Domestic Homicide Review

Ann/November 2018

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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1. Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and the support provided to Claire, Rose and Dan, residents of Kent, prior to the death of Ann, Claire's mother and grandmother of Rose and Dan on November 2018.

1.2 Around 9pm on this day, police were contacted by Rose, stating her father was outside trying to get into the house. There was a Restraining Order in place preventing her father coming to the home address and she was very frightened that he would gain entry. Police were dispatched to attend the address.

1.3 A short time later Rose, still on the phone to the police, told the call handler she could smell smoke and couldn't breathe. She further advised that she was now trapped upstairs, her nan and pet dog were on the floor not moving and she was going to jump from the bedroom window to escape the flames. On police arrival they found the house ablaze and Rose lying in the garden, suffering from smoke inhalation and injuries to her legs. Ann was trapped in the house. When the Fire and Rescue Service arrived, Ann was removed from the house and taken to hospital. Life was declared extinct at 22.50hrs. A subsequent post-mortem identified the cause of death as asphyxiation.

1.4 George, the father of Rose and estranged husband of Claire, was arrested a short time later and subsequently charged with murder and attempted murder. Following a three-week trial, he was found guilty on both counts and sentenced to 32 years imprisonment.

1.5 This DHR examines the involvement that organisations had between January 2018 and November 2018 with;

- Ann (a white British female in her 60's), - Deceased, mother of Claire
- Claire (a white British female in her 40's), - Survivor of domestic abuse
- Rose (a white British female child under 16), - Daughter of Claire
- Dan (a white British male in his 20's) – Son of Claire
- George (a white British male in his 50's) - Perpetrator

1.6 The start date of the 1st January 2018 was selected on the basis that the family were largely unknown to the agencies prior to this date.

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

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

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

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

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

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

f) highlight good practice.

1.8 This review began on the 22nd January 2019, following a decision by the DHR Core Group, ratified by the Chair of the Kent Community Safety Partnership, that the case met the criteria for conducting a DHR.

1.9 This report has been anonymised and the personal names contained within it are pseudonyms. This does not include the DHR Panel members.

1.10 The pseudonyms were chosen by the members of the family with particular care taken over the name chosen for the deceased. The perpetrator was not consulted.

2. Terms of Reference

2.1 The Review Panel first met on 27th February 2019 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of this report.

3. Methodology

3.1 The detailed information on which this report is based was provided by Independent Management Reports (IMRs), completed by each organisation that had significant involvement with any of the individuals cited at paragraph 1.5. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

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

4. Involvement of Family Members and Friends

4.1 The following family members were known to the Review Panel:

Name	Relationship to Ann (Deceased):	Relationship to George (Offender):
Claire	Daughter	Estranged wife
Rose	Granddaughter	Daughter
Dan	Grandson	Stepson
Robert	Friend	Cousin

4.2 The Independent Chair met with Claire and Rose on the 27th February 2019 to explain the purpose of the review. A copy of the Home Office DHR leaflet for family members was given to them. The content of this was explained, including the availability of independent advocacy services. A signed consent form was obtained from both Claire and Rose to access any records pertinent to them.

4.3 The Independent Chair met Claire, Robert and Dan after the trial had concluded on the 16th June 2019, to seek their views and feelings on what each organisation they had contact with had done well and what could be improved. The information they provided was subsequently used to challenge and test the submissions made by the participating organisations at the initial IMR meeting held on the 20th June 2019.

4.4 To 'hear the voice of the child', the Chair met with Rose on the 1st July 2019. This was to seek her views, thoughts and feelings. This conversation was conducted at her school, in the presence of her mother and the school's Designated Safeguarding Lead. This venue was specifically chosen to ensure that the appropriate counselling and pastoral support provided by the school was available to Rose should she need it.

4.5 It is appropriate to acknowledge that the school have been very supportive throughout the whole process, helping Rose to cope with the trauma she has suffered.

4.6 On the same day, the Independent Chair took the opportunity to speak to the mother and aunt of George. Details of the Home Office Guidance and a letter of introduction incorporating an invitation to participate in the review were delivered by the Police Family Liaison Officer (FLO) in advance of this meeting. Both his mother and aunt had fully supported George at his trial. They are still convinced of his innocence and are determined to financially support, at any cost, his appeal. However, it was apparent both were acutely aware of the impact this incident has had on their family relationships and both seemed genuinely broken-hearted that any contact with Rose, and to some extent Claire, is now over.

4.7 During these interactions, the Independent Chair took the opportunity to personally express, on behalf of all the participating organisations, his sincere condolences following the death of Ann, and a recognition of the significant adverse impact this event has had on all of the family members involved.

4.8 The Independent Chair has remained in regular contact with Claire, updating her on the progress of the review and highlighting key milestones and dates. This concluded with a meeting with the family on the 11th December 2019, where the final draft of the Overview Report was shared. A further discussion took place with Claire on the 17th December 2019, over the phone. The family were very happy with the Overview Report and did not want to make any changes. They felt the gaps identified by the report were balanced and fair.

5. Contributing Organisations

5.1 Each of the following organisations were subject of an IMR:

- A Kent Clinical Commissioning Group (CCG) covering the GP surgery
- Kent Police
- A Kent Acute NHS Trust
- Kent & Medway NHS Social Care Partnership Trust (KMPT) (Mental Health)
- Kent County Council (KCC) Children's Social Work Services
- Kent, Surrey and Sussex Community Rehabilitation Company (KSSCRC)
- Kent Education Safeguarding Service

5.2 In addition to the IMRs, the Kent Fire and Rescue Service and Ambulance Service were requested to submit brief reports on their involvement with the family following their encounter with them on the night of the fire. Victim Support provided a brief explanation of their involvement, which was limited to contact after the fatal fire.

6. Review Panel Members

6.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with the individuals highlighted at paragraph 1.5. It also included a senior member of the Kent Community Safety Team and an independent advisor from a Kent based domestic abuse service. Unfortunately, the independent advisor could not attend the two panel meetings personally due to other commitments but fully participated in the numerous document reviews following each meeting. The written responses provided were both comprehensive and insightful. During the review process contact was made with a peer support specialist from the charity

Advocacy after Fatal Domestic Abuse (AAFDA). This subject matter expert quality assured the draft report and assisted with providing the necessary support to family members.

6.2 The members of the panel were:

Claire Axon-Peters	NHS Clinical Commissioning Group
Afifa Ali	KCC Children's Social Work Service
Samantha Mercer	Kent Police
Debbie Tolhurst	Kent and Medway NHS Social Care Partnership Trust (KMPT) (Mental Health)
Tamsin Fletcher	Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)
Peter Lewer	Kent Education Safeguarding Service
Sarah Nichols	Kent Safeguarding Children Board
Catherine Collins	Kent Adult Social Care and Health
Kathleen Dardry	KCC Community Safety
Deborah Cartwright	Oasis - Domestic Abuse Service (Document review only)
David Pryde	Independent Chair

6.3 Panel members hold senior positions in their organisations and have not had contact or involvement with the persons involved in this review. The panel met on three occasions during the process. The Terms of Reference meeting was on 27th February 2019. The first IMR meeting was held on 20th June 2019 to review the initial responses from each organisation. The panel met again on 9th September 2019 to consider the draft Overview Report.

7. The Independent Chair and Author

7.1 The Independent Chair and author of this overview report is a retired Hampshire Police Chief Officer, who has no association with any of the organisations represented on the panel. He did serve with Kent Police, leaving the organisation in 2007 on promotion. This previous service has provided him with a good understanding of the structure of public services in Kent and Medway. He has experience and knowledge of domestic abuse issues and legislation, and a thorough understanding of the roles and responsibilities of those involved in a multi-agency approach dealing with domestic abuse.

7.2 The Independent Chair has considerable experience conducting reviews (including Serious Case and Safeguarding Reviews), investigations and inspections. He has carried out senior level disciplinary investigations and spent ten years chairing both police and support staff discipline tribunals. The Chair was an accredited Senior Investigating Officer (SIO) and Gold Commander. He has completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.

7.3 The Independent Chair is currently the Safeguarding Advisor to the Bishop of Winchester and carries out the role of Independent Chair for the Winchester Diocese Safeguarding Board, covering Church of England places of worship, institutions and schools in Hampshire and parts of Dorset. This provides him with the opportunity to maintain his ongoing professional development. To support this goal, he is an associate member of the Social Care Institute of Excellence.

8. Other Reviews/Investigations

8.1 Kent Police made a self-referral to The Independent Office for Police Conduct (IOPC). The Independent Chair has been in close liaison with the lead investigator. He requested Kent Police give their permission to share their chronology and IMR with the IOPC. This was to assist them to bring their investigation to a timely conclusion and help the family bring final closure to the challenges they have faced. Kent Police Professional Standards Department did not give their permission to share this information with the IOPC and did not give any explanation as to why they chose this course of action.

