO, who had built up a relationship with George's mother, decided that the family would not be contacted regarding the completion or publication of the review. This was to prevent any further harm and distress to George's mother.

9.3 Further dissemination will include:

a. The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Clinical Commissioning Group (**now the Integrated Care Board (ICB)** and the Office of the Kent Police and Crime Commissioner amongst others.
b. The Kent and Medway Safeguarding Adults Board.
c. The Kent Safeguarding Children Multi-agency partnership.
d. Additional agencies and professionals identified who would benefit from having the learning shared with them.

10. Equality and Diversity

10.1 The nine protected characteristics under the Equality Act 2010[2] were reviewed and due consideration given as to whether or not these were applicable. This was benchmarked against the doctrine of intersectionality[3] and that the Panel should consider *"everything and anything that can marginalise people"*.

10.2 George was from Eastern Europe and not fluent in English. George was alcohol dependent (self-admitted) and a rough sleeper. George was a perpetrator of domestic abuse and a victim of domestic abuse. Thus, there were multiple aspects of intersectionality at play which meant George may have not received or had access to the support from agencies and organisations.

10.3 While there were some difficulties in effective communication because of the language barrier, there was no evidence this then manifested itself into deliberate, indirect, or unintentional discrimination towards George based on race.

10.4 The Eastern European community in Kent is well established, a legacy from a significant influx in 2004 when several former Communist Nations joined the European Union. There is a view that this section of the community is becoming more integrated with mainstream society through the passage of time. The cultural advisor felt there must have been some unconscious bias because of George's Eastern European heritage and that Eastern European people had always been victims of institutional discrimination in the UK.

10.5 The Panel did not feel able to challenge this viewpoint. There may well have been some unconscious bias by agencies because of George's ethnic background, but there was nothing immediately obvious to the panel members to evidence this.

10.6 The Panel discussed at length the complexities of this case which included issues such as rough sleeping, the added confusion of being both a victim and perpetrator of domestic abuse, the cycle of an unhealthy abusive relationship, alcohol dependency and being a male victim of domestic abuse.

[2] Equality Act 2010, Section 4
[3] Intersectionality, explained: meet Kimberlé Crenshaw, who ...

10.7 The Panel acknowledged the actions previously taken by the various organisations concerned the protection of Mary from George. It was recognised George was also a victim of domestic abuse, following acts of violence committed by Mary. There was a general feeling this was a feature that did not resonate with agencies at the time and the focus was to protect Mary.

10.8 The Panel sought reassurance that male victims of domestic abuse did have support services available to them in Kent. It has been confirmed this is the case via Men's Advice Line (https://mensadviceline.org.uk) and also the Kent and Medway Domestic Abuse Services website (https://www.domesticabuseservices.org.uk).

10.9 However, it was noted that while these services would have been available to George, he may not have accessed them or known about them due to the potential language barriers and some cultural inhibitions about admitting being a male victim of domestic abuse. It is a learning point for all organisations that there are bespoke specialist support services available to members of ethnic minorities and these should be offered in appropriate circumstances. In this case a referral to the Eastern European Charity BARKA[4] would have been helpful to mitigate any cultural barriers.

10.10 This view is supported by research conducted into several DHRs and SCRs where the victims were all from Eastern Europe. This was undertaken by a student of Police Studies at Liverpool John Moore's University, who is also serving officer with Merseyside Police[5]. This review concluded language and culture did have a significant role to play in the victims' engagement with statutory and third sector agencies. This research has not been formally published but can be made available.

11. Background Information

11.1 George was homeless or more accurately a rough sleeper for a substantial period covered by this review. Except for the time he spent in prison, George was sleeping in the open for all of 2019. George was known to agencies from around 2010 but did not engage with or actively seek help from them. The reasons for this disengagement are not known, but the comments at paragraph 10.10 above do provide some insight as to why this may have been the case.

[4] Barka UK charity based in London.
[5] The author has not been identified to preserve the anonymity of George.

11.2 A homeless person can have a place to stay, for instance, living with relatives temporarily, 'sofa surfing' with friends, taking a place in a night shelter or other place of refuge. A rough sleeper has no fixed address and all agencies do not recognise a street corner or alleyway as a permanent address[6]. George was alcohol dependent (self-admitted)[7] and in an "on/off" relationship with Mary. George was both a perpetrator and victim of domestic abuse involving Mary.

11.3 Mary was a rough sleeper for most of the time this review covers. She did stay in hostels or other emergency accommodation at various times following physical assaults committed against her by George. Mary had a long history and association with many of the agencies contributing to this process. A consistent factor with these agencies was one of dis-engagement after initial contact. Mary was both a victim and perpetrator of domestic abuse involving George. Mary was alcohol dependent (self-admitted). Mary has four adult children, all of whom were removed from an early age and were looked after by their maternal grandmother. There has been no contact with them for a significant period.

11.4 Andy was a rough sleeper in the three months immediately prior to the murder. Andy was a frequent user of alcohol and known to the various criminal justice agencies. Andy had a history of domestic abuse as a victim and perpetrator with intimate partners. The exposure to the various organisations taking part in this review was limited in terms of Safeguarding. Andy is included in this process because of his conviction for the murder of George.

11.5 All three subjects in this review belonged to a small community of 8 to 12 individuals who were street drinkers and rough sleepers**.** This group of people frequented a town centre in Kent that did have the facilities and capabilities to assist homeless people.

11.6 George and Mary were unable to take advantage of the support offered to them and had no other option but to sleep rough. This outcome would have been influenced by their exclusion from possible support because of their behaviour and services not being equipped to meet their needs. By this, I mean they behaved in such a way that this automatically excluded them from securing support from many services. (George and Mary could be aggressive, uncooperative, and violent). This is a dilemma that professionals face regularly. Individuals do make decisions that are not in their best interests and these

[6] What is sleeping rough?
[7] See Appendix C, page 68, for an explanation of 'self-admitted'.

decisions do have to be respected. Unless there are issues of mental capacity, there are no interventions that can be imposed on an individual against their will. There were no identified concerns about the mental capacity of George or Mary. They were still open to outreach support but that did not address their real need to secure accommodation.

11.7 For many people who are suffering with addictions the issue of choice is taken away from them[8]. Addiction is a disorder that is complex (although not a disability under the Equality Act). Individuals experience compulsions for the addiction despite the serious health and/or social consequences this may bring. The Panel felt it would be wrong to label people with addictions as having the freedom of choice. This view resonates with a recent best practice guide by Prof. Preston-Shoot on Adult Safeguarding and Homelessness[9]. Consequently, comment has been restricted to statements of fact and no judgement made about choice. There is also a view that a good approach in trying help people in this situation is to adopt a trauma centred approach. Rather than dealing with the problem of addiction, identify and deal with the issues that are driving the addiction. This is a sensible approach to take and to some extent this was explored with Mary when she sought help and was considering a reconciliation with her estranged children. A trauma centred approach is now being promoted in Kent and Medway by Adult Social Care[10] as best practice and as recommended by Prof. Preston-Shoot in his practice guides.

11.8 An observation was made that the lifestyle George and Mary had and their inability to access services because of this, has identified possible gaps in the provision of services. This may be true, but it is interesting to note that during the COVID-19 pandemic, special measures were brought in to protect the homeless during this crisis and previous rough sleepers in this area were provided temporary accommodation in hotels[11]. While this does remove a significant barrier in accessing support services, it does not guarantee support services will be able to successfully engage, but it does open the door to this being a possibility.

11.9 The rough sleepers based themselves on spare ground in a residential area. They erected tents and makeshift shelters to protect themselves from the elements.

[8] Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews
[9] https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice
[10] https://www.kent.gov.uk/social-care-and-health/information-for-social-care-professionals/space-matters
[11] https://www.local.gov.uk/publications/lessons-learnt-councils-response-rough-sleeping-during-covid-19-pandemic

11.10 There was a conscious decision by the relevant authorities locally not to actively intervene with this arrangement. While not ideal, it was a location that was manageable in terms of reducing the potential of risk and harm to the rough sleepers from others outside of their community[12]. A fixed location meant agencies and support charities could actively engage with their clientele and provided an opportunity for regular contact to be maintained.

11.11 When the "on/off" relationship, as described by various outreach professionals, between George and Mary started is difficult to determine. Mary moved to the area in May 2017, so it would be any point after that a relationship could have formed. By February 2018 both were recognised to be partners through their association as street drinkers, although it is not clear if they were co-habiting in the flat George had access to in 2018.

11.12 As will be seen further on in this report, Mary made multiple allegations of assault against George, several of which led to convictions and/or remands in custody. While not reflected in charges, the nature of the assaults was violent. It normally involved multiple strikes to the head or grabbing Mary by the throat and throwing her to the ground. There was an allegation of attempted strangulation, but this allegation was withdrawn. This was prior to non-fatal strangulation becoming a substantive offence[13]. Mary consistently, as did George, declined to support any prosecution.

11.13 What was also consistent were the DARA risk assessments. Every encounter reported was assessed as high risk and generated a MARAC referral. There was a recognition of how volatile George could be when drinking and that Mary was even more vulnerable when she had also been drinking. The DARA assessments recognised that George could be coercive and controlling, although this was not taken forward because Mary declined to make a complaint. Mary complained on several occasions that George was always asking for money to buy alcohol. It is not known if this was the catalyst to assault Mary if there was no money to give, but this is sufficient to suggest Mary was a victim of economic abuse[14].

11.14 Mary and George had a history of using violence towards others and both had served prison time for these offences. Bar one occasion, the incidents of violence in this relationship were all one way. Mary was therefore more often the victim in the relationship. Mary remained in the relationship. This is

[12] Porchlight Rough Sleeping Video https://www.youtube.com/watch?v=voyOJtNs34Q
[13] New non-fatal strangulation offence comes into force.
[14] Surviving Economic Abuse: Transforming responses to economic abuse

not uncommon. There are many reasons why women maintain an abusive relationship[15]. Alcohol dependency and being homeless would have been significant influencing factors, but the only person who can offer any insight into why this relationship or association was maintained, is Mary.

12. Chronology

12.1 The time frame for this DHR is between 01 February 2018 and the date of George's death. George and Mary have records going back almost a decade but, in both cases, there are large gaps in these records, sometimes stretching years. This period was selected as the nearest point where there was evidence that George and Mary were partners and were part of a small group of people, some of whom were homeless, who were street drinkers and frequented the town centre.

12.2 In February 2018 Mary was spoken to by a patrolling Police Community Support Officer (PCSO) who noticed Mary had bruising around the eye. Mary alleged George had been violent the previous week when they were both drunk. A Crime Report was raised but no further action taken as Mary did not want the police to pursue an investigation.

12.3 In March 2018 Andy was accused of assaulting a former partner's new boyfriend and arrested. There was no corroborating evidence and witness accounts supported Andy's version of events. No further action was taken.

12.4 Andy was referred to a health practitioner whilst in police custody following a reference to the custody sergeant to self-harm. The health practitioner attempted to build a rapport, but Andy did not engage. Andy stated he was of *"sound mind and happy".* The support worker concluded there were no concerns around mental health wellbeing or vulnerability.

12.5 Later the same day Andy telephoned the police Control Room and stated he felt suicidal and at risk of self-harm. The police provided the appropriate advice and contacted the 'on call' Community Mental Health Team (CMHT). In consultation with the CMHT, the police agreed this team were best placed to offer the appropriate help and support. The 'on call' CMHT made several attempts to contact Andy that evening by telephone, but Andy did not answer. Further attempts were made by the 'on call' team the next day to contact Andy. When these were unsuccessful (Andy was not answering his mobile), the matter was passed to the local Community Mental Health Team.

[15] Why don't women leave? - Women's Aid

12.6 The local CMHT staff tried to make contact by telephone and left several messages on voice mail. A visit was made to Andy's last known address and a letter left requesting Andy get in touch. Various additional attempts were made to reach out to Andy culminating in a decision to discharge the referral in May 2018 following no response to their multiple requests to get in touch.

12.7 In May 2018 Mary was admitted to hospital for 24 hours suffering from dehydration and alcohol withdrawal. It was noted Mary was homeless.

12.8 George was admitted to hospital following a visit to the local GP. George was treated for a bleeding ulcer and discharged four days later.

12.9 Mary attended the local hospital at the end of May 2018 feeling generally unwell. Mary admitted drinking 15 cans a day but had cut down to 3 in the last two weeks. Mary had presented with swollen legs up to the knees and blisters. Mary was treated with diuretics to reduce a body fluid overload and given supplements to address a lack of vitamins.

12.10 Mary was discharged after five days of treatment. The South East Coast Ambulance Service (SECAmb) crew taking Mary home from hospital were worried about the risk of self-neglect and raised their concerns with Adult Social Care (ASC) when Mary asked to be dropped off in the town centre rather than being taken home. (At this time Mary had access to George's flat). This referral was risk assessed and after several attempts to contact Mary on her mobile phone, no further action was taken.

12.11 In June 2018 Mary was arrested and charged for being drunk and disorderly in a public place.

12.12 In July 2018 Mary made an allegation of assault (by strangulation) and harassment against George, who was arrested, interviewed and bailed with conditions not to contact Mary. Mary subsequently provided a retraction statement and the case was discontinued. A Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) Assessment, graded as high, was completed and a Multi-Agency Risk Assessment Conference (MARAC) referral made.

12.13 In August 2018 Mary approached a Police Officer and asked for emergency accommodation because she was being regularly assaulted and abused by George. Mary was invited to attend the Police Station nearby, but did not turn up.

12.14 Twice in September 2018 Mary and George were detained together for shoplifting. On both occasions the shop owners declined to support a criminal prosecution and sought redress through a civil remedy. (The value of goods stolen on one occasion was £3).

12.15 In November 2018 Mary disclosed further assaults by George to a PCSO. George was arrested, interviewed and released under investigation. Mary planned to stay at local hostels as George was banned from these premises. A DASH assessment was completed and graded as a high risk, resulting in an automatic MARAC referral.

12.16 Within days both Mary and George were seen frequenting the town centre together. (George was not on police bail and therefore, there were no conditions in place to prevent this association).

