Kent Community Safety Partnership
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MEDWAY
COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review

George

September 2019

Executive Summary

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Commissioned by: Kent Community Safety Partnership

Medway Community Safety Partnership

Review completed: 1st November 2022

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CONTENTS

1. THE REVIEW PROCESS 2
2. CONTRIBUTING ORGANISATIONS 2
3. REVIEW PANEL MEMBERS 3
4. INDEPENDENT CHAIR AND AUTHOR 5
5. TERMS OF REFERENCE 5
6. CHRONOLOGY 6
7. CONCLUSIONS 13
9. RECOMMENDATIONS 20

1. The Review Process

1.1 This summary outlines the process undertaken by the Kent and Medway domestic homicide review panel in reviewing the homicide of George, who was a resident in their area.

1.2 The following pseudonyms have been in used in this review for the victim and perpetrators to protect their identities and those of their family members.

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

1.3 Mary (a former partner of George) and Andy (a known associate) were subsequently convicted of the murder of George, and each sentenced to nineteen years imprisonment.

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

1.5 All agencies that potentially had contact with George, Mary and Andy prior to the point of death were contacted and asked to confirm whether they had involvement with them, and if so, to secure their files.

1.6 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.

2. Contributing Organisations

2.1 The following organisations were subject of an Individual Management Report (IMR):

- Kent and Medway NHS Clinical Commissioning Group (CCG) **Now the Integrated Care Board (ICB)**
- East Kent Hospital University Foundation Trust (EKHUFT)

- National Probation Service (NPS) and Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)
- Kent Police
- KCC Adult Safeguarding
- Criminal Justice Liaison and Diversion Service (CJLDS) and Kent and Medway Partnership Trust (KMPT)
- District Council
- Porchlight
- Oasis

2.2 In addition to the IMRs, Victim Support and the MARAC Central Co-ordinator have submitted updates of information held by them on the individuals identified in paragraph 1.2.

3. Review Panel Members

3.1 The Review Panel was made up of an Independent Chair and representatives of the organisations identified in paragraph 2.1 above. It also included a member of the Kent 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

3.2 The panel members hold senior positions in their organisations and have not had 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.

3.3 The final Overview Report was completed in May 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.

3.4 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 and a former member of the Bradford Central Eastern European Migrants Forum to provide cultural advice. The comments and observations made by these two “Critical Friends” have been incorporated throughout this report where appropriate.

3.5 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.

4. Independent Chair and Author

4.1 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.

4.2 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.

4.3 The Independent Chair has experience conducting Domestic Homicide Reviews and Adult Safeguarding Reviews with enhanced 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.

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 in Criminology.

5. Terms of Reference

5.1 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.

5.2 The Terms of Reference were agreed and can be viewed at Appendix A of the Overview Report.

5.3 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 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 a number of homeless people had effectively become residents by pitching tents. What action did any agency take to effectively manage this situation and seek more suitable accommodation?

(v). 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 people likely to be involved. i.e., rough sleepers with a known background of alcohol abuse?

6. Chronology

6.1 In September 2019 the Kent Police were advised of a disturbance involving members of the homeless community resident in a makeshift campsite, the location of which, was known to them. Due to limited emergency response resources and other urgent outstanding calls, the police did not attend.

6.2 Early the next morning the police were advised of a body of a male lying motionless on the ground at this location. The police attended and found George. It was evident he had suffered severe trauma injuries to the head, back and chest. George was pronounced dead at the scene. Mary and Andy were arrested a short time later at the campsite.

6.3 George was homeless or more accurately a rough sleeper[1] 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 alcohol dependent (self-admitted) and had convictions for theft, violence and public disorder.

[1] Ministry of Housing, Communities & Local Government Rough Sleeping Strategy Page 13

6.4 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 was alcohol dependent (self-admitted) and had convictions for theft and violence. Mary seemed prepared to put up with the threat and actual use of violence by George against her to maintain the relationship. 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.

6.5 Andy was a rough sleeper in the three months immediately prior to the murder of George. Andy was a frequent user of alcohol and known to criminal justice agencies.

6.6 The review period for this DHR was set between 01 February 2018 and the date of Georges death. These dates were selected as the nearest point where there was evidence that both George and Mary were partners and both were part of a small group of people who were street drinkers, who congregated in the town centre during the day and were rough sleepers at night.

6.2 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. Mary did not want any action taken.

6.3 In March 2018 Andy was accused of assaulting a former partners new boyfriend and arrested. Andy was referred to a health practitioner whilst in police custody when he made a comment about self-harm. The health practitioner attempted to build a rapport, but Andy did not engage. Andy stated he was of *"sound mind and happy"* and the support worker concluded there were no concerns around mental health wellbeing or vulnerability.

