Kent Community Safety Partnership
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MEDWAY
COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review
Louise
December 2020
Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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1 The Review Process

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

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

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

1.4 All agencies that potentially had contact with the victim and/or the perpetrator were asked to secure their files.

1.5 The following pseudonyms have been used to protect the identities of the victim and perpetrator:

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

1.6 The following pseudonyms have been used to protect the identities of the victims immediate family members:

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

1.7 Gary entered a guilty plea to manslaughter on the grounds of diminished responsibility which was accepted by the Crown Prosecution Service in December 2021. In mid 2022, Gary was sentenced to 16 years imprisonment with a further 4 years on Licence to run consecutively to reflect the Crown Court Judges concern Gary continued to represent a danger to others.

2 Contributors to the Review

2.1 The information in this report is based on Individual Management Reports (IMRs) completed by each organisation that had significant involvement with Louise and Gary. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Louise and Gary during the period covered by the review.

2.2 The following organisations contributed to this process:

Agency/ Contributor	Nature of Contribution
KCC Adult Social Care	IMR
Kent & Medway CCG	IMR
East Kent Hospital University NHS Foundation Trust (EKHUFT)	IMR
Kent Police	IMR
South East Coast Ambulance Service (SECAmb)	IMR
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	IMR
Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC) (Probation)	IMR
The Forward Trust	IMR and Addiction Specialist
Clarion Housing	Domestic Abuse Specialist (IDVA)
Victim Support	Victim Advocacy

3 Review Panel Members

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

3.2 The members of the panel were:

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

4 Independent Chair and Author

4.1 The Independent Chair and the author of this Executive Summary 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.

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

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

4.4 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 from Cambridge University in Criminology.

5 Terms of Reference

5.1 The Review Panel first met on 05 May 2021 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined.

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

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

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

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

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

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

6 Summary Chronology

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

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

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

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[1] Alcohol and domestic abuse | Alcohol Change UK

[2] Alcohol, Aggression, and Violence: From Public Health to Neuroscience - PMC (nih.gov)

6.4 Gary has two estranged siblings, a brother and a sister. Gary had regular contact with both his parents, who live locally. Gary was described as a troubled child who did not attend school and got involved in petty crime. Gary spent a period of imprisonment after he stabbed a stranger in the street following a verbal altercation in 1998.

6.5 Louise and Gary were alcohol dependent (self-admitted), suffered from depression and were the victims and perpetrators of domestic abuse against each other.

6.6 Thus, Louise and Gary were exposed to the cumulative risks posed by domestic abuse, mental health issues and substance misuse. This trio of vulnerabilities are normally used as a high-risk indicator to safeguard children, but they are equally applicable to vulnerable adults when it comes to assessing the potential risk of harm.[3] Several organisations did not pick up the significant increase of risk these three factors brought because there were no children in the household. It is proposed to review this current practice as part of Recommendation 8.

6.7 A decision was made to keep the time parameter for this DHR short as there appeared to be a relatively rapid deterioration of the relationship between Gary and Louise over a period of months in 2020.

6.8 In March 2020 Louise called 999 in distress, alleging she had been assaulted by Gary. Louise stated to the attending police officers that Gary had hit her head on the wall and pulled her hair. Gary admitted doing this and was arrested. Louise would not support a prosecution. Gary was cautioned and released.

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

6.10 Adult Social Care processed the police referral via the Area Referral Management Service (ARMS) who sent a letter the following day advising both Louise and Gary to contact their GP and Forward Trust (alcohol support service). The case was closed.

[3] https://safelives.org.uk/sites/default/files/resources/Risk,%20threat%20and%20toxic%20trio.pdf

6.11 ARMS made no effort to contact either Louise or Gary, which was in breach of their standing policy and procedures for referrals of this nature.

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

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

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

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

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

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

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

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

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

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

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

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

6.24 In September 2020 Gary was charged with assault on Louise and bailed to court. (For the offence at paragraph 6.22). Louise stated the only reason she had supported a prosecution was to ensure Gary received mental health support.