12.17 In December 2018 Mary was arrested for being drunk and disorderly.

12.18 In January 2019 Mary reported another allegation of assault. George was arrested, charged and remanded into custody for this assault and the offence reported in November 2018. The DASH assessment was graded as high, and a further MARAC referral made.

12.19 George entered a guilty plea at court and was sentenced to a 12-month Community Order which included 150 hours unpaid work. (For the offences at paragraph 12.18).

12.20 On the same day, at the same court, Mary entered a guilty plea to being drunk and disorderly (paragraph 12.17). Mary was sentenced to a 12-month Community Order with a 9-month Alcohol Treatment Requirement (ATR) and a 15-day Rehabilitation Activity Requirement (RAR).

12.21 In February 2019 George received a final warning for failing to comply with the unpaid work order.

12.22 Mary was served a warning letter about abusive conduct towards staff after attending a substance misuse clinic. The letter advised Mary would not be able to access this support service if this behaviour continued.

12.23 In February 2019 whilst sleeping rough in disabled toilets, Marys mobile phone and personal possessions were stolen at knife point. At the same time George was assaulted by persons unknown. This was reported to the police. No suspects were identified.

12.24 In March 2019 Mary received a tent from a homeless outreach agency to facilitate a relocation to where other rough sleepers slept together for safety reasons. This was confirmed by a police intelligence report that noted both Mary and George were now living in a tent at this location.

12.25 Mary later advised the CRC Responsible Officer that George was sleeping in a separate tent and that they were no longer together as a couple.

12.26 Andy was arrested in March 2019 on suspicion of assault. It was alleged Andy scratched the neck of the victim with a knife. No further action was taken as the witnesses were deemed unreliable and there was no supporting evidence.

12.27 Mary was arrested in April 2019 after entering a charity shop in an intoxicated state, spilling beer over items on display and trying to remove clothing from the premises, verbally abusing the staff in the process. Mary was charged and released on bail.

12.28 A few days later Mary collected a Social Security voucher for £288 and cashed it. Both Mary and George went on a drinking binge. During the early hours of the following morning, Mary woke in her tent and discovered the remaining cash had gone missing. Mary also had facial injuries and blamed George for the assault and theft of cash. A MARAC referral was made following a DASH assessment graded as high. George was arrested but Mary declined to support a prosecution.

12.29 Later the same month police arrested George. Mary alleged George had punched her in the face. George was charged and bailed with conditions. Mary was provided with emergency accommodation.

12.30 Mary was relocated outside the immediate area and although unhappy with the new location, Mary had significantly reduced the amount of alcohol consumed and was engaging with a Homeless Outreach Worker.

12.31 In May 2019 an allegation was made to the police that Andy had kicked and thrown stones at a dog, causing the animal distress and injury.

12.32 Andy was arrested and whilst in custody was referred to the CJLDS for a vulnerability assessment following a self-reported 'split personality disorder' to the custody sergeant. Andy was unkempt in appearance with messy hair, beard and dirty clothing. Andy was calm in demeanour and polite but declined to engage. There were no acute signs of mental instability noted by the Support Worker.

12.33 George was arrested in May 2019 for shoplifting and a breach of bail conditions (not to contact Mary). George was charged and remanded to prison custody.

12.34 Mary attended a scheduled meeting with the CRC Responsible Officer and ATR Support Worker. Mary was now back in the local area in temporary accommodation. Of significant note was that this was the first afternoon meeting Mary had turned up sober.

12.35 In May 2019 Andy and his partner were arrested for assaulting each other. Both declined to support a prosecution and the investigation was discontinued. DASH assessments for both were graded as medium.

12.36 A week later Andy alleged he was assaulted by his partner. Andy refused to support a prosecution or complete a DASH assessment. No further action was taken.

12.37 Mary attended a scheduled meeting with the CRC Responsible Officer in June 2019. Mary presented as clean and sober and advised she intended to seek professional help for depression and anxiety. The CRC sent a pre-sentence note to the effect that Mary was engaging successfully with various support agencies and actively managing her alcohol dependency. This intention is supported by the interactions with Oasis where Mary indicated a willingness to change. The note recommended for the pending court appearance that a custodial sentence would be detrimental to the progress Mary had made on the rehabilitation journey.

12.38 In June 2019 George was released from prison custody after the case was discontinued.

12.39 Mary did not attend a scheduled Magistrates' Court Hearing and received a 12-week custodial sentence in her absence. (This was for the offences at paragraph 12.27).

12.40 In the same month Andy and another unknown person pulled a male rough sleeper from a tent, assaulted him and stole property. Andy was arrested, but the case was discontinued due to evidential difficulties.

12.41 Andy was referred by the Homeless Outreach Centre to the Community Mental Health Team. Andy had disclosed to them (the Outreach Centre) thoughts of self-harm and that there was *"another person living in his head".* Andy had no control over this person and often found himself in police custody with no idea how he had got there.

12.42 The CRC Responsible Officer for George instigated breach proceedings for not responding to the reporting requirements for the ATR court order.

12.43 Mary was arrested on warrant for not attending court. (See paragraph 12.39).

12.44 Mary appeared at Magistrates' Court via video link from prison. Based on the information provided by the CRC Responsible Officer (at paragraph 12.37), the Magistrate rescinded the original custodial sentence and replaced it with a suspended sentence order (12 weeks imprisonment) and an alcohol treatment order. Mary was released from prison custody immediately.

12.45 Mary did not attend a scheduled appointment with the CRC Responsible Officer. Mary phoned and stated that she was in hospital and would be there for a week. (No record of any hospital admission was found).

12.46 Mary and George were arrested for assaulting each other. They were heavily intoxicated at the time of their arrest. Both were interviewed and would not support a prosecution against each other. Based on compelling CCTV evidence, Mary was charged with common assault on George. A MARAC referral was submitted following a DASH assessment graded as high on behalf of George and Mary.

12.47 In July 2019 Andy did not attend the scheduled mental health assessment with the Psychiatrist arranged by the Community Mental Health Team following the referral to them. (There is considerable doubt Andy was aware of this appointment – see paragraph 13.8.9). Another appointment was made.

12.48 Mary did not attend a scheduled appointment with the CRC Responsible Officer. The same day an Outreach Worker found Mary with George in a tent. Later that afternoon, Mary attended the local Accident and Emergency Hospital and was fully examined by a GP based there. According to the records, nothing could be found medically wrong and there were no visible signs of abuse or injury. Mary was promptly discharged.

12.49 Mary contacted the CRC stating the appointment had been missed due to serious bleeding and admission to hospital that day.

12.50 Mary was arrested and charged for shouting and swearing in a public place whilst intoxicated two days later.

12.51 Andy was arrested for being drunk and disorderly in a public place and taken to hospital by the police because of breathing difficulties at 13:01hrs. Andy was abusive verbally and physically to the clinical staff, admitted to frequent crack cocaine use and refused to co-operate with the examining Doctor. He was declared 'fit to be detained' and returned to police custody at 13:51hrs.

12.52 In August 2019 Mary failed to attend a scheduled appointment with the CRC. Fast track action was taken to progress a breach of the court order(s).

12.53 A third party reported an alleged assault on Mary by George. Police attended and noted Mary had a swollen face and cuts inside her mouth. When spoken to, Mary alleged George had punched her. The DASH assessment, graded as high, led to an automatic MARAC referral. Mary later withdrew the complaint, claiming the injury was due to a mouth ulcer.

12.54 Mary was arrested for breaching the court order which had been 'fast tracked' by the CRC. (See paragraph 12.52).

12.55 On the same day, George was in police custody for the assault on Mary, reported by the third party. George was seen by a Vulnerability Practitioner who offered support to deal with the issues of homelessness and alcohol dependence. George agreed to meet the Support Worker post release at a local coffee shop.

12.56 George appeared at Magistrates' Court to answer the failure to comply with the ATR court order. The Court rescinded this order and replaced it with a 12-month suspended sentence with no conditions or orders attached. George was released.

12.57 George did not attend the meeting arranged previously with the Vulnerability Support Worker.

12.58 Mary attended Magistrates' Court for the assault on George that had been recorded on CCTV and entered a 'Not Guilty' plea (See paragraph 12.46). A trial date was set for October 2019.

12.59 In August 2019 Andy was arrested for assaulting his partner and stealing her handbag. (This was a different partner from the one referenced at paragraph 12.35). The incident was witnessed by Mary. The victim refused to support a prosecution and the investigation was closed. Andy was seen by a Vulnerability Health Practitioner whilst in custody and reminded there was a scheduled appointment for a mental health assessment with a psychiatrist the following day.

12.60 Andy did not attend the mental health assessment.

12.61 The next relevant date concerns the MARAC meeting for Mary and George. Whilst there was lots of activity by the various agencies prior to this date gathering information to service the needs of this meeting, there was no direct contact with either Mary or George since their last encounter in August by anyone to inform them of the scheduled meeting. Thus, the MARAC was not aware of what either Mary or George thought the process could do to help them and/or reduce the risk of further harm to either of them.

12.62 The MARAC focussed on the needs of Mary and glossed over the fact Mary was also a perpetrator. Both had been referred to this MARAC following the assault by Mary on George in July 2019. (See paragraph 12.46).

12.63 Post this MARAC meeting an Outreach Worker saw both Mary and George together. They noted they were both sober and appeared to be getting on well.

12.64 Shortly after this observation was made George was found dead in the circumstances described at paragraph 1.3.

13. Overview and Analysis

13.1 From the above chronology several themes can be extracted to provide a general overview.

- All three were rough sleepers, had alcohol issues and came to the attention of authorities as both perpetrators and victims of domestic abuse.

- All three were resident in the makeshift campsite in the three months leading up to George's death.

- Mary did seek help and did try to change her lifestyle. It is not known why this cooperation abruptly ceased.

- Andy avoided any form of mental health assessment.

- George did not take up offers of help from support services.

13.2 For ease of reference and as a means of a making a complex set of circumstances easier to understand, this section will analyse the role of each participating agency.

13.3 **Kent and Medway NHS CCG - Now the Integrated Care Board (ICB)**

13.3.1 This organisation supports GP Surgeries and Health Centres throughout Kent. The GP Surgery used by George was graded as 'Good' in all areas at the last CQC Inspection in 2019. The GP Surgery allocated to Mary under the special allocations scheme is now part of an amalgamated consortium of GP Practices established in May 2019.

13.3.2 George was registered at a local GP surgery and had been since 2014. George was not always homeless and according to his GP records, he had a local address for the duration of the review period. This was despite several notifications following hospital treatment reporting he was homeless.

13.3.3 George attended the practice three times between 2014 and 2019. He attended twice to have stitches removed from a head wound (it is not known how these injuries occurred) and saw a GP in May 2018 for gastric bleeding for which he was subsequently admitted to hospital for treatment. During this last visit it was noted George was not a UK citizen, an unnamed partner spoke for George and there were issues with alcohol. The two indicators of vulnerability (alcohol and language) were not flagged as such on his GP record.

13.3.4 When the GP practice was advised by the hospital that George had not attended the follow up clinics to investigate the bleeding ulcer, no action was taken. A medical note was issued by the GP in April 2019 stating 'Alcoholic' but there was no record of either a personal visit or phone consultation with a clinician. The only plausible explanation for this note is it was issued around the same time the CRC applied to the Magistrates' Court to have George's work requirement order removed.

13.3.5 In retrospect the GP practice have acknowledged George was a vulnerable adult due to homelessness, alcohol dependency and poor English. The GP Practice patients record system highlights patients who are homeless and do not have a good grasp of English. This capability has always been available, but it is now actively used. A procedure to manage non-attendance at follow up clinical visits when patients do not turn up is now in place. **(Recommendation 1).**

13.3.6 Mary was excluded from the local GP practice in October 2017 for being aggressive and abusive to staff. Mary was re-registered at another GP practice under the Special Allocations Scheme (SAS). This is a Health Centre that has facilities to protect primary care staff when dealing with violent or abusive patients.

13.3.7 There is only a small cohort of SAS patients and one surgery and many patients at the SAS surgery must travel as it covers a large geographical catchment area. In the case of Mary this would have involved a round trip of 40 miles. This could have been a disincentive to seek medical help given the personal circumstances of Mary. However, when there was a need for medical assistance, Mary called an ambulance.

13.3.8 Mary should have been contacted for an initial consultation and then seen face-to-face every six months. No initial appointment was made, nor any follow up consultations scheduled. The SAS practice have since put measures in place to ensure SAS patients (16 in total) have been seen and are subject to six-month reviews.

13.3.9 Like George, the hospital advised the SAS surgery Mary was homeless. The surgery records were not changed.

13.3.10 Mary applied to be re-registered at a local GP practice in March 2019 and was accepted but never seen. This re-registration coincided with the engagement with the CRC. There was no communication between the new GP practice and the SAS surgery because while accepted, Mary would not have been registered until after the first appointment.

13.3.11 Andy was registered at a local GP practice between 2007 and 2014. During that time, Andy did not seek any medical assistance. When this surgery closed, patients who were deemed vulnerable were automatically transferred to the new practice. Those who were not vulnerable were invited to make their own arrangements. Andy, who was in the latter category, did not register at any GP surgery or Health Centre.

13.3.12 George, Mary and Andy did not have significant contact with primary care professionals at GP surgeries. They were not supplied with, or users of, prescription drugs.

13.3.13 Despite the presence of policies for Adults at Risk, Did Not Attend notifications and language protocols at both practices, numerous opportunities were missed and had any of these policies been followed, this would have flagged both

George and Mary as potentially vulnerable. These safety nets should have triggered further follow up interventions by the GPs concerned. **(Recommendation 2).**

13.4 **East Kent Hospital University Foundation Trust (EKHUFT)**

13.4.1 This organisation manages the acute hospital and accident and emergency department for the area.

13.4.2 George attended the hospital twice during the review period. Once for the consequences of alcohol dependence, which had resulted in a bleeding ulcer. As part of the treatment aftercare plan, further support and treatment at a clinic was offered on two occasions. George did not attend these appointments. The GP was advised of George's admission, treatment and the follow up clinical support. The second visit to hospital was in police custody. George was examined, treated and discharged back to police custody.