6.5 Later the same day after Andy had been released and the allegation of assault not pursued, Andy telephoned the Police Control Room and stated he felt suicidal and at risk of self-harm. Andy was referred to the Mental Health Crisis Team who tried to get in touch with him. Follow up calls to Andy's mobile the next day were also unsuccessful. A home visit to his last known address and further attempts to contact Andy by mobile phone including leaving voice messages for him to get in touch did not generate any response. After a month, Andy's referral was discharged.

6.6 Mary was admitted to hospital in May 2018 suffering from blisters and swollen legs. Mary was treated over five days to reduce a body fluid overload and given supplements to address a lack of vitamins. The South East Coast Ambulance Service (SECAmb) crew taking Mary home 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 to the address she provided on admission. This referral was risk assessed and no further action taken predominantly because Adult Social Care were unable to contact Mary by mobile phone.

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

6.12 Two days later Mary made an allegation of assault 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.

6.13 At the end of 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 but did not turn up.

6.14 Mary and George were detained together for shoplifting twice in September 2018. 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).

6.15 In November 2018 Mary disclosed further assaults by George to a Police Community Support Officer (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.

6.16 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).

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

6.18 In January 2019 Mary disclosed 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.

6.19 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 6.18).

6.20 On the same day, at the same court, Mary entered a guilty plea to being drunk and disorderly (paragraph 6.17). 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).

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

6.22 On the same day 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 these services if this behaviour continued.

6.23 Whilst sleeping rough in disabled toilets in the town centre, Marys mobile phone and personal possessions were stolen at knife point. At the same time George was assaulted. This was reported, but no suspects were identified.

6.24 Two days later Mary received a tent from a homeless outreach agency to facilitate a relocation to where other rough sleepers slept on spare ground. This was confirmed by a police intelligence report that noted Mary and George were now living in a tent with other rough sleepers.

6.25 In March 2019 Mary advised the CRC Responsible Officer that George was sleeping in a separate tent, and they were not together.

6.26 Around the same time Andy was arrested 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.

6.27 In April 2019 Mary was arrested 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.

6.28 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.

6.29 In April 2019 George was arrested. Mary alleged George had punched her in the face. George was charged and bailed with conditions. Mary was provided with emergency accommodation.

6.30 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.

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

6.32 Following his arrest for this offence Andy 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.

6.33 In May 2019 George was arrested for shoplifting and breach of bail conditions. (Not to contact Mary). George was charged and remanded into prison custody pending trial.

6.34 Whilst George was in custody, 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 encounter that Mary had turned up sober.

6.35 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.

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

6.37 In June 2019 Mary attended a scheduled meeting with her CRC Responsible Officer. 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 Mary was engaging successfully with various support agencies and actively managing her alcohol dependency. This intention is supported by interactions with Oasis where Mary indicated a willingness to change. The note recommended for the pending court appearance a custodial sentence would be detrimental to the progress Mary had made on the rehabilitation journey.

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

6.39 Within days of Georges release, Mary failed to attend Magistrates' Court and received a 12-week custodial sentence in her absence. (This was for the offences at paragraph 6.27).

6.40 At the end of June 2019 Andy and another unknown person pulled a rough sleeper, from their tent, assaulted them and stole property. Andy was arrested, but the case discontinued due to evidential difficulties.

6.41 Following Andy's release from police custody the Homeless Outreach Centre referred Andy to Community Mental Health. Andy had disclosed to them (the Outreach Centre) thoughts of self-harm and that he had 'another person living in his head'. Andy had no control over this person and often found himself in custody with no idea how he had got there.

6.42 In July 2019 the CRC Responsible Officer for George instigated breech proceedings for not responding to the reporting requirements for the ATR court order.

6.43 Mary was arrested on warrant for failing to appear at court the same week. (See paragraph 6.39).

6.44 Four days later Mary appeared at Magistrates' Court via video link from prison. Based on the information provided by the CRC Responsible Officer (at paragraph 6.37), the Magistrates rescinded the original custodial sentence and replaced it with a suspended sentence order (12 weeks imprisonment) and alcohol treatment order. Mary was released from prison custody immediately.

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

6.46 Later the same week 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 any police action. 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.

6.47 Andy did not attend his scheduled mental health assessment with a psychiatrist arranged by the Community Mental Health Team following his referral to them. (See paragraph 6.41). There is considerable doubt Andy was aware of this appointment. Another appointment was made for late August 2019.

6.48 A week after her missed appointment (paragraph 6.45) Mary did not attend another 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 records, nothing could be found medically wrong and there were no visible signs of abuse or injury. Mary was promptly discharged.

6.49 Mary subsequently contacted the CRC stating the appointment (at paragraph 6.48) had been missed due to serious bleeding and admission to hospital.