6.25 In October 2020 Louise called the police stating Gary was angry and had injured her arm. Gary could be heard in the background and sounded intoxicated. Police attended. It transpired Louise had caused a facial injury to Gary. Gary complained that Louise had been pushing him around all week and there were indications of coercive and controlling behaviour by Louise in the DARA risk assessment.

6.26 Louise was arrested and kept in custody overnight before being released without charge as Gary would not support a prosecution. Louise did not engage with the CJLDS support worker.

6.27 The following day Gary appeared at Magistrates' Court. Gary entered a guilty plea to common assault and was sentenced to a Community Order with a 9-month Alcohol Treatment Requirement (ATR) and a 20-day Rehabilitation Activity Requirement (RAR). Whilst at court Gary was seen by a CJLDS support worker. Gary advised he did not need CJLDS assistance to contact his GP or Forward Trust. The case was discharged, and a letter sent to the GP Practice to advise them of this intervention. No mention was made of domestic abuse.

6.28 The day after his court appearance, Louise called the police alleging Gary was verbally abusive. Police attended. Both Louise and Gary were intoxicated and neither made any substantive complaint. Safeguarding advice was given and both were signposted to the mental health helpline and advised to contact their GP.

6.29 Later that evening Gary telephoned the mental health helpline (SPoA) and complained of depression and hearing voices. Gary explained he was alcohol dependent and looked after a partner who was also alcohol dependent. Gary was advised to self-refer to Forward Trust. This was a missed opportunity to make an intervention with Gary and should have generated further work to assess what could be done to help Gary and Louise.

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

6.31 In early November 2020 a Forward Trust worker completed the initial assessment with Gary and a plan was put in place to manage the court order. This assessment identified Gary had a low dependence on alcohol.

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

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

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

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

6.36 In mid-December 2020 Louise called the police stating Gary "had gone into one" about not having the TV remote. Police attended. Louise disclosed Gary had said "the voices" were telling Gary to kill Louise and the couple's

pet duck. Gary was arrested. Whilst in custody Gary was seen by the CJLDS support worker. Gary admitted he had a problem with alcohol, but he was actively engaged with Forward Trust and under the care of his GP for depression. CJLDS concluded there was nothing more they could offer. There was no reference to domestic abuse or the issue of voices telling Gary to harm his partner. There was no recognition of any safeguarding risk to Louise.

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

6.38 Gary kept his next telephone appointment with Forward Trust. Gary did disclose his recent arrest to the support worker but made no mention of the threats of harm he had allegedly made towards Louise.

6.39 A week later Gary kept his telephone appointment with Forward Trust. Gary advised the support worker he had obtained non-alcoholic drinks to celebrate Christmas with Louise. It is acknowledged it is difficult to assess how much alcohol is being consumed, when the only contact is by pre-arranged telephone calls.

6.40 On the same day Gary did not keep a face-to-face appointment with the KSS CRC Responsible Officer (RO). A telephone appointment was made instead. Gary advised there was no alcohol in the house, and he had spoken to Forward Trust earlier to discuss how he would manage the festive season without alcohol. The RO advised Gary they would make a home visit in the next week or so.

6.41 Also on the same day, the KMPT SPoA received the "urgent" police mental health referral that had been raised a week earlier. The referral had been delayed due to a backlog in the police back office and some confusion what "urgent" meant when the accompanying DARA risk assessment was not graded as High. This "urgent" referral was assessed as an amber risk. An amber risk does not require an immediate intervention but does require contact with the subject of the referral within 72 hours.

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

6.43 The CMHT reviewed the referral made by SPoA the following morning and concluded Gary posed no risk and discharged the referral. This was based on a lack of understanding what the role of CJLDS now was. It was also compounded by a belief a person with an alcohol dependency and mental health issues, had to seek treatment for their alcohol dependency before anything could be done about their mental health. This view would appear to be widely held by frontline staff.

6.44 It did not help the "urgent" referral was a week old. There was no reference to the auditory hallucinations, nor any consideration given to any potential safeguarding risks to Louise. It was recommended Gary was referred to Adult Social Care and Gary should make a self-referral to Forward Trust to get support for his alcohol misuse.