13.4.3 Mary had four attendances during the relevant time. Mary was treated for tremors and generally feeling unwell after abstaining from alcohol for a few days. After various tests, Mary was treated for alcohol detoxification, excess fluid and vitamin deficiency. Mary was discharged three days later. It was good practice that the release from hospital contained a detailed after treatment care plan.

13.4.4 When Mary was released, a SECAmb patient transfer ambulance was arranged to take Mary to the address that had been given to the hospital on admission. Mary decided she did not want to go to this address and asked to be dropped off in the town centre. It may seem odd that ambulance staff did not drop off Mary at home, but they have no legal powers to insist a patient remains in the ambulance if they do not wish to do so. The ambulance crew had no option other than to agree to this request. They did however make a safeguarding referral to Adult Social Care. This was good practice. (SECAmb are a standalone organisation and are not managed by EKHUFT).

13.4.5 The second visit concerned a minor head injury which Mary claimed was due to an alleged assault. Mary was triaged by a Nurse and gave a home address and contact number. After waiting four hours, Mary left before any further treatment could be administered. The alleged assault was not reported to the police by either Mary or the Hospital.

13.4.6 The third visit followed the assault by George in April 2019. Mary was conveyed to hospital by the police. After being clinically assessed for an abrasion to the head a referral was made to the hospital based Independent Domestic Violence

Advisor (IDVA). This triggered a referral to the Adult Safeguarding Team, and it was noted Oasis Domestic Abuse Services were involved. Hospital records had already flagged Mary as a MARAC victim and a further submission to MARAC was made. Mary presented as homeless. A friend was contacted, and Mary was discharged into their care when deemed medically fit to leave. Engagement with the Hospital IDVA and multi-agency referrals was good practice.

13.4.7 The final visit was in July 2019. Mary did not give a coherent or consistent narrative as to why she had come to A&E. An examination and routine tests could find nothing medically wrong**.** It was noted Mary was flagged to MARAC but there was no indication of any injuries or abuse. As Mary was medically stable and had full mental capacity (no indication of alcohol intoxication) Mary was discharged. It was this visit that was referenced to the CRC as the reason for missing a scheduled appointment. It would not be unreasonable to conclude this visit was driven by a need to legitimise this missed appointment.

13.4.8 Andy was brought to A&E whilst in police custody in July 2019. Andy was very aggressive physically and verbally, spitting and threatening staff with violence to such an extent that no observations or tests could be carried out. The Doctor concluded Andy was fit to be detained as there were no indications of any breathing difficulties, which was the reason the police had brought Andy to A&E.

13.4.9 Having an IDVA available in the Accident and Emergency Department is an invaluable resource to protect and support victims of domestic abuse. This is good practice. **(Recommendation 3).**

13.4.10 The Trust have also recognised a growing number of patients seeking treatment are homeless. There is a bespoke web page to advise staff how to deal with patients who present as homeless, a policy to flag homeless patients on the IT system and the creation of a dedicated role - The Homelessness Practitioner - who has been in post since September 2020. All these provisions are good practice and should be disseminated as such to other Acute Hospital Trusts.

13.5 National Probation Service (NPS) / Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)

13.5.1 KSS Community Rehabilitation Company (KSS CRC) was a private sector supplier of probation services. They managed and delivered rehabilitation strategies to convicted offenders who were assessed as posing a low to medium risk of causing serious future harm. The National Probation Service are present in Court and provided pre-sentencing reports and determine the

initial risk assessment of low, medium or high post sentence. CRC staff on frontline duties are called a 'Responsible Officer' as against the more familiar terminology of 'Probation Officer'. The Ministry of Justice have now reinstated the Probation Service into a single organisation and dismantled CRC structures.

13.5.2 KSS CRC was unique to other organisations in this overview report insofar as they conducted a Serious Further Offences Review (SFOR) and submitted a formal report of their findings to Her Majesties Prison and Probation Service. The benefit of this approach is the submission to this process is assisted by a very thorough and detailed response that identified what actions must be taken to close gaps or omissions on two levels. The first level is what must be done with the staff involved and what their personal development action plans look like. The second level is what needs to be done or has been done organisationally to counteract a single point of failure at a practitioner level. This involved changes to policy, procedure, operational practice and organisational structure.

13.5.3 KSS CRC was an organisation that functioned on standard operating procedures that required documented risk assessments, reports, management plans and customer engagement all within set target delivery dates and time parameters. For instance, KSS CRC had a tiering process that determined how often there needed to be 'face-to-face' engagement. The system was called RAG+P standing for Red, Amber, Green and Purple. Red and Purple required weekly engagement. Amber was fortnightly and Green was monthly.

13.5.4 <u>Interventions with Mary</u>

13.5.5 Mary was assessed following the guilty plea for being drunk and disorderly. The court sanction was a 12-month Community Service Order, a 9-month Alcohol Treatment Requirement (ATR) and a 15-day Rehabilitation Activity Requirement (RAR).

13.5.6 This initial risk assessment was made without reference to other statutory agencies, specifically the police and Social Services. This was against policy and consistent with practice identified in Kent DHR Ann. It meant the Responsible Officer graded their assessment of risk without due regard to the circumstances of Marys previous criminal conduct, relying entirely on the information supplied by Mary to contextualise the facts available. In fairness to the Assessment Officer this was due to the absence of an effective information sharing arrangement between the CRC and the police.

13.5.7 This gap in operating practice was addressed when it was recognised as an organisational issue in December 2018 and a monitoring process introduced to support a new information sharing agreement. This new system was in the process of being introduced when Mary was assessed. At the last internal audit in November 2019 62% of all initial assessments involved contact with one or more external organisation.

13.5.8 Following the risk assessment, a RAG+P should have been completed for Mary. There is no record this was done. Both processes should have been reviewed by a Supervising Officer and quality assured. The initial risk assessment was reviewed, but the gaps subsequently identified in the SFOR were not picked up. This does question how thorough or effective this review was. There was no explanation given why there was no RAG+P assessment.

13.5.9 The next and final stage in the process is a risk management plan/sentence plan. This was completed for Mary, but the SFOR identified gaps that should have been actioned and may have reduced the risk Mary posed to others and/or further offending. This also casts doubt on the quality of this plan. This process should have been the subject of scrutiny by a Supervising Officer. This did not take place.

13.5.10 The risk assessment and the corresponding management and sentencing plans should be reviewed after 12 weeks and/or in response to any significant event such as an arrest or charge for a new offence. No such review was undertaken after 12 weeks nor was one completed when Mary was subsequently arrested.

13.5.11 This is another area that KSS CRC were aware of. Senior Managers were tasked to monitor review assessments and chase up overdue reports. The process was overseen at an executive level by the Assistant Chief Probation Officer responsible for the Excellence and Effectiveness Team. This did demonstrate how serious the organisation regarded this process.

13.5.12 While clearly there were some procedural and process omissions, the Responsible Officer(s) did some good work and intervention with Mary, displaying flexibility and empathy. They also worked very effectively with local partner agencies at a personal level, albeit their records/notes did not always reflect this effort. (Some of the partner agencies records noted the effective and productive interventions by KSS CRC staff). Worthy of mention

was the approach taken to meet Mary's particular needs. Meetings were held in a local multi agency hub rather than their office based some distance away. When Mary was banned from this location, CRC sourced an alternative venue so they could encourage continued engagement with other support agencies.

13.5.13 CRC also managed between May and June 2019 to get Mary to tackle her alcohol dependence, obtain temporary accommodation rather than sleeping rough and generally engage with other support services to help a change of lifestyle. It is not known why Mary abruptly stopped this, but it may be no coincidence the disengagement with the CRC ran in tandem with George's release from prison.

13.5.14 Mary was last seen by the Responsible Officer in June 2019 when a recommendation was made for a non-custodial sentence for Marys next court appearance. Mary failed to attend Magistrates' Court and was sentenced to 12 weeks imprisonment. Mary was later arrested and taken straight to prison, pending her appearance at court.

13.5.15 The custody sanction was changed by Magistrates to a Suspended Sentence Order (SSO) for 12 weeks, supported by an ATR based on the earlier submission by CRC that a custody sentence would not help Mary's current rehabilitation journey. It is at this point there was a disconnect between the NPS at court, the prison service where Mary was being held and the CRC who were responsible for the court-imposed conditions. Mary appeared at court via a video link from prison. This meant when the sentence was changed, the release from prison was immediate. The NPS Court Officer did not inform the CRC of the new sentence. The prison did not contact the CRC to advise of the imminent release of Mary from their care.

13.5.16 Mary went to the community hub the following day and tried to speak to the Responsible Officer. The Responsible Officer, on being made aware Mary had attended the community hub, tried to establish why Mary was not in prison. It took two days to confirm Mary had been released and the custody sentence suspended. This breakdown of interdepartmental communication was attributed to inexperienced staff, poor IT capability and rigid working practices.

13.5.17 The CRC introduced new working practices which provided more flexibility and a communications protocol with NPS Courts supported by IT to prevent a reoccurrence of this communications breakdown. This meant vulnerable people were not released from prison back on to the streets without the opportunity to make some form of positive intervention.

13.5.18 Mary did not attend a scheduled appointment and the excuse this clashed with urgent hospital treatment was accepted. Two days later, Mary was arrested. Mary did not attend the next scheduled appointment and gave the excuse it was because of another hospital appointment. This explanation was accepted. The next day Mary was arrested for being drunk and disorderly. Mary missed the next scheduled meeting and action was taken to fast track the non-compliance with the court orders in place.

13.5.19 Had any checks been made to confirm the reasons given for the earlier non-attendance (hospital appointments) or contact made with the police, these excuses would have been quickly established as untrue and details of the arrests disclosed.

13.5.20 In August 2019 Mary was arrested for non-compliance. There is no record of what the outcome was at court other than it was adjourned to October 2019. A breach of the Community Order could have led to the 12-week custodial sentence being invoked. Presumably, the court took no action and the Community Order remained unchanged until it could be dealt with at the next court date.

13.5.21 Mary appeared at court on for the common assault on George and entered a 'Not Guilty' plea. The case was adjourned to October 2019. There appears to be no action taken to the ongoing breach of the Community Order, which is a matter that remained entirely within the jurisdiction of the court.

13.5.22 There are no notes on the CRC submission about what they did with Mary after the last court appearance. If, as it appears to be the case, Mary did have a Community Order still in force, there was no effort made to contact or engage with Mary. At the very least some contact with the NPS, Court Service or CPS should have been made to establish what the Community Order status was. At the last MARAC meeting held for Mary and George, the CRC reported Mary was currently in breach of the Community Order. The minutes of the meeting attribute this to a completely different person which may be an error by the minute taker, but it is not known if the Community Order was still current.

13.5.23 <u>Interventions with George</u>

13.5.24 George was assessed following the guilty pleas to common assault and battery on Mary. He was sentenced to a 12-month Community Order with a 10-day RAR and 150 hours unpaid work.

13.5.25 In common with Mary, the risk assessment was conducted in isolation and with no contact with other agencies. As a matter of good practice, acknowledging English was not George's first language, a telephone interpreter was used to facilitate this process.

13.5.26 George was assessed as Green on the RAG+P scale, meaning George was deemed a low risk and required monthly reporting. The CRC review acknowledged it was difficult to justify such a grading, especially when the index offences were for assault in a domestic abuse context. At the time the organisation had recently moved to a new risk assessment tool and the Assessment Officer was unfamiliar with the system. The CRC review did not accept this as a legitimate reason for such an oversight and addressed this matter with a personal development plan.

13.5.27 Again in common with Mary, there was limited management oversight. Mandatory reviews and supervisor interventions that should have taken place, did not occur. George was arrested twice during this period of supervision for assaulting Mary. Neither of these events prompted a risk assessment review despite clear evidence of violence, increased risk of harm and domestic abuse.

13.5.28 In February 2019 George was given a final warning for failing to comply with the unpaid work order. This demonstrated early intervention for non-compliance, but after that, contact was very limited. In fact, there were only two face-to-face engagements between the start of this supervision and July 2019, when CRC instigated breach proceedings. There were several reasons for this. George was difficult to contact and there were periods in police custody and prison. There was an expectation of limited contact with a monthly reporting requirement. This was flawed in any event as the reporting requirement should have been increased to weekly attendance following the two arrests for assault on Mary.

13.5.29 The CRC did use the community hub to try and engage and used the police to pass on messages when George was on conditional bail. The CRC also recognised the 150 hours unpaid work order was unsuitable because of George's alcohol dependency and lifestyle. This order was revoked and replaced with an Alcohol Treatment Requirement at their request. This was good practice. This recognised there was little or no prospect of George complying with the work order, and it was an attempt to get George to address the challenges caused by alcohol dependency. The CRC invoked breach proceedings in July 2019 for failing to comply with this amended order and this demonstrated robust enforcement.

13.5.30 The CRC involvement with George ceased when the Community Sentence Order was replaced with a suspended sentence with no conditions.

13.5.31 The lack of management oversight with Mary and George was compounded by the fact the CRC Adult Safeguarding Policy requires mandatory management oversight in cases involving domestic abuse and/or where a case is referred to a MARAC. From the submission provided by the CRC a view could be taken that oversight in these cases was reactive and passive rather than probing and proactive. Staff stated, "*they would receive management support if they needed it…".*

13.5.32 In retrospect the manager concerned agreed this oversight was insufficient and informal discussions over the phone that were not recorded or documented in case notes, did not serve the needs of their staff nor hold them to account in a manner that was consistent and auditable.

13.5.33 KSS CRC completed a management oversight review. This recommended the appointment of two additional Senior Probation Officers to monitor performance as it related to timeliness of reports and reviews. This was to free up capacity for locally deployed Senior Probation Officers to focus on the quality of practice and engage with their reporting staff on a one-to-one basis, recording their findings and interventions on the case management system.