8.2 Her Majesty's Prison and Probation Service commissioned a Serious Further Offence Review. This review was completed on the 12th April 2019 when the identified gaps in practice were incorporated into an improvement action plan.

8.3 The Chair has been in contact with HM Coroner's Office for Kent.

9. Publication

9.1 This Overview Report will be made publicly available on the Kent County Council and Medway Council websites. Copies will be provided to the family prior to publication and their views sought before a final report is submitted. The final report will be shared with partner agencies, including the Police and Crime Commissioner, to support any learning from this review.

10. Equality and Diversity

10.1 The nine protected characteristics under the Equality Act 2010 have been reviewed and due consideration given as to whether or not these were applicable.

10.2 The age of Ann was considered. She was in good health and not under any medical care. That she was in her mid-sixties did not have a bearing on the issues raised within this review.

10.3 The mental health of George during the weeks prior to the fire was discussed by the participating members of the review panel. While clearly there were concerns about his mental well-being, the treatment he received was not at odds with the Equality Act.

10.4 Considerable discussion took place as to the age of Rose, who was viewed as a vulnerable child/young person. Particularly whether her age influenced the responses provided by the agencies involved. Rose was not treated as a victim in her own right. The Panel took the view that there were a number of factors influencing this outcome.

10.5 A number of agencies did not follow established statutory guidelines and best practice to protect young people. (The Childrens Act et al). This was not some form of unconscious bias based on age, but more a product of less than satisfactory professional practice and judgement. Agencies also concentrated on the risks Rose's father posed to her mum, rather than any risks he posed to her. It is a significant gap when the impact of domestic abuse on a child[1] is taken into consideration. Her needs were effectively overtaken by concentrating solely on the risks posed to her mum.

10.6 Had Rose been sixteen years old, she would have been a victim of domestic abuse as per the current Government definition of domestic abuse. This would have facilitated a bespoke DASH assessment for her. Her age meant she was reliant on support delivered through the mechanisms in place to protect young people alongside the recognition that such support was required for a child living with domestic abuse. (See Appendix B for domestic abuse definition).

10.7 The panel concluded, given the observations made above, the issue of Rose's age, when benchmarked against both the spirit of and the specific provisions in, the Equality Act were not applicable. The agencies failed to follow the statutory guidelines of managing risk and impact of domestic violence on a child which should have ensured Rose's needs were recognised and addressed.

11. Background Information

11.1 The victim in this case, Ann, lived alone in a housing association property around the corner from her daughter, Claire. Claire lived in her home with her two children, Rose and Dan. Claire had recently separated from her husband George, who following two convictions of assault on Claire, was the subject of

[1] Bellis, M.A., et al. (2016). Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Cardiff: Public Health Wales NHS Trust. Available from http://www.wales.nhs.uk/sitesplus/888/page/88504

a Harassment Restraining Court Order, preventing him attending the former family home or contacting Claire in anyway.

11.2 On the night of her death Ann was babysitting Rose at her daughter's house.

11.3 The details of the circumstances of Ann's death and the subsequent outcome of the investigation are detailed in the Introduction.

11.4 The following pen portrait may assist in providing a little more insight into the relationships between the family members involved.

11.5 Ann lived in close proximity to Claire. She was divorced and devoted to the well-being of her grandchildren, Rose and Dan. Ann often worked with Claire in her cleaning jobs and both were very close. They were in contact on a daily basis. Ann had a difficult relationship with George, to such an extent that she would not visit the house when he was present. This was a consequence of an earlier incident approximately five years ago when George assaulted Ann's brother (now deceased).

11.6 Claire married George seventeen years ago. Claire had a son from a previous relationship (Dan) and with the birth of Rose, the household was generally recognised as stable and happy. It is not clear exactly when the relationship between Claire and George started to become untenable, but both Claire and George made visits to their GP in February 2018 seeking help for depression. Around the middle of October 2018 Claire told George that their marriage was over, and things deteriorated very quickly after that.

11.7 Claire has described that she was always making excuses for George; that his abrupt and abrasive manner was just 'George being George'. She also described his past heavy drinking, excessive sexual demands and 'disgusting' sexual preferences. These were behaviours she was no longer prepared to put up with. (The term 'disgusting' was not explored further as Chair held the view that this was intimate personal information and had Claire wished to elaborate on what these were, she would have done so).

11.8 Rose is an academically sound early secondary school pupil who has an exemplary record of behaviour and attendance. Rose describes her relationship with her Dad as non-existent. He didn't talk to or show any interest in her. She mentioned that when she was younger and other kids' Dads picked them up from school, she often wished her Dad would do the same. He never did. She felt his only interest was in the three children from his previous marriage. The relationship between Rose and her Dad became more strained around October 2017, when Rose witnessed her father carrying out a sexual act in the front room whilst watching television. She asked him to stop. He refused to do so. She retreated to her bedroom and called her mum. This information was only disclosed to the police after the fatal fire.

11.9 Dan is a single man who is in steady employment. He did not get on with George. He was frightened of him until a few years ago and generally tried to

stay out of his way. According to Claire, George was very jealous of the relationship she had with Dan from a very young age. Following the first arrest of George, Dan stayed in at night because he was worried about the safety of his sister. He noted that George didn't come to the house when he knew he was indoors.

11.10 Robert owns a successful business. He is a cousin of George. His mother died when he was young, and he was brought up by a distant aunt. When she passed away two years ago he decided to reignite contact with this side of the family. Robert was very supportive to Claire when he witnessed George's conduct and behaviour. Robert became something of a confidant to Claire as the marriage unwound.

11.11 George has been described as 'an old-fashioned dad' by Claire and other family members. When this comment was explored further, they explained George had the view that it was up to mum to deal with the children and he did not have an active role to play. The very nature of his employment meant he worked irregular hours and as consequence he had irregular habits when it came to sleeping and eating. He was a heavy drinker but gave up a few years ago when his aunt took him to alcoholics anonymous after Claire gave him an ultimatum; he had to choose between "her or the drink". He resumed drinking to excess and allegedly used cannabis regularly when the marriage broke down and he was living with his mum. His mother and aunt both state that he withdrew into himself and would not talk to anyone during the time he stayed at his mum's house when this was his bail/curfew address.

12. Chronology

12.1 Although outside the time parameters set, the police were called to the family home in 2009 following a verbal altercation between Claire and George. No further police action was taken. There was no further contact with the police involving incidents of this nature until 2018.

12.2 On the 12th February 2018 George attended his local GP surgery. He stated that he was depressed, had felt low for the last six months and was not sleeping. The GP noted there was no active suicide ideation and agreed to his request to be treated by medication rather than counselling. A review was set for two weeks' time. George did not make a follow up appointment and the prescription was not repeated.

12.3 On the 23rd February 2018 Claire telephoned the same doctor's surgery and advised the receptionist that she was suffering with depression, she was tearful, and was having problems with her husband. An appointment was made to see the Doctor the same day. She disclosed to the GP that she had been feeling low, was tearful and had no enthusiasm. She asked to be put on anti-depressants. The GP agreed to her request and set a two-week review period.

12.4 On the 9th March 2018 Claire attended the GP surgery and complained of some unpleasant side effects and requested she be given another type of drug. The GP agreed to do this and noted her depression was still ongoing. Another review date was set.

12.5 On the 27th April 2018 Claire attended the GP surgery and disclosed to the Doctor that she felt the drugs were not having much effect. The prescription was renewed. Claire was encouraged to seek additional counselling support. This was the last time Claire attended the surgery for her depression.

12.6 On the 17th October 2018 Claire took George to the local A&E to seek help for severe back pain. After his treatment and release during the early hours of the 18th October 2018, there was an argument between them, culminating in George becoming very aggressive and violently hitting the window of the car. Claire was very frightened. She stopped the car and got out. George also got out of the car and snatched the car keys from her, causing a small cut to her thumb, before driving off in the car.

12.7 Claire contacted the police and reported the incident at 04.24hrs. She also expressed fear for the safety of her son and daughter who were at home. The police attended both Claire's location and the family home, where they found George lying on the ground at the front of the house. An ambulance was called, and after treatment George was arrested and taken into police custody.

12.8 Claire was initially reluctant to make any formal complaint but also disclosed to the police that George had assaulted her two days previously. She described waking up in the middle of the night to discover George lying beside her carrying out a sexual act. She got out of bed and went from room to room to get away from him and, at some point, she was struck on the back of the head from behind by George who had been following her around the house.

12.9 The attending officers completed a DASH assessment and graded the risk of harm as medium. They also persuaded Claire to make a full statement detailing the two incidents.

12.10 George was interviewed and charged with two counts of common assault, the theft of Claire's car keys and taking a vehicle without consent. He was released on police bail to appear at Magistrates' Court the following morning. His police bail conditions stated he was not to contact Claire either directly or indirectly and not to attend the family home for any reason.