6.50 A few days later Mary was arrested and charged for shouting and swearing in a public place whilst drunk.

6.51 Andy was arrested for being drunk and disorderly (not the same incident that Mary was arrested for) and taken to hospital by the police because of breathing difficulties. 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.

6.52 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).

6.53 A day after this missed appointment a third party reported an alleged assault on Mary by George. Police attended and noted Mary had a swollen face and cuts inside the mouth. When spoken to, Mary alleged George had punched her. The DASH assessment, graded as high, led to an automatic MARAC referral.

6.54 Two days later Mary was arrested for breaching the court order which had been 'fast tracked' by the CRC. (See paragraph 6.52).

6.55 On the same day, George was in police custody for the assault on Mary, as reported at para 6.53. 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 his release at a local coffee shop.

6.56 George appeared at Magistrates' Court the next day 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.

6.57 George did not attend the meeting arranged two days previously with the Vulnerability Support Worker.

6.58 In August 2019 Mary attended Magistrates' Court for the assault on George in July and entered a 'Not Guilty' plea (See paragraph 6.46). A trial date was set for the end of October 2019.

6.59 Andy was arrested for assaulting his partner and stealing her handbag. (This was a different partner from the one referenced at paragraph 6.35). 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. Maps and contact details were provided.

6.60 Andy did not attend the scheduled mental health assessment.

6.61 A MARAC meeting for Mary and George was held following the assaults reported in July. Whilst there was lots of activity by the various agencies prior to the meeting gathering information, there was no direct contact with either Mary or George 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.

6.62 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 in July 2019. (See paragraph 6.46).

6.62 An Outreach Worker subsequently saw both Mary and George together. They noted they were both sober and appeared to be getting on well.

6.63 A few days after the Outreach Worker saw them together, George was found dead.

7. Conclusions

7.1 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, rather than being homeless[2].

7.2 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

[2] Alcohol, crime and disorder

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[3].

7.3 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.

7.4 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.

7.5 This DHR will not solve the problem of rough sleeping. That remains the remit of the Governments published strategy and ambition to eradicate rough sleeping by 2027[4]. 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[5].

7.6 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.

7.7 I have carefully considered the issue of unconscious bias across the spectrum of intersectionality[6]. This was prompted, in part, by a comment made by the Police PCSO following an allegation of assault by Mary in February 2018 and the actions of several agencies that dealt with all three subjects of this review. 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.

[3] https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice
[4] Ministry of Housing, Communities & Local Government Rough Sleeping Strategy
[5] https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice
[6] Intersectionality, explained: meet Kimberlé Crenshaw, who ...

7.8 Decisions made were not driven by the fact the subjects 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.

7.9 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.

7.10 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. 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.

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

7.12 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.

7.13 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.

7.14 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 post release. Thus, any period of imprisonment would only have provided a short period of respite rather than a lifestyle change for either of them.

7.15 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.

7.16 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.

7.17 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.

7.18 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 I have drawn based on this case 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.

7.19 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 therefore 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.

7.20 Addressing the five key issues highlighted in the Terms of Reference (see paragraph 5.3), the following observations are made;

7.20.1 *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?*

7.20.2 Closing the referrals was done within the guidelines 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 because all three were difficult to contact by conventional means. 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.

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

7.20.4 The MARAC process was ineffective. This gap is addressed in Recommendation 9.

7.20.5 *Point (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?*

7.20.6 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, they just didn't want the assistance that could be provided. The barrier for positive intervention was not communication, but the resources that were available at that time.

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

7.20.8 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 rough sleepers who also have complex needs with additional funding[7].

7.20.9 There were multiple offers of help but perhaps 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 CRC). A trauma 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 Prof Preston-Scott[8] and this approached has since been widely endorsed as where the future lies in terms of professional practice with statutory and voluntary organisations.

7.20.10 In support of the Government's Homelessness and Rough Sleeping Strategy the District Council responsible for this area has recognised the importance of understanding 'the why'. In their Statutory Action Plan required as part of this strategy, the 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 these social, economic or government policy that are contributing to this problem.

7.20.11 *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?*

7.20.12 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).**

7.20.13 *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?*

[7] Support for people sleeping rough in England, June 2023
[8] https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice

7.20.14 This point 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).**

8. Lessons to be learnt

8.1 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).**

8.2 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 confirm these are complied with. This requires proactive management supervision, which this DHR has identified as an area for improvement. **(Recommendations 2, 5 and 8).**

8.3 Organisations both Statutory and Third Sector rarely 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.

8.4 The MARAC process is universally viewed as a valuable process. 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 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).**

8.5 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.

9. Recommendations

9.1 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 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	MARAC Steering Group and DHR Steering Group

		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).	
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)