13.5.34 There are no recommendations in this DHR for this organisation. This is because it ceased to exist on 26 June 2021. All current processes and procedures will be replaced by the Probation Service operating practices.

13.5.35 The Probation Service are sighted on the contents of this DHR and acknowledge the need for robust management oversight and the adherence to policies and standards in general. The Probation Service are content the implementation of the "Touchpoint" management oversight guidance will deliver the necessary vigour to these areas of learning from this report.

13.6 **Kent Police**

13.6.1 In September 2017 Kent Police introduced a new policing model and strategy to support and focus on vulnerable people. At its inception the programme created an additional 111 police staff roles with 26 police Investigators creating Vulnerable Investigation Teams (VIT). VIT provide a specialist investigative response to domestic abuse.

13.6.2 Domestic abuse incidents are attended by uniformed Response Officers in the first instance. Using the established Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) risk assessment, incidents are graded standard, medium or high. All incidents graded as high are managed by members of the VIT. This enables specialist support to either pursue a prosecution or take the necessary action to reduce future potential harm or risk through the MARAC process. (Multi Agency Risk Assessment Conference).

13.6.3 In July 2019 DASH was replaced by DARA within the Kent Police service. (Domestic Abuse Risk Assessment). DARA has been developed using international evidence, the experience of practitioners and the advice of survivors of domestic abuse. It is designed to make it easier for Response Officers to identify the presence of coercive and controlling behaviour. Coercive control is an offence, but it is also an indicator of potential serious future harm, including homicide.

13.6.4 In this DHR previous issues of incorrect or poor professional judgement applied to the grading of DASH assessments were not evident. (See Kent DHR Ann 2018)[16]. The DASH risk assessments completed during the review dates for Mary and George were all correctly graded and referred to the MARAC process.

13.6.5 In February 2018 Mary reported an assault by George but did not want to support a prosecution. The investigation was reviewed by an Inspector who noted, "*although this case is evidentially weak, I think an intervention of some description is merited bearing in mind the repeat nature of this victim. Please speak to the relevant Community Team (named) and see if there is anything they can help with re her safeguarding, support services for her alcoholism etc."*

13.6.6 In March 2018 the Domestic Abuse PCSO noted - *"I am well aware of the IP (Mary) and shall not be actively seeking her out to give her advice on alcohol issues. She is a long-standing street drinker, anti-police and violent. If I should see her whilst out and about, I will attempt to engage in conversation*." It is unfortunate a more positive approach was not adopted, and some effort made, even if a negative outcome could be reasonably predicted. However, the PCSO has highlighted Mary was anti police and violent and the PCSO did make an undertaking to try and engage if the opportunity arose.

[16] https://www.kent.gov.uk/__data/assets/pdf_file/0008/118988/AnnNov-2018-Overview-Report.pdf

13.6.7 Between July 2018 and August 2018 an investigation took place following an allegation of assault by George on Mary. Mary reported their relationship was volatile because of their alcohol dependence. George was arrested and a DASH assessment undertaken with Mary. This identified indicators of controlling and coercive behaviour; however, it was not recorded as such on the DASH assessment and other measures to reduce the risk of harm were not considered. Mary later provided a retraction statement and on the advice of the CPS, no prosecution took place. It is likely the omission to pursue or record the coercive behaviour was a consequence of this retraction.

13.6.8 In August 2018 Mary approached a police officer in the town centre and asked for emergency accommodation because of the abusive relationship with George. Mary was invited to attend the police station a short distance away, but Mary never turned up. In the following weeks Mary and George were seen together in the town centre by patrolling police officers, but the mindset of the police seems to be there was no point in reaching out to Mary, even though the initial contact was unsolicited.

13.6.9 This was a missed opportunity to engage with Mary or at least seek the assistance of Third Sector Organisations to offer their help and reduce the risk of further assaults.

13.6.10 In November 2018 Mary disclosed to a PCSO another assault by George. It was noted that Mary had numerous facial injuries. Mary stated the assault had occurred a couple of weeks previously. A DASH assessment was undertaken and assessed as high. Safeguarding was considered. Mary intended to stay at different church hostels because George was banned from these premises and wanted to seek additional help from domestic abuse specialists. George was arrested, interviewed and Released Under Investigation (RUI). Within a week both Mary and George were seen back together in the town centre.

13.6.11 In December 2018 Mary was arrested and charged for being drunk and disorderly.

13.6.12 In January 2019, whilst Mary was being spoken to by police in relation to an earlier assault (November 2018) a further assault was disclosed. Mary declined to answer the DASH questions. (However, the officer exercised their professional judgement and submitted a DASH assessment graded as high). George was arrested, charged and remanded into custody for two offences of assault against Mary.

13.6.13 The first MARAC hearing was held in January 2019. It was noted Mary was not supportive of the MARAC process and George was in prison. The recommendation was to encourage Mary to engage with domestic abuse Support Workers.

13.6.14 Both appeared at court in January 2019 and were sentenced to Community Orders with conditions for the offences detailed at paragraphs 13.6.11 and 13.6.12.

13.6.15 In February 2019 Mary was robbed at knife point and George was assaulted while sleeping in a town centre toilet. No suspects were identified. After this incident they both relocated to where other rough sleepers congregated at night.

13.6.16 In April 2019 Mary was arrested and charged with theft and criminal damage after entering a charity shop and attempting to steal clothes whilst intoxicated.

13.6.17 Mary collected a social security voucher for £288 and cashed it. Mary and George both went on a drinking binge. During the early hours of the following morning, Mary woke up in the tent and discovered the remaining cash had gone missing. Mary had some facial injuries and accused George of assault and the theft of the missing money. A MARAC referral automatically followed a DASH assessment which was graded as high risk. George was arrested for assault, but Mary later declined to support a prosecution and no further action taken.

13.6.18 In April 2019 the police attended the location used by rough sleepers and arrested George. Mary alleged to the police that George had throttled and punched her in the face in their tent. George was charged and bailed with conditions not to contact Mary. Mary was provided with emergency accommodation by the local council facilitated by an application by Porchlight (Homeless outreach charity). This was a very effective intervention by the police who worked with partners to provide Mary with a means to break away from George, without merely relying on bail conditions imposed on George as means of protection.

13.6.19 In May 2019 George was arrested for shoplifting and breaching existing bail conditions not to contact Mary. This led to a remand in custody. (George was released from prison a month later when the prosecution case was discontinued).

13.6.20 In July 2019 police were called to a disturbance at a food trailer in the town centre. On arrival they spoke with Mary and George who were both heavily intoxicated. Mary disclosed an assault by George prior to the arrival of the Officers and a further assault the previous evening in their tent. Town centre CCTV, who originally reported the disturbance to the police, stated that they had witnessed and recorded an assault by Mary on George.

13.6.21 George was arrested and interviewed. Mary was spoken to when sober. Mary retracted the allegations of assault, in the tent and at the food trailer. Mary denied assaulting George at the food trailer despite CCTV images to the contrary. George was released and no further action taken.

13.6.22 Mary was arrested and interviewed about the assault on George captured on CCTV. Although George declined to support a prosecution, the CPS authorised a charge of Common Assault on the evidence of the CCTV footage. Mary was charged and bailed to Court. A MARAC referral was made for both, as victims and perpetrators.

13.6.23 In August 2019 police received a report that George had assaulted Mary. Officers noted that Mary had a large swelling to the face and cuts inside her mouth. Mary stated the injuries were caused by a punch to the face, thrown by George. George was arrested, interviewed and bailed with conditions not to contact Mary.

13.6.24 Mary was spoken to again the following morning when sober. Mary stated the swelling and cuts were caused by a mouth abscess. Despite multiple attempts by specialist VIT Officers to persuade Mary to cooperate with the investigation, Mary would not provide a statement. The investigation was filed as NFA (No further action). A DASH assessment was graded as high.

13.6.25 Around the time that it is suspected George was murdered, a call was received from a member of the public reporting noise, drinking and fighting involving members of the rough sleeping community. No police patrols were available to respond and in the absence of any further reports, the matter was later deferred to a follow up visit the next day by the local police Community Team. Early the following morning, the police received a further call reporting the body of a man lying on the ground.

13.6.26 The police attended promptly and found George with significant trauma injuries to the head and back. Life was pronounced extinct at the scene. Both Mary and Andy were arrested a short time later.

13.6.27 The non-attendance of the police in response to the report of noise and fighting is an issue that has been reviewed by the Independent Office of Police Conduct. (IOPC). Their investigation concluded the police response was appropriate given the circumstances and available resources at the time.

13.6.28 Between December 2018 and September 2019, the police made 7 referrals to MARAC which were heard during 4 separate meetings. These were all in respect of the domestic abuse offences committed against Mary. A joint referral was made in respect of George because he was a victim of an assault. This was for the offence for which Mary was charged (See paragraph 13.6.22). This referral was lost in the clutter of the multiple reports made on behalf of Mary and practitioners felt there was a direct conflict of interest if they were asked to deal with both Mary and George simultaneously.

13.6.29 This was not unconscious bias favouring Mary over George because Mary was a woman. It was a pragmatic recognition George was a serial perpetrator of domestic abuse and perhaps their joint referral to the MARAC process was more a by-product of another alleged assault against Mary. At the time, based on the information available, it was not unreasonable to judge the risk of harm to Mary was greater than any risk of harm coming to George.

13.6.30 It does pose the question however, whether George was ever considered a victim. This was a concern raised at a Panel Meeting and this was reinforced by the fact this DHR concerned the death of George at the hands of Mary and not the other way round. It is a reasonable conclusion to draw that George was not treated by the MARAC as a victim. For the record it is worth reiterating it is widely recognised and accepted by all the professionals present that domestic violence victims are not exclusively female and can be male and that they do find it harder to speak out. Statistics on Male Victims of Domestic Abuse - (mankind.org.uk) Half of male victims (49%) fail to tell anyone they are a victim of domestic abuse and are two and a half times less likely to tell anyone than female victims (19%).

13.6.31 The police IMR submission questioned how effective the MARAC process was in reducing the risk of harm to Mary. This is a significant observation, given all the MARAC referrals were generated by the police. This issue is examined in more detail under the MARAC heading.

13.6.32 The IMR also made no mention of the use or consideration of the use of Domestic Violence Protection Orders. The panel felt this omission needed to be examined in more detail.

13.6.33 Domestic Violence Protection Notices and Orders (DVPN and DVPO) were introduced by the Crime and Security Act (CSA 2010). A Domestic Violence Protection Notice and Order is aimed at perpetrators who present an on-going risk of violence to the victim with the objective of securing a co-ordinated approach across agencies for the protection of victims and the management of perpetrators. The legislation is predominantly used when a criminal investigation fails to meet the evidential test to proceed to a prosecution and there are no bail conditions available to protect the victim. Failing to comply with a DVPO constitutes a criminal offence and normally carries an automatic custodial sentence if breached.

13.6.34 Relevant to this review is that this process has been used for members of the homeless community in the past. One order was approved, and one order was denied by reviewing Magistrates. It is reassuring to know because a victim is homeless, this is not a bar to this legislation being used.

13.6.35 There are certain conditions that apply when considering this legislation. It cannot be used when a perpetrator has been charged, is on bail or released under investigation for an offence related to domestic abuse. In the police interactions with George and Mary, George was either charged or on conditional bail in all but one of the incidents. In this one case it was not considered appropriate to make an application because Mary had been charged with common assault.

13.6.35 DVPOs and DVPNs can be used to mitigate any risk. They are not restricted to DASH assessments that are graded as high risk. The only stipulation is that on the balance of probabilities there is violence or a fear/threat of violence against the victim. In the case of Andy, several incidents that have been previously referenced could have been considered as suitable for a DVPO. They may well have been, but this was not recorded on the crime report. The test that must be applied is whether the practice of using this legislation is widespread and business as usual.

13.6.36 VIT Officers view a DVPO as an action of last resort to protect victims of domestic abuse and use this process regularly. They welcome the new provisions in the Domestic Abuse Act[17] that broaden the ability of other parties to seek this redress at Magistrates' Court.

[17] **Domestic Abuse Bill** (https://www.gov.uk/government/collections/domestic-abuse-bill)

13.6.37 The DHR Panel also wanted to explore the facts around the non-attendance of the police on the night of George's death. This was not, in anyway, a challenge to the findings of the IOPC and their investigation. They merely wanted to be reassured due consideration had been given to the potential risks a MARAC victim faced, when a report of a violent incident was made at a location where they could be present.

13.6.38 The Police Command and Control System is called STORM. There is a capability on STORM to add operational information to any address or location. It is normal practice to ensure an address where a MARAC victim lives is flagged as such. This provides the call hander additional information when making a risk assessment and grading the response required in real time.

13.6.39 In this case, while Mary was a known MARAC victim, Mary was listed as NFA (Homeless). There was intelligence that Mary was living at the makeshift camp. When the call to the Police Control Room was made, this information was not known to the call taker because there was no information on STORM. Therefore, this intelligence information could have been added to STORM for this location. This is a learning point for the police. **(Recommendation 4).**

13.6.40 For ease of reading and understanding, the involvement of the police with Andy has been separated from the commentary of George and Mary. The justification for this DHR was to examine the relationship and history of George and Mary. Andy did not become part of the rough sleeping community until around late June 2019. However, Andy is intrinsically linked to the death of George and therefore his interaction with statutory agencies should be considered.

13.6.41 Andy was arrested following an allegation of assault against a former partners new boyfriend in March 2018. The investigation concluded there was no case to answer and no further action taken.

13.6.42 Andy was referred to a Vulnerability Support Worker for a well-being check because of a comment Andy made about self-harm to the custody sergeant. This is good practice. However, Andy did not engage with this support worker and was released when it was determined there were no indications of any mental health instability.

13.6.43 Later that evening Andy telephoned the police control room and stated he felt suicidal and at risk of self-harm. The police provided the appropriate immediate support to Andy and contacted the out of hours Mental Health Team. There was a discussion between the police and the Mental Health

Team that identified Andy had been seen earlier in the day and a judgement made there were no immediate vulnerabilities nor were there any mental well-being concerns. The 'on call' team agreed to get back in touch with Andy and offer any necessary assistance. This interagency liaison is good practice.