12.11 Within minutes of his release from police custody, George sent Claire a Facebook message at 23.21hrs stating *"What the f**k".* Claire chose to ignore this message and did not contact the police.

12.12 Around 00.59hrs on the 19th October 2018 Claire and her son Dan heard a loud bang outside the house. Using track my iPhone, Claire was able to trace George's mobile and discovered it was located in the back garden/close proximity to the house. When they opened the front door, they noticed Claire's

car alarm had been activated. As the car did not lock, they concluded that the bang they had heard earlier was the car door being shut.

12.13 Claire called the police. They attended and completed another DASH assessment, grading the risk as medium. A Domestic Abuse Notification (DAN) was also sent to Children's Social Services. George was arrested a short time later.

12.14 George appeared in court the next day. The police opposed bail, pointing out that his current bail address was unsuitable, given that this address was at his mother's house in the next street. George was bailed with the same conditions imposed by the police to appear at Magistrates' Court on the 29th October 2018.

12.15 At 06.14hrs on the 25th October 2018 Claire was woken up by noise from the back garden. She ran to the back bedroom and discovered a ladder propped against the house wall next to an open window, which she promptly shut. Claire then heard George speaking through the letter box telling her *"Please do not phone the police, talk to me please"*. Claire ignored him and a short time later heard the ladder being moved. She then saw George standing on the patio area at the rear of the house.

12.16 Police attended but failed to locate George. A DASH and S-DASH assessment were completed and assessed as a medium risk.

12.17 Children's Social Services telephoned Claire the same day at 10.51hrs in response to the Domestic Abuse Notification (DAN) they had received from the police at 22.50hrs on the 23rd October 2018. This was the DAN submitted in relation to his breach of police bail on the 19th October 2018 and provided brief details of the offences alleged to have been committed. Claire was given contact numbers for local support services for victims of domestic abuse.

12.18 At 19.11hrs on the 28th October 2018 Claire contacted the police. Claire complained that her daughter Rose had been receiving text messages from George and that he wanted to see her. Rose was becoming distressed by these texts. Claire also disclosed that she had been sent text messages from George begging her to rethink their relationship. A DASH assessment graded the risk as medium. George had still not been arrested for the ladder incident on the 25th October 2018.

12.19 Claire rang the police on the 29th October 2018 at their request at 09.11hrs. Whilst she was on the phone she received another text from George. Police attended and took a statement from Claire.

12.20 George was located and arrested for breaching his bail at 11.50hrs the same day. He was taken to the Magistrates' Court that afternoon, where the three breaches of bail on the 25th, 28th and 29th October 2018 were brought to the court's attention. He was bailed again, with no changes to his bail conditions, to next appear at the Magistrates' Court on the 5th November 2018.

12.21 At 23.38hrs on the 30th October 2018 Claire contacted the police to complain George was texting Rose constantly and had sent over 100 texts in one day. Rose was becoming overwhelmed by the volume and content of the messages. No patrols were available until 03.40hrs so a decision was made to call Claire back later that morning. Police did ring back at 09.54hrs and an appointment made to see Claire on 1st November 2018.

12.22 At 13.31hrs on the 31st October 2018 Rose contacted her mum to advise her that George was in the back garden, on the pretext of collecting some tools. Claire contacted the police, but they did not attend due to the scheduled appointment for the next day to deal with the latest breaches of bail.

12.23 Later on that evening Claire contacted the police at 20.18hrs reporting text messages George had sent to Rose threatening to assault Robert, on the basis that he believed Robert was having an affair with Claire. Rose was really upset by the threats and the fact that she had been bombarded with another 100 plus texts during the day.

12.24 At 08.49hrs on the 1st November 2018 Claire contacted the police and reported that she had found a note she believed to have come from George.

12.25 The note said *"Why are you doing this to him I thought you was my friend, you are wrong. I will tell him everything I'm watching you, he don't deserve that".*

12.26 Claire is adamant the writing on the note was George's writing. From the content of the note it is possible that this was an attempt by George to isolate Claire from her childhood friend, who was also George's cousin. Claire had previously disclosed the difficulties she was having with George to this person and how unhappy she was with his sexual demands and preferences. This friendship was terminated when the marriage broke up.

12.27 Claire attended the police station for her prearranged appointment at 17.00hrs and provided a further statement to cover the most recent breaches of bail.

12.28 At 20.25hrs on the 2nd November 2018 Claire contacted the police stating George was at the house and was trying to force entry via the back door. She further advised that George had spoken to Rose earlier and told her *"He was going to get her mother back for this".* Rose asked him *"Are you going to kill her?".* George responded, *"That is nothing to do with you*". He also told Rose that he intended to kill himself.

12.29 Police attended the home address and completed a DASH and S-DASH assessment, grading both as a medium risk. They located George, who was intoxicated, at an address nearby and arrested him.

12.30 George appeared at court the following day. Both the police and the Crown Prosecution Service (CPS) opposed bail. They recommended he remain in custody until his next court date on the 5th November 2018. This was as much

for his own protection as that of Claire, Rose and Dan. George was released by the court with no changes to his bail conditions.

12.31 On the 4th November 2018 Robert contacted the police to advise them that George had travelled to the South Coast where he, Robert, lived in a caravan park. At that time Claire and Rose were staying with Robert. He further advised that George had been texting Claire stating he *"knows where they are"* and George had checked with reception as to the exact whereabouts of Robert's mobile home. Kent Police would have appeared to have taken no further action on the information provided by Robert, apart from completing another DASH assessment. This did not identify Rose as being involved and therefore no referral was made to Children's Social Services.

12.32 George appeared at Magistrates' Court on the 5th November 2018. He entered a guilty plea to two charges of assault on Claire. The theft charge and taking a vehicle without consent were discontinued by the CPS. He was sentenced to;

(1) A twelve-month Community Order;
(2) Rehabilitation Activity Requirement for fifteen days;
(3) Curfew between 1800hrs-03.30hrs and an electronic tag for 3 months;
(4) Restraining Order - Protection from Harassment until the 4th November 2021;
(5) Costs and Victim Surcharge.

12.33 On the 9th November 2018 George attended his initial induction with the Community Rehabilitation Company, where the rules and regulations of the court-imposed sanctions were explained to him.

12.34 At 18.37hrs on the 11th November 2018 George was admitted to the local A&E after he had taken a quantity of paracetamol mixed with alcohol. Earlier, he had sent a Facebook message to his mother saying *"Goodbye"*. Around about the same time a family friend noticed George sitting in his van by the roadside, which he thought was odd, and stopped to speak to him. He realised that George was unwell and contacted his mother, who called an ambulance.

12.35 On the 12th November 2018 whilst still in hospital, George was assessed by the local Psychiatry Liaison Team within the timeframes required. Their assessment concluded that he did not present a risk to himself or to others and his aftercare post release could be managed by his GP.

12.36 On the 13th November 2018 George was released from hospital having completed treatment to counteract potential effects of toxicity from the overdose that George was at risk of. George was taken into the care of his mum, who agreed to take him home. George was contacted by the Community Rehabilitation Company and asked to explain why he had breached his curfew. George advised them he had taken an overdose and had been in hospital. An appointment was made to see him the following day.

12.37 On the same day the school Rose attends contacted Claire to question a sudden drop in attendance. Claire advised the school she had separated from her husband and Rose had been affected by this. She also disclosed her husband had taken an overdose and was still in hospital.

12.38 On the 14th November 2018 George kept the appointment with his probation officer and his overdose was discussed at length. Arrangements were made for a follow up visit by George on the 20th November 2018.

12.39 At 18.25hrs on the same day, Claire and Rose contacted the police separately and reported George was at the back gate of the house shouting *"I want my effing telly".* Whilst on the phone to the police call handler, George left the scene. The police did not attend and provided safety advice over the telephone.

12.40 On the 15th November 2018 Claire contacted the police to ascertain what was happening in relation to the incident the day before. The police did attend, took a statement and raised an action on the incident log to arrest George.

12.41 Later that month Claire was with Robert at his caravan on the South Coast. Rose was at the family home being looked after by her grandmother, Ann. At 18.16hrs Robert called the police stating George had been texting Claire and sending unwanted text messages in breach of the Restraining Order. He further disclosed that George had contacted Rose and told her he knew her mum was away. He was outside the house and he was going to find Claire and Robert and burn the caravan down.

12.42 Robert made it clear to the police call handler that he was significantly concerned George was about to do something stupid and he should be arrested without delay. The police response was to telephone Ann (on Rose's mobile) and provide safety advice. No police officers were dispatched to the address in Kent.

12.43 At 21.01hrs Rose contacted the police and advised George was outside the house and both she and her grandmother were very frightened. George was banging on the windows and back gate in an apparent effort to get into the house. A police patrol was dispatched at 21.04hrs.