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

7 Key Issues and Conclusions

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

7.2 There is a key distinction to be made. People who are alcohol dependent and commit domestic abuse pose a different risk to people who drink to excess and then engage in domestic abuse. In a recent Alcohol Change UK publication it notes people who live vulnerable and chaotic lives, often with no regard for their general wellbeing, can still be assessed as having the mental capacity to make choices.[4] The issue of choice was something the Review Panel did highlight very early on as problematic. The Panel felt the ideas and suggestions in this publication did merit some further work on a multi-agency basis.

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

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

7.4 This response has been raised with the Clinical Director at KMPT. It was acknowledged there is a reluctance to adopt a dual diagnosis approach which was highlighted in the IMR. This is not just a local issue; it is a national problem, and this is reflected in the work currently being undertaken to remove barriers to access support for people with alcohol and mental health challenges. This work is referred to as the Community Mental Health Transformation Framework and has a focus on addressing needs irrespective of primary and secondary support.[5]

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

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

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

[5] Community mental health services - NHS England

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

7.9 Fortunately, this disconnect is in the process of being resolved. A new IT system is being developed called the Kent and Medway Care Record System[6]. This will allow all Health and Social Care Professionals access to a patients/client single record making communication between different organisations much easier, quicker and more efficient. This system has seen some technical slippage and it will not now be introduced until 2023, which is disappointing. In the interim ASC now have access to relevant parts of the KMPT record management system. While this is not ideal, it does close some information gaps between both organisation.

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

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

7.12 There was an interesting discussion on the risk assessment process, driven in the main by the fact the police now use the DARA risk assessment tool, while all the other Agencies continue to use the more established DASH risk assessment process. The switch to DARA followed a College of Policing two-year study to identify more effective ways of identifying coercive control and to be less reliant on reaching a score that automatically mandated a MARAC referral.[7]

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[6] Kent and Medway Care Record

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.20.3 It is not known if the police ever disclosed to Louise Gary's previous conviction history, which could have been a consideration under Clare's law.[8] Louise stated she never believed any threats Gary made, but that may or may not have been based on her knowledge of Gary's time in prison. On the basis the IMR made no mention of this, the presumption must be the police did not make Gary's conviction for a serious violent offence known to Louise.

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

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

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

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

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

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

judgement is likely to be challenged, contact should be made to gather further information and explain why this assessment of urgency is not being supported. (Recommendation 3).

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

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

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

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

7.22.4 A court imposed Mental Health Treatment Requirement Order could have been applied for when Gary was sentenced to the ATR, but this requires Gary to consent to this process. When Gary was seen by the CJLDS worker at Magistrates Court prior to sentencing he declined any mental health support, which accounts for why this option was not progressed.[9]

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

[9] Introduction to the courts and mental health

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

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

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

7.23.3 The demand on many organisations rose exponentially with a corresponding reduction of available staff resources through home working, self-isolation and new operating practices. These new operating practices did not have the supervision or IT infrastructure in place to

provide the necessary support to function efficiently. It is relevant to comment the most organisations have had the opportunity to reflect on what their initial response was to Covid 19 and have concluded that, what they did then, is not what they would do now.

7 Lessons to be Learnt

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

8.2 The current default position of deferring to alcohol first in terms of resolution does not have a high success rate.

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

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

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

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

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

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

9 Recommendations

9.1 The Review Panel make the following recommendations for this DHR:

	Paragraph in Overview Report	**Recommendation**	**Organisation**
1.	16.1.2	Agencies should be aware which "Front Door" Service should be their first point of contact. Both ARMS and SPoA need to circulate their referral criteria.	KCC ASC KMPT

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

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

Appendix A

Kent & Medway Domestic Homicide Review

Victim – Louise

Terms of Reference (Anonymised) - Part 1

1. Background

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

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

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

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

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

2. The Purpose of DHR

2.1 The purpose of this review is to:

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

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

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

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

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

vi. highlight good practice.

3. The Focus of DHR

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

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

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

4. DHR Methodology

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

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

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

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

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

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

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

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

5. Specific Issues to be Addressed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

xiv. Did any staff make use of available training?

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

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