13.6.44 Andy next came to notice a year later, in March 2019. It was alleged Andy had scratched the neck of the complainant with a knife. A prosecution file was submitted to the CPS who concluded the witnesses were unreliable and discontinued the case. (The victim was not part of the rough sleeping community nor a current or former partner).

13.6.45 In May 2019 Andy was arrested for animal cruelty. The prosecution was taken forward by the RSPCA. Whilst in custody, Andy was referred for a vulnerability assessment.

13.6.46 A week later Andy and his partner were arrested for assaulting each other. Both declined to support a prosecution. A DASH assessment was graded as medium. No further action was taken.

13.6.47 The following week Andy was assaulted by his partner. Andy declined to support a prosecution or complete a DASH assessment. No further action was taken.

13.6.48 In June 2019 a member of the rough sleeping community alleged Andy and another person unknown pulled him out of their tent and stole property. Due to a lack of corroborating evidence the case was discontinued.

13.6.49 In July 2019 Andy was arrested for being drunk and disorderly. Andy complained of chest pains and was taken to hospital. Andy was examined and declared fit to be detained.

13.6.50 The following month Andy was arrested for assaulting his partner and stealing her handbag. This was a different partner from the previous assault. Both were staying in a tent with the other rough sleepers. Mary witnessed the assault and theft, but the victim refused to support a prosecution. Andy gave a barely plausible explanation, but it was enough to shed doubt on the account given by Mary. No further action was taken. A DASH assessment was graded as medium. Andy was referred for a vulnerability assessment whilst in custody.

13.6.51 Andy was arrested each time offences were reported to the police. It can be difficult for the police and CPS to pursue a prosecution when the victim declines to cooperate and there are no other witnesses. However, there are provisions available to give a victim's evidence remotely such as taking a victims account at the time of the offence and recording this on body worn video. This is an account that can be replayed in court without the victim's consent. The police are very aware they can use this tactic as a means of supporting victims who are simply too frightened to give evidence.

13.6.52 On several occasions Andy was referred to a Vulnerability/Mental Health Practitioner whilst in police custody. Having this capability is good practice and valued by the police as means of safeguarding detainees who have expressed an intention to self-harm or have other apparent vulnerabilities.

13.7 **KCC Adult Social Care**

13.7.1 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.

13.7.2 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.

13.7.3 In October 2018 Community Mental Health Social Workers transferred back to KCC line management from the Kent and Medway NHS and Social Care Partnership Trust (KMPT). KMPT provide secondary mental health services across the whole of Kent and the Unitary Authority and remain a separate organisation. KMPT also support GPs and other service providers in the provision of primary mental health care in the community.

13.7.4 As part of this organisational transition, it was agreed that workers would continue to record on RIO until the new KCC Adult Social Care client record system called MOSAIC was introduced. MOSAIC was designed to absorb records held on two KCC Adult Care legacy systems.

13.7.5 As an interim measure and until MOSAIC became fully operational in October 2019, mental health social care professionals continued to use RIO until July 2019; when they used the AIS system for a short period to record case notes. Access arrangements to RIO for social care staff were agreed with KMPT after this time.

13.7.6 In May 2018 the Central Referral Unit (CRU), received a safeguarding alert from the ambulance crew taking Mary home after being discharged from hospital. The CRU are officed based and the first point of contact for safeguarding partners to refer anyone they have concerns for. Their role is to identify who is best placed to deal with any risks identified and to refer the client on to the relevant department or support agency when appropriate. CRU staff do have access to professionally qualified social workers to seek advice.

13.7.7 An initial risk assessment was completed. Various contacts were made with other agencies (police and KMPT). Based on the information provided, it was concluded there was no immediate cause for concern. Unfortunately, despite numerous attempts by telephone, no contact was made with Mary and therefore, any contribution Mary wished to make regarding any needs or preferences, was not available to the initial assessor.

13.7.8 The decision to take no further action was ratified by a Senior Practitioner the following month and the referral closed. The review of the case notes has identified gaps in recording full details of the rationale to close the referral and some omissions in following policy about sign posting to other agencies, but nothing crucial to the overall decision-making process.

13.7.9 The CRU forwarded on the referral and risk assessment to the local Adult Community Team (ACT) for their information only. There was a three-week time delay in this notification and rather than being for information only it should have identified no contact had been made with Mary. This would have prompted another review to ascertain whether this gap could be closed by local staff who were not office based and not reliant solely on remote contact by telephone.

13.7.10 Since late 2019, initial referrals that cannot be resolved within a 72-hour time frame, are flagged to the relevant ACT (now called Locality Teams) and cases where persons have not been contacted highlighted. This is good practice and a policy that actively supports the ethos of ‘Making Safeguarding Personal’.

13.7.11 In April 2019 the police referred Mary to KMPT as a person vulnerable to domestic abuse. KMPT contacted the CRU, and a joint triage process was undertaken.

13.7.12 The referral was passed to the local Community Mental Health Team on the same day. A follow up request by CRU for a screening assessment was sent in June 2019. This was completed in July 2019, when contact was made with Mary by a Mental Health Social Worker.

13.7.13 The IMR commented *"It is a concern almost two months passed before action and a further two weeks before the mental health social care duty worker screening took place on ……."*.

13.7.14 No explanation was provided why there was such a delay. To compound this lack of accountability, the mental health screening document that was completed could not be found. This was described as a *"crucial document"* by the IMR writer. The explanation for this missing document was that records from local systems may not have been transferred across to the new MOSAIC system. **(Recommendation 5).** However, it is of note there is a record of a telephone call by duty worker with Mary on the Mosaic system. During the call efforts were made to arrange an appointment to discuss Mary's housing, however Mary stated she was going away to London but would be in contact with the team on her return.

13.7.15 A precis of the interview with Mary in July 2019 was found on a RIO record. The record notes Mary provided erratic responses and was difficult to understand. Mary declined any assistance with housing and stated they were about to go 'on holiday' and had no concerns about being assaulted again as there had been no contact with George following his release from prison. It was clear Mary was not willing to engage. The record was marked up 'no further action' and filed.

13.7.16 The IMR does comment that the Social Worker could have been more thorough in their engagement with Mary and did take at face value what they were being told. The context to this conversation was Mary would have been aware the recent non-attendance at court would have generated an arrest warrant, although Mary was probably not aware the court had imposed a three-month prison sentence. Mary would not have been inclined to engage and seek help because to do so led to the risk of an early arrest.

13.7.17 There will always be challenges in merging the culture and working practices as line management changes from one organisation to another. The delay of almost two months in actioning the referral at paragraph 13.7.11 was probably attributable to this merger and different methods of recording information on different systems. It is also likely to be no coincidence these gaps in document management occurred at the same time as the organisation was bringing in a new IT system.

13.7.18 Since this date, practice has changed. Client details, referrals, risk assessments, decision making with supporting rationale and management oversight are all contained on the MOSAIC system. This provides a cradle to grave audit trail and provides a mechanism to close the previously identified gaps, provided the policy and procedure is followed.

13.7.19 The problems of record migration from legacy systems to MOSAIC has also been recognised. A full systems analytical audit was commissioned to identify why records did not move across and what action needs to be taken to retrieve this missing information. This process has now identified what records are missing and a programme of document retrieval is work in progress. **(Recommendation 6).**

13.8 Kent and Medway NHS Social Care and Partnership Trust (KMPT)

13.8.1 The Criminal Justice Liaison and Diversion Service are part of KMPT. They work very closely with other services/departments in KMPT, who provide secondary mental health care. They use the KMPT record management system (RIO). CJLDS provide a screening and assessment service to adults and children caught up in the Criminal Justice System. They operate in Courts, police custody suites and the wider community to identify a range of issues that may have contributed to offending behaviour.

13.8.2 One of the objectives of this organisation is to identify vulnerable people and divert them out of the criminal justice system.

13.8.3 The service changed in 2019 and a vulnerabilities assessment should not be confused with a mental health assessment. While there are still some registered mental health nurses in the CJLDS, most practitioners are not qualified nurses. If a registered mental health nurse does carry out a vulnerabilities assessment it is exactly that and it is not a process that can diagnose mental health needs. This is an entirely separate process.

13.8.4 <u>Engagement with George.</u>

13.8.5 George was seen by CJLDS whilst in police custody in August 2019. Prior to this date he had no contact with mental health services. When assessed George had no financial or mental health needs but needed some help with alcohol dependence and being homeless. A CJLDS support worker arranged for a follow up meeting two days after he was released from police custody outside a local coffee shop. George did not turn up. A follow up call was not answered. George was discussed at a local management meeting and a decision made to discharge the referral on the grounds of a lack of engagement. This was in line with the non-attendance policy.

13.8.6 Engagement with Mary

13.8.7 In April 2019 Mary was in police custody on suspicion of causing criminal damage. The CJLDS practitioner tried to engage with Mary and offered a vulnerability assessment explaining the help that could be provided. Mary declined to participate in the assessment or any offers of additional support.

13.8.8 Engagement with Andy

13.8.9 Andy was first seen by a CJLDS practitioner in March 2018, whilst in police custody for assault. Andy did not engage but did share a lot of background information and previous history. There was nothing said that caused the practitioner to conclude there were any mental health concerns or areas of vulnerability.

13.8.10 Andy telephoned the police later that day and this contact was managed by the out of hours mental health team. They tried to contact Andy on several occasions that evening and again over the next few days but were unsuccessful. The referral was passed to the Community Mental Health Team (CMHT) who also made attempts to contact Andy by telephone and letter, which included a visit to his last known address. (At this time Andy was not homeless). The referral was closed due to non-engagement, which was compliant with KMPT DNA (Did not attend) policy.

13.8.11 Andy was next seen in April 2019 in police custody following an allegation of assault. Andy did not engage. By this time Andy was homeless and the practitioner offered to help with this situation. Andy declined stating “I am going travelling”.

13.8.12 In May 2019 Andy was in custody for animal cruelty. Andy was unkempt in appearance and had noticeable body odour. Andy commented, “every time he was in custody mental health tried to carry out an assessment”. Andy was initially referred to the CJDLS because of a disclosure to the police he had ‘a split personality’. Andy declined to expand on the detail other than acknowledge he did have some issues, but he could cope with these and did not want any help.

13.8.13 There is research that indicates acts of cruelty to animals are not mere indications of a minor personality flaw in the abuser; they are symptomatic of a deep mental disturbance[18]. However, cruelty to animals is not a mental

[18] Animal Abuse and Human Abuse: Partners in Crime (https://www.peta.org/issues/animal-companion-issues/animal-companion-factsheets/animal-abuse-human-abuse-partners-crime/)

health issue. It is an indicator the perpetrator may have a propensity for violence, and therefore, they present a far greater risk to others than a person who has not abused animals. It is worthy of note a history of animal abuse is a key indicator on the DASH risk assessment.

13.8.14 The practitioner noted "*He has been accused of kicking a dog to death. He was referred for assessment due to self-reported 'split personality' and due to the nature of the crime".* Accepting Andy did not want to cooperate, the practitioner, having noted the rationale for the referral, should have sought additional internal expert help/guidance given these two clear warning signs.

13.8.15 In July 2019 Andy was referred to KMPT by a homeless outreach centre due to thoughts of self-harm. It also disclosed Andy believed he had another person living inside his head and that person who was called 'Jason' took over. The outreach centre further advised Andy often found himself in police custody with no idea how he had got there.

13.8.16 A letter was sent by KMPT to Andy's home address offering a psychiatrist assessment in July 2019. Andy did not attend. Another invitation was sent to a different address for an appointment in August 2019.

13.8.17 Both letters explained the process and advised the outcome of the assessment would be shared with the GP. Andy was not registered with a GP. From the records available, it was more likely than not Andy was homeless and at neither of these addresses. Sending letters to these locations with an invitation for an assessment was unlikely to be a successful means of engagement.

13.8.18 In August 2019 Andy was in custody following an allegation of robbery. Andy cooperated with the vulnerability assessment and disclosed hearing voices, and that they did not stop. Andy also stated his mental health was "not too bad" and there was no desire to self-harm. These statements do seem slightly contradictory. The issue of the 'voices' was not explored. Andy was not asked to explain who the voice was or what the voice was saying.

13.8.19 The CJLDS worker ought to have referred the issue of the voices to, or at least had a discussion with, a more qualified mental health practitioner to assess the potential implications of these disclosures. This has identified a gap in the training and awareness of mental health issues, especially the significance of auditory hallucinations, for CJLDS support workers who carry out this process. This is addressed in the action plan.

13.8.20 Probably, the scheduled appointment with the psychiatrist at 11.30am the next day influenced the decision-making process. The CJLDS support worker focused on this, providing a map, address and contact details for this meeting to make sure Andy attended.

13.8.21 Andy did not attend the appointment. As Andy did not attend a second scheduled appointment and had been seen the previous day by a CJLDS support worker, who identified no mental health symptoms, Andy's referral was discharged.

13.8.22 This decision has identified gaps in knowledge in what the CJLDS function is within KMPT. The decision to discharge is perfectly reasonable if a full mental health assessment had been carried out the previous day and no issues identified. It was not a full mental health assessment but a vulnerabilities assessment that was conducted and this did not explore the issue of voices. This matter is dealt with under the CJLDS/KMPT action plan. **(Recommendation 7).**

13.8.23 It is not clear whether the emphasis on prevention/intervention was focused on self-harm, or the risk Andy posed to others. The original referral was about self-harm, and this was explored at each encounter. If the decision to discharge was made on a low risk of self-harm, then this was reasonable on the grounds there appeared to be no risk of self-harm.

13.8.24 If the risk assessment to discharge was made because Andy also presented a low risk of harm or violence to others, this is not quite as clear. Each custody detention and subsequent mental health referral was predicated by an act of violence. The influence of the "voice" and how Andy ended up in police custody with no idea why are indicators of instability. It is also worthy of note that Andy had moved from a position of not cooperating and denial when engaging with CJLDS staff to the last encounter where he did engage with the process. By not exploring the issue of the voice in his head, this was a missed opportunity to glean more information about Andy's mental health well-being and refer him to a qualified mental health practitioner for further assessment.