12.44 Rose and Ann made their way upstairs to a bedroom on the advice of the police. Rose heard a window smash, followed by the smoke alarm going off. Rose smelt smoke and had trouble breathing. When she opened the door, she saw flames and dense smoke. Ann and the family dog by this time were both lying on the bedroom floor not moving. Rose felt that she was burning and made the decision to jump from the bedroom window to escape the flames.

12.45 The first police patrol arrived at 21.16hrs and found Rose outside being assisted by neighbours. Ann was still inside the house, trapped by the flames. On arrival of the Fire and Rescue Service, Ann was removed from the house and taken straight to hospital. Life was pronounced extinct at 22.50hrs.

12.46 George was located at his mother's address and arrested at 21.40hrs.

12.47 Rose was taken to hospital and treated for smoke inhalation and an injury to her leg. Claire and Robert joined her there.

13. Overview and Analysis

13.0.1 All of the agencies involved, with the exception of the police, had very limited exposure to the family given the timescales involved. All have carried out a detailed examination of their processes and procedures and in all cases have identified areas for improvement.

13.0.2 For ease of reference it is sensible to review the actions of each agency individually and in the chronological order they came into contact with Claire, Rose and George.

13.1 The GP Practice

13.1.1 The surgery saw Claire and George separately in February 2018, both seeking help for depression. Claire mentioned difficulties with her husband to the receptionist but not apparently to the GP. Therefore, the GP treated each patient individually for the symptoms they presented.

13.1.2 George made one visit and did not make a follow up appointment. Claire made three visits over a couple of months. On each occasion Claire saw a different GP. It is not unreasonable for the surgery to assume if both George and Claire did not make any further appointments, the medication prescribed was either no longer required and/or they were seeking alternative treatment as had been recommended to them by their GP.

13.1.3 The practice had no records relating to either domestic abuse or safeguarding concerns for any member of the family.

13.1.4 The practice received a letter from Kent Police requesting a view as to George's suitability to hold a shotgun licence in October 2018. George had disclosed in his application that he had visited his GP for depression. They replied within 7 days that they could not comment on his mental well-being given the passage of time since his last visit to the surgery.

13.1.5 The practice received the discharge notice from A&E following George's suicide attempt and scanned it on to the system on the 13th November 2018. It was not reviewed by a GP until the 24th November 2018. This has been recognised as a gap and an area for improvement.

13.2 Kent Police

13.2.1 The first incident reported to the police on the 18th October 2018 was dealt with effectively. The police attended promptly, persuaded a reluctant witness to make a complaint and arrested George, who was subsequently charged and released on conditional bail with the instructions not to contact Claire either directly or indirectly, or to attend the former marital home for any reason.

13.2.2 A DASH assessment was completed and graded as a medium risk. However, Section 10 of the DASH form asks whether there any children or stepchildren in the house*?'* The response provided to the question was '*No'*. This meant the presence of Rose during the first assault was missed by the police manager in the Central Referral Unit, who consequently did not share details of this incident with Children's Social Services in accordance with policy. Rose, though cited as a witness on the DASH assessment and Crime Report, was not spoken to nor a statement taken from her.

13.2.3 George was a shotgun licence holder and had been since 2008. His shotgun licence, ammunition and an air rifle were seized following his initial arrest. A shotgun licence is renewed every five years. His most recent application was a routine five-year renewal. As George did not possess a shotgun at the time of his application, one can only speculate as to the reasons why he should make such an application.

13.2.4 What this review has identified is that there is currently no provision or process in place for the Police Firearms Licensing Department to be contacted by health professionals worried about a patient's state of mind. This is a process that could be utilised by GPs who are already aware if any of their patients are firearms licence holders.

13.2.5 Following George's release from police custody and his almost immediate breach of his bail conditions when he sent a text to Claire and then allegedly went to the marital home, police attended promptly and arrested George for the breaches of bail. A DASH risk assessment was completed and, even though it noted George had alcohol and mental health issues and had previously tried to commit suicide, the risk remained graded as medium.

13.2.6 George appeared at Magistrates' Court the next day on the 19th October 2018. The police request was for a remand in custody. This was the first occasion the police identified the current bail address of George's mother as highly unsuitable, because it was located in the next street to the former marital home. It was pointed out such close proximity offered Claire limited protection.

13.2.7 George was bailed to appear again at Magistrates' Court on the 29th October 2018 with the same bail conditions imposed by the police. He was not to contact Claire either directly or indirectly and he was not to attend the marital home, save for one occasion in the presence of the police.

13.2.8 Why did the Magistrates decide to allow bail on the same conditions? Further examination of the police remand in custody application perhaps provides a plausible explanation. In the section which specifically states what bail conditions are considered appropriate if the remand in custody is not granted, no mention is made of the need to change the bail address. If you couple this omission with the fact George remained graded as a medium risk on the DASH assessment, the Magistrates' decision was based on the information provided.

13.2.9 The breach of bail incident on the 25th October 2018 was when George placed a ladder against the house wall and was subsequently seen standing on the patio. The police attended but other than an immediate area search, there is nothing more recorded about what actions were taken to trace and arrest George. In fact, the call record (Storm) and the incident record on Athena were both closed on the 26th October 2018 with no arrest being made. There should have been a comprehensive record made of what actions had been taken to arrest George and the incident record not closed until his arrest had been carried out.

13.2.10 A DASH and S-DASH assessment was completed for this incident and graded as medium. This is despite the fact that the assessments recorded a significant impact on Claire - fear of being killed, an escalation of coercive, controlling and stalking behaviours, a disregard for court bail and an obsession to rekindle their relationship.

13.2.11 It is pushing the boundaries of credibility to maintain a risk assessment as medium in these circumstances. It is also a significant concern that this assessment would have been independently reviewed and 'signed off' by a supervising officer.

13.2.12 Rose was identified as being present and a referral to Children's Social Services was made. There is, however, no record of Rose being spoken to by Children's Social Services nor any action taken by the police regarding the text messages being sent by George to Claire.

13.2.13 The next incident on the 28th October 2018 concerned Claire's complaint to the police that Rose was receiving distressing text messages from her Dad and that she, Claire, was also receiving text messages from George. A DASH assessment was completed and inexplicably (in the absence of any explanation from the recording police officer) Section 10 was not completed correctly. As a result, no referral was made to Children's Social Services.

13.2.14 The DASH assessment was also graded as medium. It would appear that this incident was treated in isolation to the other breaches of bail. It was only subsequently recorded as a Harassment without Violence. Had this assessment been completed with due consideration to the other incidents, it is highly unlikely the assessment would have remained medium.

13.2.15 The police response to Claire's telephone contact (at their request) with them on the 29th October 2018 resulted in George's prompt arrest and appearance at court for breaches of bail on the 25th, 28th and 29th October 2018. He was released by the court on the same conditions as before. The CPS did not oppose bail. One can only speculate what view both the CPS and/or the Magistrates' Court would have taken with regard to bail had the DASH/SDASH assessments been graded as high.

13.2.16 The incidents on the 30th October and 31st October 2018 reported by Claire were dealt with inappropriately. By this stage George was persistently using Rose as a conduit to engage indirectly with Claire, demonstrating clear evidence of intimidation and stalking behaviour. This is within 48 hours of being released on court bail. Add the fact that a young vulnerable person was terrified. To manage these incidents by way of appointment on the 1st November 2018 is, at best, a poor service and does not reflect well on an organisation that is committed to victim care.

13.2.17 Kent Police operate a policy of managing some incidents by appointment when they are not high risk or do not require an immediate attendance. There are a number of exceptions, one of which is domestic abuse involving a crime. In this case, because the incidents were recorded as breaches of bail and not also as the crime of Harassment, which they should have been, this exception was not applied.

13.2.18 Claire attended the police station on 1st November 2018 and provided a statement concerning recent incidents where George had breached his bail. What the statement did not include were the alleged breach of bail incidents on the 30th and 31st October 2018. It would also appear that the relevant records that should have been raised were not. No incident record or crime report was raised for the breach of bail involving the written note found in the garden.

13.4.19 Each breach of bail should have a separate record, detailing each specific incident. Not recording the incident breaches national crime reporting standards. This omission also has other consequences. In this case, the alleged incidents on the 30th October 2018 and the 1st November 2018 were not brought to the attention of the court when George next appeared before Magistrates on the 3rd November 2018.

13.2.20 The next incident on the 2nd November 2018, when Claire reported that George was trying to force entry to house, resulted in the prompt arrest of George who was detained for a court appearance the next day. A DASH/S-DASH assessment was completed. The DASH assessment highlighted a number of high-risk DASH factors and evidence of stalking behaviour but was still graded as a medium risk. The S-DASH did not reflect accurately the incidents and escalating behaviour of George and therefore was also assessed as a medium risk.

13.2.21 Both the police and Crown Prosecution Service opposed bail at Court on the 3rd November 2018, seeking a remand in custody until his next scheduled court date on the 5th November 2018. As part of the remand application, the unsuitability of his current bail address was highlighted. Crucially, as previously mentioned, a number of the breaches in his conditions over the previous few days were omitted. The section where the police are asked to provide appropriate bail conditions made no mention of the unsuitable bail address and George was still regarded as a medium risk. With these gaps and based on the information before them, the Magistrates were entitled to release him on the same conditions.

13.2.22 The incident reported on the 4th November 2018, which involved further breaches of bail with intimidating text messages to Claire and Rose, was not investigated. A DASH assessment was completed and again deemed to be a medium risk. It also failed to identify Rose as a victim, with the resulting failure to alert Children's Social Services of her involvement. It appears that this incident was treated in isolation to all the other incidents, which reflects a failure to recognise the growing risk George posed to his estranged wife, daughter and cousin.

13.2.23 George appeared in court on the 5th November 2018, entering a guilty plea. It is not known what consideration the court took of his consistent breaches of bail. However, the information provided to the Magistrates prior to sentencing was less than complete. (See paragraph 13.4.3).

13.2.24 On the 14th November 2018 Claire reported to the police that George was at the back gate demanding his television. Whilst she was on the telephone to the police operator, he left. The police response was to offer safety advice. Based on past history and conduct, a more appropriate response would have been to send a police patrol to take a statement from Claire and Dan and arrest George for a breach of his Restraining Order without further delay.

13.2.25 At 08.08hrs on the 15th November 2018 Claire contacted the police to ascertain what was happening with the previous day's incident. The police did attend at 13.22hrs, took a statement and marked up the call incident record that George should be arrested when he returned home to his bail address to comply with his curfew. The call incident record was closed with a note that the arrest process could be managed via the Non-Crime incident report.

13.2.26 At this time Kent Police were in the process of changing their existing crime recording system Genesis to the new crime recording system, Athena. During the transition process, while the system records an officer attending and creating a Non-Crime Incident, this did not manifest itself on the system until the 19th November 2018. There were a number of system failures during the transition and this record would have appeared 'to have been lost in the ether' for forty-eight hours. While the call record should not have been closed without the outstanding arrest being actioned, this decision was made

on the assumption that his arrest would have been managed by another process. It was only after the event that the problems of the system transition became apparent.

13.2.27 The next contact with the police relates to the call made by Robert at 18.16hrs later that November in 2018, complaining that George was still contacting Claire via text and sending intimidating texts to Rose.

13.2.28 This is a key phone call. Robert articulates the risk that George poses in unequivocal terms. The assumption by the police call handler would appear to be that George was on his way to the South Coast to cause serious injury or harm to Robert and Claire.

13.2.29 No patrol was dispatched to check on George's whereabouts - he should have been at his bail address and under the control of his electronic tag as his curfew started at 18.00hrs.

13.2.30 Had this action been taken and George arrested for the outstanding breaches of the Restraining Order, the events later that evening would have been prevented.

13.2.31 This is a point of specific concern for the family. They cannot understand why no action was taken to arrest George. This is an issue they have raised with the IOPC and this forms part of their investigation into the rationale behind the decisions taken by police staff that evening.

13.2.32 In the event, the police response was to contact Ann via Rose's mobile phone and offer safety advice.

13.2.33 The police response to the phone call made by Rose at 21.00hrs immediately recognised the seriousness of the incident and they promptly dispatched a patrol.

13.2.34 Following Rose's subsequent and distressing commentary as the fire engulfed the house, significant police resources were deployed, which led to the early arrest of George.

13.2.35 The post incident investigation, while not part of this review, was undoubtedly thorough, leading to a conviction and a substantial period of imprisonment.

13.2.36 Claire and Robert are particularly critical of the lack of communication with them at the hospital and that their requests for information were not answered quickly enough.

13.2.37 By contrast the family, and Rose herself, cannot praise highly enough the interaction, care, consideration and compassion displayed by the appointed Family Liaison Officer (FLO) in the aftermath of the incident, and her role during the investigation and subsequent trial.

13.2.38 It will be apparent that there are a number of gaps in this overview. This is a direct consequence of the ongoing IOPC investigation which prevents further probing as to what the officers involved did or did not do.

13.2.39 This must be a caveat to the following analysis.

13.2.40 The risk management tool RARA (Appendix B) is not articulated fully in any one of the reports. Had this process been used effectively, it would have undoubtedly highlighted the escalation of risk, repeat victimisation and stalking.

13.2.41 DASH assessments were completed on almost every occasion. However, its use did not truly articulate the risk George posed to Claire or Rose. This may be because DASH, as an assessment tool to identify risk, is no longer fit for purpose or alternatively it was simply because it was not used properly. The Panel took the view it is likely to be a combination of both factors.

13.2.42 Recent research by Turner, Medina and Brown[2] indicates the value of DASH as a process to indicate the risk of extreme violence/homicide is of limited value. There are also actions in place by the College of Policing to develop and trial a new version of the DASH assessment process. Regardless of which process is followed, if it is not completed thoroughly and properly the subsequent assessment regarding the potential risk of harm will always be flawed.

13.2.43 The inability of officers to correctly respond to the DASH Section 10 question is a concern. The question reads as follows:

> '*Are there any children or stepchildren that don't belong to the abuser in the household? Or are there other dependents in the household (e.g. older relative)? Include comment and include all details of children in the household. Record the location of the children in the household'*.

13.2.44 The question, while wordy, is explicit - the details of all children should be recorded. If the answer is 'Yes' to this question, then the CRU would have reviewed the incident and made a decision as to whether or not a Children's Social Services Domestic Abuse Notification should be generated.

13.2.45 Without speaking to the officers concerned it is difficult to understand why, on more than one occasion, this part of the form was completed incorrectly.

13.2.46 Each DASH assessment is reviewed by police supervisors in the Central Referral Unit. This 'safety net' of external supervision or scrutiny missed a number of opportunities to actively intervene on several occasions because the form was not completed properly. If the response to the question was left blank, then the omission should have been challenged.

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[2] Turner, E. Medina, J. Brown, G. 2019 'Dashing Hopes? The Predictive Accuracy of Domestic Abuse Risk Assessment by Police' *The British Journal of Criminology.*

13.2.47 Another missed opportunity concerns the alternative pathway to a MARAC referral. While the DASH assessments were assessed as medium, no consideration was given to their volume or frequency. Had the number of DASH assessments submitted over such a short period of time been considered, there was more than enough evidence to justify a referral to MARAC on the grounds of 'potential escalation'. Frontline staff should have picked up on this, but the failure to do so by the CRU, who should have had a holistic overview of all the assessments, is a significant failing.

13.2.48 Rose was the subject of multiple incidents of non-violent harassment by George. No reports record that she was spoken to independently, nor treated as a victim in her own right.

13.2.49 Had she been recognised as a victim, this would have triggered child protection referrals, a strategy discussion and a decision to carry out a Section 47 joint or single agency investigation. This process would have brought 'vigour and grip' to the investigation process.

13.2.50 In the end 'the voice of the child' was not considered.

13.2.51 This meant Rose never had the protection of additional bail conditions to protect her interests. Given George repeatedly ignored the bail conditions imposed, this may be something of a moot point.

13.2.52 However, it is hard to imagine a Magistrates' Court ignoring the needs of a child when dealing with a breach of bail that involved a vulnerable young person. Had this information been available, it would have significantly influenced a decision to remand in custody as against granting further bail.

13.2.53 Following the first incident when George was charged and bailed, all subsequent incidents were subsequently dealt with as a breach of police/court bail.

13.2.54 There was only one incident that was properly recorded as harassment. It is as if each incident was treated in isolation and, where the connection was made with previous incidents, it was not a complete picture which inevitably undermined both the reporting officers and Magistrates' understanding that George's behaviour was not only escalating but had transformed to stalking.

13.2.55 The risks stalking brings to the well-being and safety of those subject to such conduct are well known and would have been acted upon, or at the very least prompted some searching questions from all of the agencies charged with protecting the vulnerable.

13.2.56 This view can be reinforced by the fact that Claire was never graded as a high-risk victim in any of the DASH assessments.

13.2.57 A high-risk victim is automatically referred to a Multi-Agency Risk Assessment Conference (MARAC). This would have prompted a multi-

agency response which would have delivered a higher level of oversight, information sharing and safety planning.

13.2.58 Kent Police missed the opportunity on several occasions to share information with partners, correctly record incidents, fully investigate incidents and expedite the arrest of George.

13.2.59 To provide some mitigation to this observation, partners equally missed opportunities to engage and share information with the police or to display a professional curiosity that what they were being told by George was factually correct. This interaction could have prompted a different approach or response by the police.

13.2.60 Kent Police did not recognise Rose as a victim in her own right.

13.3 Kent Children's Social Services

13.3.1 On the 1st October 2018 Children's Social Services implemented a new process for the first point of contact for members of the public and other agencies, known as 'Front Door'.