13.8.25 It is fair to recognise the options open to CJLDS staff to deal effectively with non-compliance are limited. The powers of detention available under the Mental Health Act set a very high bar before they can be exercised. In the circumstances described, they were not remotely close to reaching this bar.

13.8.26 It is conceded the comments about Andy's mental stability have been influenced by the murder trial defence where Andy stated it was the voice in his head or his 'alter ego', who killed George.

13.9 **District Council**

13.9.1 The District Council is the lead member of the local Community Safety Partnership. (CSP). The local CSP are required to produce a three-year strategic plan that addresses issues of public safety, anti-social behaviour and community well-being that are bespoke to that locality. The strategic plan is broken down into SMART action plans with targets and objectives set on an annual basis.

13.9.2 The District Council has a Community Safety Unit whose primary responsibility is to engage with and support agencies who have a responsibility for delivering the actions and objectives set out in the annual plan which can be found on the Council's website.

13.9.3 The District Council includes information on their website about The Homelessness Reduction Act[19] and its related duties and requirement to help all eligible applicants - regardless of whether they are a "priority" or not. The District Council in common with many Local Authorities recognise the challenge Homelessness presents and what their legal obligations are. To address this the Council has increased the availability of its housing stock to accommodate homeless people and commissioned an additional 8 one bedroomed flats that became available in March 2021.

13.9.4 Additionally, the District Council has a Homelessness and Rough Sleeping Strategy 2020-2024 (updated June 2021). The following high-level commitments are listed for the District Council to continue to strive to: End rough sleeping; Prevent all forms of homelessness; Improve temporary accommodation and end the use of bed and breakfast and; Provide better housing outcomes for local people. The associated action plan includes work with various partners to tackle homelessness 'together'. The District Council received £470k in bespoke funding in 2020/21 to support the governments Rough Sleeping Strategy which aims to half the number of rough sleepers by 2022 and eradicate it completely by 2027.

13.9.5 At a strategic County level, "all the Kent Local Authorities and Medway Council are represented on the Kent Housing Options Sub Group (KHOG), which works together to improve on excellent Housing Option services provided across the County, to monitor performance, share best practice and liaise with partner organisations and agencies. The group meets four times a year and has working groups to review protocols and address specific topics.

[19] Homelessness Reduction Act: policy factsheets - GOV.UK (www.gov.uk)

The aim of this sub group is to continue to share best practice in terms of homelessness, housing options, allocations, lettings and service delivery. To respond and ensure that services are monitored and developed to meet changes in legislation, to explore solutions and working practice to assist in the delivery of new affordable urban and rural housing."[20]

13.9.6 Rough Sleepers in the area have a CSP working group chaired by the police, involving key statutory agencies and members of the third sector. At this forum, individuals are discussed and agencies tasked to deliver agreed interventions. This is a 'joined up' local approach to manage the problems associated with rough sleeping collectively. This process, however, is heavily reliant on the active engagement by rough sleepers, especially if this intervention is led by third sector agencies.

13.9.7 The District Council in common with many Local Authorities recognise the challenge Homelessness presents. To address this the Council has increased the availability of its housing stock to accommodate homeless people and commissioned an additional 8 one bedroomed flats that became available in March 2021.

13.9.8 The District Council received £470k in bespoke funding in 2020/21 to support the governments Rough Sleeping Strategy, which aims to half the number of rough sleepers by 2022 and eradicate it completely by 2027.

13.9.9 As previously mentioned all rough sleepers were found accommodation during the COVID-19 crisis. It is, however, still something of a changing landscape and new rough sleepers continue to present themselves for assistance.

13.10 **Porchlight**

13.10.1 Porchlight rough sleeper services assess housing, social and healthcare needs, working with partner agencies to help rough sleepers move towards a more positive future.

13.10.2 Porchlight predicate their service on active outreach. This means Support Workers seek out rough sleepers and engage with them in situ. This is a face-to-face engagement rather than the contact being made remotely. (i.e. by letter or mobile phone).

[20] Kent Housing Options Sub Group (KHOG) - Kent Housing Group

13.10.3 Porchlight had dealings with Mary stretching back to 2008. Historically, Mary was supported in hostel/housing/private sector rental, but all these arrangements were not sustainable due to the personal challenges caused by Mary's alcohol dependency.

13.10.4 During the relevant period of this review, there was a lot of 'ad hoc' street interventions with Mary and by default George, who was often in Mary's company. These were not always recorded in the organisations case notes and the Porchlight review has acknowledged this short coming. An unintended consequence of this limited record keeping meant internal processes to monitor progress were not effective as the information was not there to review. **(Recommendation 8).**

13.10.5 Porchlight, however, did give pragmatic assistance. They provided a tent and sleeping bag when Mary decided to camp with other rough sleepers. They also made sure Mary had a mobile phone that was in credit.

13.10.6 Porchlight were never asked to attend a MARAC or provide a covering report. This was a missed opportunity to provide the MARAC process with information that would have assisted them developing an effective intervention plan.

13.10.7 Another missed opportunity was the option for Porchlight workers to be tasked by or work more closely with other agencies. Several organisations have stated their inability to contact Mary hampered their efforts to intervene or provide help. Porchlight could have been a means to communicate effectively with Mary. Even if these offers for help via Porchlight Field Workers were politely declined, this is infinitely better than referrals or case notes being closed because Mary did not answer her mobile phone or respond to voice mail messages.

13.10.8 It would be good practice for health and social care agencies specifically involved with homeless people to contact Porchlight, or their equivalent, and make them aware of their involvement to foster a multi-agency approach to service provision and/or problem solving.

13.11 **Oasis**

13.11.1 Oasis Domestic Abuse Service are contracted by Kent County Council to support medium and high-risk victims of domestic abuse. High risk victims are managed by a dedicated MARAC IDVA Team (Independent Domestic Violence Advisor).

13.11.2 George and Andy were not known to this organisation. Mary was first referred to Oasis in December 2018. At that time Mary was living in a local night shelter. Mary was uncontactable and therefore, it is not known whether Mary would have taken up offers of help.

13.11.3 The MARAC process tasked Oasis four times to contact Mary. Numerous attempts were made to get in touch but these in the main were unsuccessful. When contact was made, Mary, for reasons unknown, did not want to engage.

13.11.4 IDVAs are highly valued and respected members of the MARAC process, but in this case their effectiveness was significantly undermined by their inability to communicate with Mary and/or the reluctance of Mary to work with them. There was an over reliance by the MARAC on the role of the IDVA to problem solve when they were not able to do so.

13.11.5 IDVA representatives need to be more robust and reject unreasonable MARAC actions when they are not able to assist because the victim is not contactable or does not ask for their assistance and support when contact is eventually made.

13.12 **Victim Support**

13.12.1 In Kent, Victim Support are provided a list of all victims of crime by the police.

13.12.2 Victim Support offer a service for victims of crime who are willing to engage with them. While they will always try to make an initial contact with victims, there is limited capacity to pursue victims who either do not respond or are harder to reach by telephone. When a victim does not respond to the initial contact the police are updated to this effect. This happened in this case.

13.12.3 Victim Support were aware of all the reports of crime committed against Mary, George and Andy. Attempts to contact them were made with no success except for one occasion. This was when Mary had been relocated to another council district but attempts to transfer Mary to the local service provider were rejected by Mary.

13.12.4 Victim Support have successfully supported rough sleepers in the past. The organisation has an ethos of helping anyone regardless of their background or personal circumstances. The key to securing their assistance is a willingness to engage with them. The organisation does not have the capacity or funding to pursue individuals who do not want their assistance.

13.13 **Multi Agency Risk Assessment Conference (MARAC)**

13.13.1 The MARAC process has been in place in Kent since 2009. The stated purpose of a MARAC meeting (reproduced from the MARAC minutes template) is:

- To share information to increase the safety, health and well-being of the victims – adults and their children,
- To determine whether the perpetrator poses a significant risk to any individual or to the general community,
- To jointly construct and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm,
- To reduce repeat victimisation,
- To improve agency accountability,
- Improve support for staff involved in high risk DV cases.

The responsibility to take appropriate action rests with individual agencies; it is not transferred to MARAC. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions are taken to increase public safety.

13.13.2 The general view of Practitioners involved in the MARAC process and who were also part of the Overview Panel is a MARAC can add real value to safeguarding vulnerable people.

13.13.3 Several organisations in their responses to this DHR however, questioned the value of the MARAC process and what positive impact it had, if any, in this case.

13.13.4 It is acknowledged that a lack of successful engagement between Mary and agencies did impact on the effectiveness of the MARAC. A legitimate question to pose is *"How much reliance should organisations place on a MARAC referral in terms of future safeguarding, if the victim does not cooperate?"* The answer to this question is one for the MARAC chair to consider. If the MARAC is having no impact on reducing risk, this position should not be perpetuated meeting after meeting. This is poor practice. This was highlighted in this review where Mary was a repeat victim and referred to the MARAC multiple times. These multiple referrals seem to have had no impact on the actions generated from the MARAC process.

13.13.5 IDVA representatives at MARAC should not be the option of last resort. This will require a change of mindset from the current default position accepting MARAC taskings, without question, to one that is realistic about how likely their involvement will have a successful outcome. The same tasking should not rollover month after month which happened in this case, even when the IDVA reported there had been no contact with Mary in the preceding months. This should be covered under the proposed MARAC process review.

13.13.6 Had Mary been the victim in this DHR and not George, the MARAC process would have been the subject of a 'deep dive' review. As it is, even a cursory scrutiny of the MARAC process has raised some concerns. By way of example, of the six stated aims of a MARAC meeting that have been reproduced at paragraph 13.13.1, the consensus from the members of the DHR Panel is the majority of these were not met in relation to Mary.

13.13.7 The MARAC process has featured in previous Kent DHRs. Comment was made and recommendations put forward in DHR Jason 2016 and DHR Mary 2018. Some of the issues raised in these reviews remain current. In a very recent Kent and Medway Safeguarding Adults Review (SAR Jodie) the only recommendation from this process was to conduct a review of ten recent referrals to test how effective the MARAC process was.

13.13.8 The MARAC meeting minutes held for Mary have highlighted some key themes. Consistency of approach was hampered by different levels of participation by statutory and voluntary organisations. Those that did participate did not always provide current and accurate information. There were several gaps in representation and organisations you could reasonably expect to be present, were not. If a risk management plan and associated actions were discussed, considered and agreed, these were not documented.

13.13.9 The MARAC process should *"facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety".* In this case, there is room for improvement in what the MARAC was supposed to achieve, as against what it did achieve. **(Recommendation 9).**

14. Conclusions

14.1 The main headline in this DHR is the victim and perpetrators were rough sleepers. Being homeless was a contributing component leading up to the unfortunate circumstances surrounding the death of George, however, alcohol dependency was also a major causation factor. Intoxication is more likely to increase a propensity for violence[21].

14.2 Both George and Mary had a significant history of alcohol dependence. What was different when they became homeless was this alcohol driven domestic abuse became more visible and agencies did respond well, within the constraints they faced. The biggest challenge was non-engagement and the impact this approach had on efforts to assist or intervene positively. Adopting a trauma centred approach to deal with the issues that are driving the addiction may provide another route into engaging effectively.

14.3 Andy was only homeless for a relatively short period of time. His alcohol dependence was not quite as apparent as George and Mary because he did not admit to having one. What was apparent in the months leading up to the murder of George, was Andy's deteriorating mental state.

14.4 The concept that keeping rough sleepers together in one area provided a degree of collective protection from being the victims of assault or other crimes is probably no longer valid. It may have offered a degree of protection from gratuitous violence from others outside of their community, but it did not protect them from themselves.

14.5 This DHR will not solve the problem of rough sleeping. That remains the remit of the Government's published strategy and ambition to eradicate rough sleeping by 2027[22]. What this DHR can do is to alert safeguarding organisations and agencies that special measures or considerations need to be put in place when dealing with homeless people and rough sleepers. You cannot rely on telephone contact or sending letters to last known addresses, especially when some simple checks will identify more effective ways of engagement through the information held by other agencies.

[21] Alcohol, crime and disorder
[22] Ministry of Housing, Communities & Local Government Rough Sleeping Strategy

14.6 There are some good examples of organisations being flexible and adapting normal working practices to meet the needs of rough sleepers. There are equally some examples of failing to recognise normal procedures will simply not work when engaging with this part of our community. These examples have been highlighted throughout this report.

14.7 I have carefully considered the issue of unconscious bias across the spectrum of intersectionality. This was prompted in part by the comments made by the Police PCSO at paragraph 13.6.6 and the actions of several agencies that dealt with George, Mary and Andy. I have concluded while there are some gaps, this is not a major feature of the conduct of any of the organisations or individuals involved. In other words, this was not institutionalised in the context, of say, the MacPherson Report, but some statutory agencies would benefit from making some minor adjustments for the small number of people who are rough sleepers, to provide a more inclusive service.

14.8 Decisions made were not driven by the fact George, Mary and Andy were rough sleepers, they were driven by the lack of engagement with the organisations concerned. This lack of engagement was a consequence of being homeless, being difficult to contact by conventional means and their alcohol dependency.

14.9 It is difficult to separate the interdependence of being a rough sleeper and being alcohol dependent. It succinctly demonstrates that all organisations need to tackle multiple problems simultaneously, rather than try to compartmentalise each issue as a standalone problem. Had the MARAC process been effective, this might have happened. The CRC did achieve some success with Mary in this regard. The key difference was Mary was prepared to co-operate and engage on her own volition with the various support services available.

14.10 A few organisations demonstrated considerable patience and perseverance in trying to help George, Mary and Andy change their circumstances. Previous rejections of offers of assistance or help did not prevent these offers being repeated and the CJLDS interventions is a good example of this. Despite multiple rejections of recent offers of help, the practitioners did consistently persevere with all three to try and assist them.