13.3.2 The purpose of this unit is to provide an early triage process to determine whether the threshold for Children's Social Work intervention is met. The system introduced more scrutiny and professional judgement to the screening process applied by front line staff by their immediate management.

13.3.3 Inevitably with any new process there is a transition period, and at the relevant time there were some staffing gaps.

13.3.4 Front Door received their first Domestic Abuse Notification (DAN) from the police by email after close of business on the 23rd October 2018. This detailed the arrest of George and the subsequent charges laid against him for the assault on Claire and his later breach of police bail conditions. This prompted a telephone call to Claire at 10.50hrs on 25th October 2018, providing safety advice and sign posting to relevant support services for victims of domestic abuse.

13.3.5 A second DAN was received on the 26th October 2018 relating to the ladder incident which occurred around 06.10hrs on the 25th October 2018. It is of note that the telephone call to Claire was made on the same morning as the ladder incident, but before the DAN relating to this incident was received.

13.3.6 As a result of the two DANs, further information was sought from the police regarding the details of the assault on the 18th October 2018.

13.3.7 A further DAN was received on the 4th November 2018. This detailed the incident on the 2nd November 2018 when George tried to gain entry to the marital home via the backdoor. The DASH assessment made reference to George previously following Claire around the house whilst performing a

sexual act on himself, and a conversation with Rose that he intended to kill himself as he had “nothing left to live for”.

13.3.8 Apart from the telephone conversation with Claire, the response to the three DANs was ‘record for information only’.

13.3.9 The next referral received related to the fatal fire and detailed that Rose was in hospital. This prompted a decision to instigate a Section 47 Enquiry.

13.3.10 A final DAN was received from the police on the 22nd November 2018. This related to the incident that occurred on the 14th November 2018, when George breached his restraining order in an attempt to recover his television. The only plausible explanation as to why there was such a delay in this notification being sent/received is the previously referred to system failures in the Kent Police IT system as they moved from Genesis to Athena.

13.3.11 In the self-analysis the organisation has identified that following the third DAN referral (para 13.3.5), contact should have been made with Claire to clarify whether Rose had witnessed George’s sexual behaviour around the house, and what was the potential impact on Rose with her father’s current behaviour, especially after the comments about his intention to self-harm.

13.3.12 The DAN had made no reference to Rose being present (during the assault) and the further request for information around the original assault was also silent on whether or not Rose had witnessed this incident, as against simply being present in the house. While it was good practice to seek further clarification on the information provided, the right questions were not asked.

13.3.13 There is also an acknowledgement that their response focused on providing Claire with the necessary support, to the exclusion of Rose, based on the information available to them at that time.

13.3.14 It is reasonable to point out that had Children’s Social Services been privy to all of the incidents known to the police and the information they possessed, coupled with knowledge of the attempted suicide, their decision to file the reports as effectively ‘no further action’ would have been quickly reviewed.

13.4 The National Probation Service and Community Rehabilitation Company

13.4.1 The National Probation Service (NPS) provide a report to the Court to give a Judge or Magistrate an assessment of the issues the defendant has, the level of risk they pose and what sentence may assist in preventing further re-offending.

13.4.2 George entered a guilty plea to two counts of common assault when he appeared at Magistrates’ Court on 5th November 2018. The NPS provided an oral report to the bench.

13.4.3 In the self-analysis the NPS have acknowledged that there were a number of gaps in the information provided to the sentencing Magistrates. Significantly no reference was made about the sexual element of the offence i.e. George carrying out a sexual act and chasing Claire around the house before he assaulted her in the presence of Rose.

13.4.4 The risk assessment described George to be a low to medium risk of psychological harm to Claire. No reference of risk to Rose was made. In fact, the safeguarding element of the report was largely blank.

13.4.5 The probation officer making the oral report and subsequent corresponding documentation was relatively new in post and was working with minimal supervision and support, in what is regarded to be a very busy court. The NPS have identified that these issues are an organisational gap and have since introduced a number of measures following the Serious Further Offence Review (SFO Review). The SFO is a statutory requirement when a person under supervision commits a further serious offence.

13.4.6 Once an offender is sentenced, the NPS use an assessment tool called the Risk of Serious Recidivism Score (RSR) to assess who should manage the convicted person. A person who is assessed to be a high risk is managed by the NPS. A person who is assessed as a low to medium risk is managed by a Community Rehabilitation Company (CRC). This system is currently under review as part of the broader Criminal Justice improvement agenda.

13.4.7 The threshold score for the NPS to manage an offender is set at 6.9. In George's case he was assessed at 0.22. Even though the assessment was based on incomplete information, if the forms had been completed thoroughly and to the highest possible standard, with the index offences involved, George would not have met the threshold for the case to be allocated to the NPS.

13.4.8 The decision to manage George by the CRC was made on the 6th November 2018. He attended his initial meeting on the 9th November 2018 where the rules and restrictions placed upon him by the sentencing court were fully explained.

13.4.9 Following this initial meeting the CRC complete a risk assessment and a sentence plan on a system called OASys. (Offender Assessment System). This also involves the submission of a form to Children's Social Services seeking any information they have that may relate to any safeguarding issues they may be aware of to any children of the offender.

13.4.10 It is of note that no reference was made of this request by Children's Social Services in their document submission. It is also of note that standard operating procedures within CRC require a 'chase up' to Social Services within seven days if no reply has been received. No 'chase up' was undertaken, although it is fair to acknowledge only eight days had passed between the request being made and the fatal fire.

13.4.11 There are two layers of OASys. There is a basic check and a standard check where a more comprehensive risk assessment is undertaken.

13.4.12 A basic check should not be used if there is evidence of domestic abuse.

13.4.13 In George's case a basic check was undertaken, a decision sanctioned by the Reporting Officers manager. The reason given was that it was a pragmatic decision to manage a critical workload due to severe staff shortages at that time.

13.4.14 There was also a standing instruction that when a basic check had been utilised against the operational guidelines, a full OASys risk assessment had to be completed within a month. Given the timescales involved in this case, this did not happen.

13.4.15 SARA (Spousal Assault Risk Assessment) is a standalone process that should be completed at the start of an order when there is evidence of domestic abuse. This is automatically triggered when a standard check is used. It is not triggered when a basic check is used and so consequently no SARA was completed.

13.4.16 On the 13th November 2018 the CRC, following contact from the electronic tagging company notifying a breach of curfew, telephoned George to seek an explanation. He informed them he had been in hospital following an overdose. An appointment was made to see him the next day.

13.4.17 George kept his appointment on the 14th November 2018. He produced his discharge papers to account for the breaches in his curfew and he was signposted to contact the Samaritans, the Mental Health Crisis Team and his GP. A further appointment was set for the 20th November 2018. This was good practice on the basis that his original risk assessment would have not required such intensive supervision.

13.4.18 In the self-analysis conducted by both the NPS and CRC, there is a clear admission that the assessments completed by both organisations were of below average quality. The NPS provided an RSR score that was inaccurate, which undoubtedly influenced the thinking of the CRC in terms of future risk. The OASys system was completed at the basic layer, which meant there was no thorough analysis or assessment of George and the risk he posed to both himself and others.

13.4.19 At the follow up meeting on the 14th November 2018 after his discharge from hospital, the focus was on the wellbeing of George, at the expense of considering the wider picture as to what this meant in terms of risks to others.

13.4.20 Put another way, 'the toxic trio' of mental health, substance misuse and domestic abuse was missed. Had this been identified, it would have prompted further contact with partner agencies, who would have provided information in addition to the information selectively provided to them by

George. This would have provided the basis of a better-informed risk analysis of the potential threat George posed.

13.4.21 The Serious Further Offences Review identified a number of recommendations to change working practices and procedures. The delivery of this action plan will close the gaps identified in this review.

13.4.22 The OASys system has since been decommissioned in the CRC and a new system brought in called M-SAT (My Solution Assessment Tool). M-SAT became fully operational in December 2018 and effectively closes all the gaps identified with OASys.

13.4.23 Significantly with M-SAT there is no option other than to carry out a full risk assessment and comprehensive sentence plan, bespoke to the needs of the individual and the risks he/she may pose.

13.5 A Kent NHS Acute Hospital Trust

13.5.1 George attended A&E by ambulance on the 11th November 2018. He was assessed using the hospitals SMaRT risk assessment tool and a medical care plan was initiated.

13.5.2 As part of the care plan he was referred to Psychiatric Liaison Services for an assessment following his medical recovery from the overdose.

13.5.3 Having completed his psychiatric assessment, George was discharged from the Ambulatory Care Unit on the 13th November 2018.

13.5.4 The Emergency Department followed standard medical practice to treat patients who have overdosed on paracetamol and alcohol. They identified George was an absconding risk and placed him in a bed that was under observation, recording a description of him and the clothes he was wearing. This is good practice.

13.5.5 The staff were curious enough to probe why he had taken an overdose and why he was wearing an electronic tag. He provided an explanation that he had recently split up from his wife and she had a Restraining Order against him, which he had subsequently breached, hence the tag. Recently published research highlights an eight-stage progression to homicide relating to Intimate Partner Femicide.[3] Separation is at stage 4 of this timeline. In hindsight, with an awareness of these eight stages and their escalation of risk of homicide, a greater level of concern and caution may be expected when the recent separation from his wife and accompanying Restraining Order came to light.

13.5.6 The staff took at face value what they had been told and did not make any checks with the police to verify why he was wearing a tag. Given that they

[3] MoncktonSmith, Jane (2019) Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide. Violence Against Women. ISSN 15528448

had already identified him as a possible absconder, they were potentially exposing themselves to unnecessary risk as to the potential level of threat George posed to them without further investigation. However, they did make a judgement that there was no suggestion from George that he intended to commit further criminal acts.

13.5.7 What is missing from the commentary contained in the notes are any comments or questions about potential safeguarding risks to children. If the hospital staff did ask about Rose, they did not make a record of it.

13.6 Psychiatry Liaison Team (KMPT)

13.6.1 George was referred to the Psychiatry Liaison Team as part of his treatment plan following his overdose. George saw two registered mental health nurses for an assessment within the 48-hour guidelines whilst still a patient in A&E on the 12th November 2018.

13.6.2 The practitioners followed policy and completed a detailed risk assessment and explored his intentions about his estranged wife and daughter in terms of possible risk and harm. They also explored his relationship with alcohol and what treatment he was currently undergoing, with private counselling and his GP, to help him deal with his depression and the impact of his recent marital break-up.

13.6.3 The team concluded, based solely on the answers provided by George, that he did not have any acute mental illness that required intervention from a secondary mental health service. The team were satisfied that his statement that he was engaged with private counselling and was in contact with his GP was true. This was in accordance with NICE guidelines for the first line of treatment for low to moderate levels of depression.

13.6.4 In the analysis by the Mental Health Trust there is a recognition that George was less than truthful about his current circumstances and the relationships he had with his estranged wife and daughter. He also underplayed why he was on an electronic tag.

13.6.5 While probing questions were asked in different ways about his alcohol consumption, relationships and his inner thoughts and feelings, the fact he provided consistent answers seemed to reassure the practitioners that what they were being told was accurate and true.

13.6.6 No checks were made with the police to obtain further information, albeit he was wearing an electronic tag and had admitted some criminality. No contact was made with Children's Social Services, albeit a child had been identified as potentially at risk. Both these organisations would have been in a position to provide contextual background information. In the case of Children's Social Services, because the case had been closed there would have been no additional information passed over, other than that the case was closed.

However, a note would have been made of the suicide attempt by Children's Social Services which would have been of some benefit to that organisation.

13.6.7 There is some suggestion that these organisations in the past have been reluctant to share information. This perception may have influenced the decision not to make any contact.

13.6.8 No checks were made with his GP. As this contact would involve one health professional to another, it is more likely than not that some medical history would have been shared. It does seem a little odd that the mental health practitioners judged a single visit to the GP for depression eight months ago as 'a patient under the care of their GP' for mental health concerns. This assumes that they were aware that his last visit to his GP was some time ago.

13.6.9 The review has identified a number of training gaps and additional work that needs to be done in relation to patients who present wearing an electronic tag, not least an automatic referral to the police liaison officer. These learning points are covered in the action plan.

13.7 Rose's School

13.7.1 Rose joined the school on transition from her primary school in September 2017. The school is rated by Ofsted as 'Good'. It is a mixed secondary academy divided into four colleges, with around 350 pupils in each college.

13.7.2 Rose has been described by staff who knew her as a quiet, unassuming student who did not need any academic or pastoral support. Her attendance during the academic year 2017 - 2018 was recorded at 97% with all absences authorised and appropriately recorded.

13.7.3 In October 2018 her attendance at school dropped significantly, prompting a member of the pastoral care team to contact Claire to query why this was the case.

13.7.4 Claire advised the school that she had recently split up from her husband and Rose *"was really affected by this"*. Claire also advised the school that her estranged husband had taken an overdose and was still in hospital. Claire did not ask for any additional support, other than to monitor the wellbeing of Rose whilst she was at school.

13.7.5 The member of pastoral support e-mailed their supervisor with an update. No further action was taken.

13.7.6 The school recognise and acknowledge, given the information presented to them regarding the breakdown of the marriage, the fact Claire was affected by this and the attempted suicide by Rose's Dad, that this should have been raised with the Designated Safeguarding Lead for the Academy. This would have prompted direct engagement with multi-agency partners and triggered

an intervention with Rose personally to find out and assess how she was coping.

13.7.7 Had the school been privy to the information supplied by the 'Operation Encompass' initiative, 'vis a vis' multiple notifications of domestic abuse incidents at the home of a pupil, the school would have taken action and engaged with Rose and other agency partners. At that time 'Operation Encompass' was limited to primary schools.

13.8 George

13.8.1 The panel gave due consideration as to whether or not George should be spoken to as part of the review process. After all, only George can give an account as to why he did what he did and what, from his perspective, could have been done differently to help him.

13.8.2 The fact that George is still in denial (he is actively pursuing grounds for an appeal) and given his previous dishonesty in his dealings with various agencies, it was concluded that this course of action would not be appropriate. A significant factor in coming to this decision was the potential negative impact this could have had on both Claire and Rose.

13.9 Other Observations

13.9.1 Although outside the relevant time frame, the family wanted to raise the following issues as part of the review process.

13.9.2 Having lost their home and all their possessions, the family are incredibly grateful for the help they received from volunteer support agencies, local charities and members of the public.

13.9.3 While they were placed in temporary accommodation, Claire had no means to earn money from her cleaning jobs. They were on half board and they did not have the financial capability to buy lunch. For a family trying to cope with the trauma they had suffered, this was an unnecessary hardship.

13.9.4 They were rehoused by the Housing Association (who had earlier made a cash payment of £500 to buy clothes) relatively quickly. This is commendable.

13.9.5 The house the family were given was completely empty. There were no beds, duvets or pillows. No white goods, no cooking utensils or plates. They had a very limited financial capability to purchase the basics. Due to austerity, hardship funds are no longer in place and all that was available were a few grants of £50 from Social Services.

13.9.6 The family expressed a sense of frustration that arrangements to secure furniture and white goods by Social Services in advance of taking up occupancy of the new house failed to materialise. It was only the kindness

of various charities, members of the public and the efforts of the voluntary sector support groups that enabled the family to furnish the house with essential items over a period of weeks. It would have been more compassionate to leave the family in temporary accommodation and furnish the house with basic essentials before moving them in.

13.9.7 Dan was initially ignored by Social Services. It was only after Claire protested that he was included in the temporary accommodation arrangements. Even though he has lost most of his possessions, he is not entitled to Criminal Injuries Compensation because he was not physically hurt.

13.9.8 To their considerable credit, Dan's employer gave him £900 to buy some clothes and more than two months off work on full pay. For a small, privately owned company, this displayed considerable kindness and compassion. The report writer has already written to the two Company Directors to officially and personally thank them for their generosity.

13.9.9 There ought to be some form of central provision to provide financial aid to families who find themselves homeless and almost destitute through the criminal conduct of another engaged in domestic abuse. Insurance is not the answer because it becomes 'null and void' if the person responsible for the damage is also the policyholder.

13.9.10 Losing a close family relative and everything you own is not only catastrophic, it is life changing. By way of a precedent, every household in the Grenfell Tower tragedy received a cash payment of £500 followed by £5,000 deposited into a bank account. This money came from central funds and was available within five days of the tragic fire.

14. Conclusions

14.1 In addition to the procedural errors made by a number of the organisations involved, there is one overarching theme - there was limited effective inter-agency working.

14.2 Where information sharing did take place, it was either incomplete or inaccurate in terms of highlighting the potential risk George posed to Claire, Rose, Dan and Robert.

14.3 The DASH process and its practical application appears to be at best problematic, at worst a contributing factor to the events that led up to and included the fatal fire.

14.4 How repeated DASH and S-DASH assessments remained at medium is difficult to justify. There is no doubt that a medium grading would have influenced the thinking of decision makers and the decisions they subsequently made. A similar finding in a previous Kent and Medway DHR; Sarah 2013, noted that "Kent Police did not appreciate that the history of domestic abuse must inform risk classification and management."

14.5 Just one DASH or S-DASH assessment graded as 'High' would have triggered inter-agency engagement through the tried and tested MARAC process.

14.6 The checks and professional judgement that should have been applied when each DASH assessment was reviewed independently by police supervisors in the CRU were not effective. In a number of cases the information detailed on the DASH did not correlate with the information on either the crime report or incident report. Thus, while the information was available to the police, it was not acted upon.