14.11 The focus of many of the organisations involved was to protect Mary from George's domestic abuse. Based on the evidence of reported assaults this was a reasonable course of action to take.

14.12 Mary was prosecuted for assaulting George. It does seem almost counter intuitive to prosecute a repeat survivor of domestic abuse. In special circumstances involving domestic abuse, when there is irrefutable independent evidence, you do not need the permission of the victim to pursue a prosecution. This provision was introduced to support victims, who for various reasons including coercive and controlling behaviour, felt unable to make a formal complaint. It is not known if these circumstances applied in this case, but the decision to prosecute was the correct one. Mary did carry out an assault on George.

14.13 By pursuing this matter there was the benefit this course of action would have led to a reduction of the risk of harm to Mary in the short term, as well as to George. It was a means of protecting them both from each other. The decision was also probably a consequence of Mary being a public nuisance and a tendency for both Mary and George to make allegations against each other and then withdraw their complaints. Had Mary been a first-time offender, it would have been unlikely a prosecution would have been pursued.

14.14 George and Mary were the subject of court sanctions. Neither were effective in terms of changing their behaviour and had events not turned out as they did, both would have spent time in custody when their suspended sentences were invoked. Previous periods in prison by George and Mary did not have a lasting effect on their lifestyle decisions. Thus, any period of imprisonment would probably only have provided a short period of respite rather than a lifestyle change for either of them.

14.15 However, getting vulnerable people off the street and into some form of accommodation will allow them more accessibility to support services that may be able to help them tackle the other issues they face. It may not solve the whole problem, but it is a positive step forward.

14.16 Interagency co-operation and information sharing still has some gaps. Where information is shared it needs to be both current and accurate. The CRC IMR felt their information sharing with the MARAC was good. I would disagree. While information was shared in a timely fashion, it was of dubious value. One update consisted of a comment, and I quote *'the current caseworker is on leave so there is no update'*. The CRC are not alone, and the recommendations will cover where improvements ought to be made.

14.17 Organisations need to comply with their own internal policies and procedures. There are several examples in this review where policy and procedure has not been followed for no discernible reason. It would be reasonable to conclude that part of the problem of not following policy rests with a need to improve management oversight and organisational leadership.

14.18 The MARAC process has a lot of social capital with participating organisations and this support should be exploited in a positive way. The MARAC in this DHR was ineffective. The gaps identified in this case do not need replaying. The conclusion the panel have drawn based on this review and some of the broader challenges the MARAC face, is the whole process needs a thorough review, sponsored at the highest levels at Kent County Council, Medway Unitary Authority and Kent Police. To do otherwise would be a missed opportunity. (This observation has now been taken forward and a new MARAC structure, funding model and working practices will take effect in April 2023).

14.19 All of the agencies had a focus on protecting Mary from George. This was understandable when it was only Mary and George under consideration. What changed the dynamics and increased the risk to both, was the inclusion of Andy in this peer group. It was only in the last few months of this review this combination came together and this did not become apparent until after the fatal event.

14.20 Addressing the specific key issues detailed at paragraph 2.3, comment has already been made throughout the body of the report. For completeness the following observations are made;

14.20.1 *Point (i) All three subjects of this case had significant engagement with professionals over a relatively short period of time. All three at some stage seemed to have fallen off the radar as professionals found it difficult to effectively engage with them and provide any help. There is a theme that as the subjects disengaged, a common response was to simply close the case. What rationale or risk assessment was used to support such a decision and were any additional measures considered or taken for people who are active rough sleepers?*

14.20.2 Closing the cases/referrals did comply with the guidelines around non-attendance or engagement but it is reasonable to comment little regard was given to the fact George, Mary and Andy were homeless. If anything, this provided a rationale to close the case/referral because all three were difficult to

contact by conventional means or did not respond. A more co-ordinated approach between agencies that did have the ability to make effective contact should have been explored and while this does not guarantee there will be engagement, it does open the door to make this a possibility.

14.20.3 *Point (ii). The deceased and one of the perpetrators were the subjects of multiple MARACs throughout 2019. This process will require careful review.*

14.20.4 As identified at paragraphs 13.13.2 – 13.13.9 the MARAC process was ineffective. This gap is addressed in Recommendation 9.

14.20.5 *Point (iii). The deceased was a European national whose first language was not English. Both the perpetrator and victim were often under the influence of alcohol and uncommunicative. Was effective communication with all concerned a barrier to positive interventions by statutory agencies?*

14.20.6 There did not appear to be any issues with a barrier to communication that concerned language. There were many instances where organisations were able to communicate with George, Mary and Andy and offer support. There is no suggestion that they did not understand what was being offered, instead they declined the assistance that could be provided. The barrier for positive intervention was not communication, but the resources that were available at that time.

14.20.7 Porchlight identified there were no refuges/hostels that could accommodate people with alcohol dependencies, who, when drinking, could behave inappropriately. What Porchlight had to offer was not what George and Mary wanted. They did not want to stop drinking or be constrained by the rules of behaviour that refuges/hostels impose.

14.20.8 As has already been pointed out these barriers were not present when rough sleepers were accommodated in hotels during the pandemic. The Government's strategy to eradicate rough sleeping recognises this gap and has encouraged Local Authorities to meet the needs of rough sleepers, who also have complex needs, with additional funding[23].

14.20.9 There were multiple offers of help but more could have been done to explore the reasons why George, Mary and Andy did not want help. (Accepting Mary did make some headway with the Community Rehabilitation Company). A trauma

[23] https://www.gov.uk/government/publications/support-for-people-sleeping-rough-in-england-june-2023/support-for-people-sleeping-rough-in-england-june-2023

informed approach to help problem solve complex issues was not in general use at that time. This has been identified as best practice as outlined by Professor Preston-Scott and this approached has since been widely endorsed as where the future lies in terms of professional practice with statutory and voluntary organisations.

14.20.10 In support of the Government's Homelessness and Rough Sleeping Strategy the Local Authority responsible for this area has recognised the importance of understanding 'the why'. In their local Homelessness Strategy (see 13.9.4) and associated Action Plan, the District Council intend to "*Conduct research to understand the underlying causes of rough sleeping to help inform the 2025 target".* This is not focused on just individual needs but also the broader drivers be they social, economic or government policy that are contributing to this problem.

14.20.11 *Point (iv). The location of this offence was spare ground in a residential area, where several homeless people had effectively become resident by pitching tents. What action did any agency take to effectively manage this situation and seek more suitable accommodation?*

14.20.12 There was a conscious decision to allow this arrangement to continue for several legitimate reasons. However, in hindsight, this did not protect the rough sleepers from themselves and at some stage this strategy should have been reviewed. Efforts were made to rehouse members of the rough sleeping community on an individual basis, but this DHR has highlighted a learning point that allowing such an arrangement to continue after several crimes have been committed is likely to end up in tragic circumstances. **(Recommendation 10).**

14.20.13 *The Police were alerted to a disturbance at the same location the deceased was subsequently found. They did not attend. Was there any form of unconscious organisational bias displayed due to the location of the disturbance and the background of the persons likely to be involved i.e., rough sleepers with a known background of alcohol abuse?*

14.20.14 This was covered by the IOPC investigation. They concluded the reason the police did not attend the initial report of a disturbance was because there were no police patrols available. The decision and dynamic risk assessment carried out was based on the information available. Had the controller been aware there was a MARAC subject at this location, this would have made this call more urgent, and the police would have attended as soon as resources became available. **(Recommendation 4).**

15. Lessons to be learnt

15.1 Maintaining accurate and up to date records is the bedrock for effective communication, decision making and harm reduction. This not only benefits the recording organisation, but it is also crucial to other partners who may use this information in their own processes. This DHR has identified some gaps in this premise. **(Recommendations 1, 4, 5, 6 and 8).**

15.2 Policy and procedures are in place for good reason. Organisations need to ensure where these are in place, they do lead practice and there is sufficient rigor internally to ensure these are complied with. This requires proactive management supervision, which this DHR has identified is an area for improvement. **(Recommendations 2, 5 and 8).**

15.3 Organisations both Statutory and Third Sector do not operate in isolation in the safeguarding arena. When conducting risk assessments or making decisions, consultation and information gathering from key partners is a critical part of these processes. There continues to be too many examples of decisions being made or action being taken that do not involve obvious safeguarding partners. Had some basic checks in this case been made with partners, the actions taken, or the decisions made by the lead organisation would have been better informed and more appropriate to the risks posed. **(Recommendations 5 and 8).**

15.4 The MARAC process is universally viewed as a valuable tool. This case uncovered some specific gaps which in turn highlighted some broader concerns of the sustainability of this process under its current guise. This DHR would strongly recommend a review to identify what would be the best way forward to deliver the aims and objectives of the MARAC process in the future. **(Recommendation 9).**

15.5 The ‘lessons learnt’ have been deliberately kept at an organisational or strategic level and although they do not apply to all the organisations involved, they do constitute a general theme or trend of operation. These broad themes will chime with the actions that are attributable to specific organisations in the next section.

16. Recommendations

16.1 The Review Panel makes the following recommendations in this DHR:

No	Rationale	Recommendation	Responsible Organisation(s)
1	Records were not updated with new personal information.	Records maintained by GP Surgeries need to be current and reflect information that they are privy to from other NHS Organisations. Where a patient is homeless, the record should be flagged as such and contribute to a Surgery based risk register of vulnerable patients.	Kent and Medway CCG **Now the Integrated Care Board (ICB)**
2	Existing policy and procedures were not applied	A process to be developed that assists Primary Care practices with quality monitoring including the monitoring of compliance with existing safeguarding policy and procedures beyond national contract measures.	Kent and Medway CCG **Now the Integrated Care Board (ICB)** CQC
3	Good Practice	There are clear benefits to having a dedicated IDVA available in Accident and Emergency, along with a dedicated Homeless Practitioner role and bespoke processes in place to deal with homelessness. This good practice should be disseminated to other Acute Hospital Trusts.	East Kent Hospital University Foundation Trust
4	Gaps in practice	The police should review current procedures to ensure all MARAC victims, where appropriate, have operational information on STORM. This information needs to be current and relevant to assist call handlers undertaking real time risk assessments.	Kent Police

5	Gaps in record keeping/content and case management protocols	Current protocols and procedures should be reviewed to ensure client files and supervision client files are completed and adhere to policy guidelines in terms of content and timeliness.	KCC Adult Social Care and Health Directorate
6	Missing information from legacy systems	Identify documents that have not migrated to MOSAIC.	KCC Adult Social Care and Health Directorate
7	Missed opportunity to identify risk	A training needs analysis should be carried out to identify what training should be provided to Liaison and Diversion Practitioners (not professionally qualified) deployed in custody suites. This should cover existing staff and new staff recruited to these roles as part of their induction training. Training should specifically cover what circumstances must be referred to a qualified mental health specialist. The role and function of CJLDS practitioners should be widely disseminated to other KMPT departments. Vulnerability assessments are not mental health assessments.	CJLDS (KMPT)
8	Gaps in record keeping and management oversight	Deliver workshop training to staff and volunteers that details what good record keeping looks like. Support managers to deliver a clear footprint across records and caseloads to ensure robust auditing and safe case progression.	Porchlight

9	MARAC	It is recommended that a programme of review and evaluation of MARACs in Kent and Medway takes place. The findings of this review are to be taken to the Kent and Medway Domestic Abuse Executive Board and the Domestic Homicide Review Steering Group with recommendations for discussion. Kent and Medway Safeguarding Adults Board to be given sight of findings. (DA Leads for KCC, Medway Council and Kent Police).	MARAC Steering Group and DHR Steering Group
10	Learning Point	Disseminate the learning from this review with local Community Safety Partnerships (CSPs) and highlight the risks associated with allowing rough sleepers to congregate in makeshift camps for a prolonged period.	Kent Community Safety Partnership (KCSP)

Appendix A DHR Terms of Reference

Kent & Medway Domestic Homicide Review

Terms of Reference - Part 1

1. Background

1.1 During September 2019 the police were informed of a disturbance at a location in a town in Kent. This location was frequented by members of the homeless community who had erected tents within the boundaries to provide shelter. The police did not attend this disturbance.

1.2 The following morning the police were contacted again by a member of the public reporting a body lying on the ground. The police attended and located the deceased, George, who had suffered severe trauma injuries to his head, back and chest.

1.3 Also at the scene were the deceased former partner Mary and an associate Andy. Both were arrested and subsequently charged with murder. Both were remanded in custody.

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 meeting was held on 5th November 2019. It confirmed that the criteria for a DHR have been met.

1.5 That agreement was 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. In accordance with established procedure this review will be referred to as DHR George 2019.

2. The Purpose of a DHR

2.1 The purpose of this review is to:

1. establish what lessons are to be learned from the domestic homicide of the victim 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 violence and abuse; and

vi. highlight good practice.

3. The Focus of this DHR

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

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

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

4. DHR Methodology

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

4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, George, Mary and Andy in circumstances relevant to domestic

abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with any of the above, 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 will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about George, Mary and Andy from 1st February 2018 to the date of George's death. If any information relating to George as the victim, or Mary and Andy as being perpetrators, or vice versa, of domestic abuse before 1st February 2018 comes to light, careful consideration should be given as to whether or not 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 be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to George, Mary or Andy. 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 must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

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

5. Specific Issues to be Addressed

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

- Were practitioners sensitive and/or responsive to the needs of George, Mary and Andy, 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) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of George, Mary and Andy? 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 George, Mary and Andy subject to a MARAC or other multi-agency fora?

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

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

- 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 victim's 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?

- 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?

- 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?

- 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?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- 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 a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard George and promote their welfare, or the way it identified, assessed and managed the risks posed by Mary and/or Andy? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- Did any staff make use of available training?
- 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?
- How accessible were the services to George, Mary and Andy?

6. Document Control

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

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

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

Appendix B - GLOSSARY

Abbreviations and acronyms are listed alphabetically.

Abbreviation/Acronym	Expansion
ACT	Adult Community Team
ASC	Adult Social Care
ATR	Alcohol Treatment Requirement
CCG	Clinical Commissioning Group (NHS) **Now the Integrated Care Board (ICB)**
CPS	Crown Prosecution Service
CQC	Care Quality Commission (NHS)
CRC	Community Rehabilitation Company
CRU	The Adults **Central Referral Unit** is a multi- disciplinary social care, health and policy hub. All adult safeguarding cases not known to social care are triaged and safeguarding enquires instigated until a team is identified.
CSA	Crime and Security Act 2010
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
DNA	Did Not Attend (NHS)
DVPN and DVPO	Domestic Violence Protection Notices and Orders
FLO	Family Liaison Officer
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Report

IOPC	Independent Office for Police Conduct
KMPT	Kent & Medway NHS & Social Care Partnership Trust
MOSAIC	Kent Adult Social Care System live from Oct 2019
MARAC	Multi Agency Risk Assessment Conference
NFA	No further action
NHS	National Health Service
NPS	National Probation Service
PCSO	Police Community Support Officer
RAR	Rehabilitation Activity Requirement
RO	Responsible Officer (CRC)
RUI	Released Under Investigation
SAS	Special Allocations Scheme
SFOR	Serious Further Offences Review (NPS)
SIO	Senior Investigating Officer
SMART	Specific Measurable Achievable Realistic Time objectives
SPO	Senior Probation Officer (CRC)
SSO	Suspended Sentence Order
VIT	Vulnerable Investigation Teams

Appendix C - Definitions

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 questions, 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.

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.

Rough Sleeping

People sleeping rough are defined as follows:

People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes' which are makeshift shelters, often comprised of cardboard boxes).

The definition does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers.

Bedded down is taken to mean either lying down or sleeping.

About to bed down includes those who are sitting in/on or near a sleeping bag or other bedding.

Alcohol Dependency

The medical members of the Panel held very strong views that it was inappropriate to describe anyone as an alcoholic. Unless the person admitted they had an alcohol problem, they could not be described as alcohol dependent, even when they may have received medical care for alcohol related conditions. It was therefore agreed to use the terms 'self-admitted' and 'not self-admitted' to describe individuals who may have an alcohol dependence.

Action Plan

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
1. Records maintained by GP Surgeries need to be current and reflect information that they are privy to from other NHS Organisations. Where a patient is homeless, the record should be flagged as such and contribute to a Surgery based risk register of vulnerable patients.	1) Kent and Medway CCG to share via primary care learning bulletin the need for primary care records to reflect information provided from other NHS organisations , including utilising coding systems where a patient is reported as homeless. 2) The Kent and Medway CCG safeguarding team to share learning around the importance of coding and records maintaninece with Primary care quality team and Primary Care contracts team in the development of the primary care quality matrix.	Designated Nurse Safeguarding Adults - Kent and Medway CCG	01/07/2021	1) A bulletin on homelessness has been produced and shared across the Kent and Medway primary care network, highlighting peoples rights and service responsibilities. 2)The CCG have a delegated responsibility from NHSEI to monitor the primary care contract compliance across Kent and Medway , aspects of quality and governance outside of the national contract are for practices as individual businesses to monitor and improve. The CCG want to ensure that practices are supported at an early stage when quality /governance issues may arise in a practice but dont yet meet an aspect of the national contract leavers. The CCG has therefore established a quality intelligence meeting and matrix for monitoring good practice a safeguarding tool has beed produced to support practices in their self assessment, section 20 includes coding guidance . and section 27 reflects actions on receipt of information from other agencies.	*Green*	Bulletin produced . Toolkit for Matrix produced and intelligence monitored via establishment of a primary care quality group
2. A process to be developed that assists Primary Care practices with quality monitoring including the monitoring of compliance with existing safeguarding policy and procedures beyond national contract measures.	Kent and Medway safeguarding team to work with Primary care quality team to establish a primary care quality matrix that captures primary care assurance beyond national contract monitoring.. Kent and Medway safeguarding team to work with Primary care quality team to establish a primary care quality matrix that captures primary care assurance beyond national contract monitoring.	Designated Nurse Safeguarding Adults - Kent and Medway CCG	01/07/2021	Toolkit described above	*Green*	Toolkit for Matrix produced and intelligence monitored via establishment of a primary care quality group
3. There are clear benefits to having a dedicated IDVA available in Accident and Emergency, along with a dedicated Homeless	To share the good					

Practioner role and bespoke processes in place to deal with homelessness. This good practice should be disseminated to other Acute Hospital Trusts.	practice of the IDVA and Homeless Nurse Services at the Area Health Reference Group	EKHUFT (Supported by CCG	25th June 2021		*Green*	Currently awaiting evidence from Health Leads Meeting minutes
4. The Police should review current procedures to ensure all MARAC victims, where appropriate, have operational information on STORM. This information needs to be current and relevant to assist call handlers undertaking real time risk assessements.	Kent Police to review Storm MARAC markers wording to ensure this is fit for purpose. MARAC Coordinator training to be updated to include considering applying for Storm OP Info in the case of rough sleepers when there is a location identified with a degree of permanency.	Kent Police	Spring 2022	The Storm wording has been reviewed and is fit for purpose. It was reviewed previously in 2020 and changed to give officers a very clear instruction on what to do should they get a job where a MARAC marker came up. The current wording is MARAC: NAME AND URN IS AT SERIOUS RISK OF HARM FROM NAME AND URN. MAKE LP INSP AWARE FOR THEIR REVIEW; IF CAD CANNOT BE ATTENDED PROMPTLY - DOCUMENT CONSIDERATIONS AND ACTIONS TAKEN. CREATED DATE CREATED This has been reviewed again by myself and the PVP DCI lead for DA. The wording is still appropriate. It is standard across all MARAC cases. It is meant to raise awareness that the case is subject to MARAC. All call-takers and dispatchers, and patrols, are aware of the high risk nature of MARAC and what this means. In respect of training- MARAC Coordinators are advised to request Storm markers in all cases where there is a fixed location (with a degree of permanence for the victim/perpetrator), for a marker to be attached to. Shortly the MARAC hub will be coming online and there will be a new bank of MARAC Admin staff taking over the role. They will also be trained to do the same as their predecessors.	*Green*	Dip checking of MARAC Coordinator knowledge on Storm Markers.
5. Current protocols and procedures should be reviewed to ensure client files and supervision client files are completed and adhere to policy guidelines in terms of content and timeliness.	Audit - to audit supervision files and link with the supervision policy to embed this as ongoing practice. To give clearer management oversight of a workers case load. Within the 'Making a Difference Everyday' approach we have a focus on meaningful measures and innovation which will assist in reviewing our recording system to assst practice and drive decision making closer to the person.	KCC Adult Social Care and Health Directorate	Complete	Supervision Audit - the Area Business Support Managers will facilitate an Audit of files from all service areas and geographical areas to ensure that Supervision is in line with the KCC Supervision policy and that an annual observation of practice takes place.Service Managers will ensure the Audit takes place and becomes embedded into 'business as usual'. Complete Supervision Audit and embed this practice annually within KCC ensuring practice observation is completed and filed with supervision record for each supervisee.	*Green*	Complete Supervision Audit and embed this practice annually within KCC ensuring practice observation is completed and filed with supervision record for each supervisee. This audit will give management oversight into supervision arrangements for operational staff. This action has now been embedded within the operational teams administrative process and work allocated for completion to business suppport officers.

6. Identify documents that have not migrated to MOSAIC. (In the Making a Difference Everyday approach we have a meaningful measures pillar, which will ensure decision making is driven by a dynamic evidence based that helps us better understand outcomes of people we support.)	A programme will be undertaken with Better.gov to ensure all files from previous systems are migrated to MOSAIC and to establish any instances where we know files have not migrated for reasons such as incorrect file naming or change of file path. In relation to the case files and documents for *Mary* we will ensure that all previous files for the person have migrated to their person record in MOSAIC.	KCC Adult Social Care and Health Directorate Operational Analytics and Systems Manager	Complete	Work has been completed and confirmation received. All of *Mary's* file is now within MOSAIC. A programme has been undertaken with Better.gov to ensure all files from previous systems have been migrated to MOSAIC and to establish any instances where we know files have not migrated for reasons such as incorrect file naming or change of file path. In relation to the case files and documents for Mary we will ensure that all previous files for the person have migrated to their person record in MOSAIC.	*Green*	Work has been completed to identify any incidents where files were not migrated to the new MOSAIC information system, relevant teams were made aware and requested to take relevant action.
7. A training needs analysis should be carried out to identify what training should be provided to Liaison and Diversion Practioners (not professionally qualified) deployed in custody suites. This should cover existing staff and new staff recruited to these roles as part of their induction training. Training should specifically cover what circumstances must be referred to a qualified mental health specialist. The role and function of CJLDS practitioners should be widely disseminated to other KMPT departments. Vulnerability assessments are not mental health assessments.	•Introduce new Liaison & Diversion Practitioner (LDP) training schedule, to include features for new and existing staff •Training to focus of common mental health issues encountered, and when to refer these to a Specialist Liaison & Diversion Practitioner (SLDP). •CJLDS to provide training sessions, educating around the role and function of CJLDS, to other KMPT teams.			A training needs analysis should be carried out to identify what training should be provided to Liaison and Diversion Practitioners (not professionally qualified) deployed in custody suites. This was conducted by looking at the training available already – KMPT and more role specific provided by NHSE – and ensuring that this was incorporated into induction. Identifying gaps where tasks, roles and responsibilities were not covered by existing training. Ensuring that training, instruction and resources were available to give staff a sufficient knowledge base to identify the range of vulnerabilities experienced by service users. Asking existing staff, particularly new members of the team, about their induction experience and how they felt it could be improved. This should cover existing staff and new staff recruited to these roles as part of their induction training. Training should specifically cover what circumstances must be referred to a qualified mental health specialist. As a result of the analysis the team has developed s in-house training – using experts by experience where possible – to supplement other resources or explain how some vulnerabilities may present in custody. This includes common mental health conditions, neurodiversity, abuse, drug alcohol issues and complex		

		CJLDS (KMPT) Team Managers	Q4 2021	emotional difficulties with an emphasis on when to refer to a specialist. Additionally, some task related training has been developed particularly around documentation and process. Where new training has been introduced all existing LDPs have been asked to complete it, it has been added to the induction requirements for new staff and been distributed to qualified staff who have management responsibility for unqualified staff. The induction process and experiential training has been extended and modified with two custody suites being used as training centres to provide additional assurance around the quality of the induction process. New starters are directly supervised by a team manager until their induction/probation period concludes. The role and function of CJLDS practitioners should be widely disseminated to other KMPT departments. Vulnerability assessments are not mental health assessments. This training was delivered in six sessions targeted at staff who come into contact with ourservice. The training continues to be offered to anyone within KMPT with regularly scheduled Lifesize sessions delivered by members of the team with administrative support from Learning and Development. 17.05.2023 Safeguarding update: All patient facing clinical roles (qualified and non-qualified) are aligned to safeguarding training Level 3 to ensure staff can identify vulnerabilities and respond to safeguarding concerns. Safeguarding training is mandatory and monitored by the Learning and development department, compliance for safeguarding adults and children level 3 training is 95%. CJLADS service screen savers have been utilised to support promotion of the work understand by CJLADS to increase understanding, in addition to open/learning events to meet the team to understand more about the service.	*Green*	Training deployment

8. Deliver workshop training to staff and volunteers that details what good record keeping looks like. Support managers to deliver a clear footprint across records and caseloads to ensure robust auditing and safe case progression.	Gaps in record keeping and management oversight	Porchlight	Oct-21	UPDATE FOR BELOW: Recording a standard part of training, all managers record 'management oversight' when they do case reviews on clients (this happened monthly) that details actions the staff need to complete as well as recording any discussion about risk. Develop an action plan outlining the steps to be taken to ensure this recommendation is achievable. Task Contract Manager and Operations Manager to devise a training programme to re-fresh staff and project managers on the importance of management oversight. Perform regular audits of files to ensure that good record keeping is meeting Porchlight standards and management oversight is given and provides direction and challenge.	*Green*	Regular audits are completed across services which scrutinise how the file is completed, safeguarding / risk management practice and safeguarding compliance. Clients journey's are better recorded, risks are identified and raised with managers, staff are provided with direction and challenge to ensure practice is consistant with service expectations.
9. It is recommended that a programme of review and evaluation of MARACs in Kent and Medway takes place. The findings of this review to be taken to the Kent and Medway Domestic Abuse Executive Board and the Domestic Homicide Review Steering Group with recommendations for discussion. Kent and Medway Safeguarding Adults Board to be given sight of findings. (DA Leads for KCC, Medway Council and Kent Police).	Undertake MARAC Review	Kent Police DA Leads	Under review	Ongoing work	Amber	Kent Police Update - This work is currently under way and is being lead from the Police perspective by the DA Lead . This is difficult to put a timescale on , however the work has commenced.
	To consider recommendations from review and take forward proposals/changes to the DASVEG.	MARAC Steering Group and DHR Steering Group	This to follow after action above achieved.	Ongoing work	Red	
10. Disseminate the learning from this review with local Community Safety Partnerships (CSPs) and highlight the risks associated with allowing rough sleepers to congregate in makeshift camps for a prolonged period of time.	To share the learning regarding the risks associated with allowing rough sleepers to congregate in makeshift camps for a prolonged period of time with local Community Safety Partnerships via email and also include this in the e-Bulletin produced by the KCSP.	KCSP	1st August 2023	1. Inclusion in the e-Bulletin circulated to Community Safety Partners across Kent and Medway. 2. Details sent via email to all Community Safety Partnerships across Kent and Medway.	Red	Increased awareness in CSPs of the risks associated with allowing rough sleepers to congregate in makeshift camps for a prolonged period of time.

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25th April 2024

Dear Cllr Clair Bell,

Thank you for resubmitting the report (George) for Kent Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in April 2024.

The QA Panel felt that this was a good report that benefitted from the inclusion of a reflection on the contributing factors and complex needs of the victim and perpetrators. The inclusion of panel representation from domestic abuse and homeless charities, along with the inclusion of links to previous DHR learning, was also helpful.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

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