14.7 The police response to a number of the complaints made by Claire about George's conduct should have been more consistent and robust. By not expediting the arrest of George as soon as possible after each breach, his behaviour was allowed to go unchecked.

14.8 By not dealing with Rose as a victim in her own right, the stalking of her by George, sending 100s of text messages to her on a daily basis, was not dealt with. It was a real missed opportunity not to assess the content and nature of these texts and come to a conclusion the risk to Claire channelled through Rose was escalating. It also meant Rose continued to be a victim and her levels of distress and anxiety were not dealt with. The threats to cause Claire serious harm or injury were made to Rose, not Claire which is also significant given George could have made these threats direct. He did after all pay little heed to his bail conditions/Restraining Order.

14.9 As highlighted in a recent Kent DHR (Rosemary 2017), there is research that suggests there are direct links to stalking and domestic homicide. This research was conducted by Jane Moncton-Smith, Karolina Szymanska and Sue Haile for the Suzy Lamplugh Trust[4].

14.10 A number of organisations took at face value what George told them as factually correct. They didn't make any checks to corroborate with other partners that what he had said was true. This meant the risk he posed to Rose was not managed.

14.11 There were more than enough indicators that, despite Rose being his daughter, he was prepared to abuse her as means of getting to her mum. George was in regular contact by text and on more than one occasion attended the home address when Rose was either present or alone in the house. His conduct and comments both by text and verbally were becoming more erratic and threatening as time progressed. As previously stated the risks to Rose were lost by the focus on managing the risk to her Mum and the involvement of Rose was effectively pushed to one side. George knew when he set fire to the house only Rose and Ann were inside. He believed Claire was not in Kent. This unequivocally demonstrates he had a total disregard for the safety of Rose. While Claire was the main focus of his attention in terms of retribution for the

[4]MoncktonSmith, J, Szymanska, K. and Haile, S (2017) Exploring the Relationship between Stalking and Homicide. Suzy Lamplugh Trust.

break-up of the marriage, Rose and Ann became collateral damage in seeking his revenge.

14.12 Here, there are parallels with the previous Kent and Medway DHR; Sarah 2013, where the daughter in the family was not adequately recognised during risk assessments or through DANs, despite her taking on the responsibility to contact the Police on a number of occasions.

14.13 Had either the Psychiatry Liaison Team or the CRC been in touch with the police, their understanding that George was a loving father with minimal contact with Rose would have been quickly dispelled. They would have also discovered that George had regularly breached his conditional bail and his Restraining Order, which are not the actions of a compliant or truthful individual.

15. Lessons to be learnt

15.1 The DASH assessments process in this case did not meet the needs of victims nor provide them with adequate protection. At no time did anyone display sufficient professional curiosity to explore why so many DASH and S-DASH assessments were completed over such a short period of time, and as a consequence, reassess and apply professional judgement to the cumulative risk posed. This, unfortunately, has similarities to issues raised in a previous Kent and Medway DHR; Sarah 2013.

15.2 The management of the DASH assessment process and the information that is shared with partners needs to be reviewed. An over reliance on a DASH assessment reaching the threshold score to be graded as high does not recognise the additional pathway of risk escalation that is also available to raise an incident to a MARAC referral.

15.3 Relying solely on one person's account as to the circumstances they find themselves in as the basis of a risk assessment on what threat that person may pose to themselves or others is inherently dangerous.

15.4 Seeking information from other partners to provide contextual information to test the veracity of the information they are being given is good practice.

15.5 The voice of the child was not only not heard; it was completely overlooked.

15.6 Issues regarding 'the voice of the child' from 'Sarah 2013' around impact of DA on a child, responding to a child exposed to DA and the information that a child can contribute in such situations, have repeated.

15.7 The warning signs and escalation of the stalking behaviour displayed by George were not recognised as a precursor to more extreme conduct.

15.8 Providing protection to victims through conditional bail and/or Restraining Orders will only be effective if these conditions are vigorously enforced and when breached, an early arrest made.

15.9 Information provided to partner agencies needs to be accurate, comprehensive, timely and given in a spirit of co-operation and collaboration. The needs of the victim should be paramount, and the effective management of alleged perpetrators should take precedence over the unintended consequences of the constraints imposed by GDPR. There is sufficient scope within these Regulations for organisations to be significantly less risk averse than they currently are when it comes to sharing information with statutory partners.

16. Recommendations

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

	Paragraph	Recommendation	Organisation
1	13.15	The GP Surgery should establish a protocol for reviewing patients who have presented at A&E following a suicide attempt. This will include dealing with scanned correspondence in a timely manner and agreeing with Kent Police a process to notify them should a Firearms licence holder and/or applicant make a suicide attempt.	CCG and Kent Police
2	13.2.41 13.2.47	How DASH is used and how to manage increased risk needs to be reviewed, particularly at an operational level. Due regard to the importance of professional curiosity and judgement should be emphasised. The plan to participate in a pilot sponsored by the College of Policing for a new domestic abuse risk assessment scheduled to start before the end of 2019 will provide additional training and awareness, especially around coercion and control, to the workforce.	Kent Police
3	13.2.43 15.5	Specific action should be taken to address the lack of understanding in responding to Section 10 of the current DASH assessment and the importance of listening and more importantly responding effectively to 'the voice of the child'.	Kent Police
4	13.2.46 13.2.47 15.1	A strategic review should be undertaken in respect of the role and responsibilities undertaken by the Information Management Unit, Force Control Room and Central Referral Unit in domestic abuse incidents. This should take due regard to the	Kent Police

	Paragraph	Recommendation	Organisation
		recommendations made by HMICFRS following their recent inspection and their view that a MASH function should be established.	
5	13.2.40	The use of the risk management tool RARA as a process to manage risk needs to be reinforced with operational officers. This will require a training review and a communication plan.	Kent Police
6	13.2.47 13.2.48 13.2.54	The Stalking SPOC initiative launched in July 2019 should be regularly reviewed to ensure best practice and lessons learned are identified at the earliest opportunity and disseminated to practitioners to enable them to deliver the best possible service to victims.	Kent Police
7	15.7	Current policy regarding the management of a breach of bail conditions/harassment orders should be reviewed. Specific measures should be introduced that ensure any breaches are actioned in a timely manner.	Kent Police
8	13.3.2 13.3.13	The measures introduced following the Ofsted inspection in January 2019 of Front Door should be revisited to ensure there is compliance with a sharper focus on risk and urgency. An accompanying training needs analysis should be undertaken with Front Door staff. This may identify further areas of training that should be undertaken to ensure the staff are both knowledgeable and confident when dealing with the complexities that are inherent with domestic abuse incidents.	Kent Children's Social Services
9	13.3.2 13.3.12	There needs to be more effective information sharing and challenge of partner agencies. The establishment of a MASH type functionality and structure should close this gap. Social Services will need to prioritise finite resources to support this initiative if they are to extract the clear benefits that such an information sharing platform provides.	Kent Social Services and Kent Police

	Paragraph	Recommendation	Organisation
10	13.4.18 13.4.21	The measures put in place following the Serious Further Offences Review in April 2019 should be revisited to ensure these are being robustly applied. These measures should also be shared with the Ministry of Justice managing the transition of Community Rehabilitation Companies as they transition back into the National Probation Service. (Home Office Quality Assurance Panel Recommendation).	KSS Community Rehabilitation Company
11	14.11 14.9	There needs to be more effective information sharing and challenge of partner agencies. The establishment of a MASH type functionality should close this gap. The CRC will need to prioritise finite resources to support this initiative if they are to extract the clear benefits such an information sharing structure has to offer.	KSS Community Rehabilitation Company and Kent Police
12	13.6.6 13.6.9 14.11 14.9	A training needs analysis should be carried out to identify current gaps in training and awareness. It has already been noted that current training focuses on victims of domestic abuse rather than perpetrators. Additional specialist training facilitated by external subject matter experts will help to reinforce the need to challenge and check with other agencies any account given by a patient who is wearing a tag or admits to previous criminality involving domestic abuse. Mandatory referral to the Police Liaison Officer in these circumstances is good practice.	KMPT and Domestic Violence Service
13	13.7.6	Additional safeguarding training should be considered best practice for schools who operate separate pastoral support systems.	Education Safeguarding Service
14	13.7.7	Operation Encompass should be expanded to include Secondary Schools in advance of the pending Domestic Abuse Bill.	Education Safeguarding Service and Kent Police

	Paragraph	Recommendation	Organisation
15	13.9.10	The Home Office should explore with the Department of Local Government, Housing and Communities the feasibility of establishing a permanent hardship fund for domestic abuse victims that mirrors the current arrangements for former residents of Grenfell Tower.	The Home Office

Kent & Medway Domestic Homicide Review

Victim – Ann

Appendix A - Terms of Reference

These terms of reference were agreed by the DHR Panel following their meeting on the 27th February 2019.

Background

In November 2018, police officers attended a dwelling house in Kent. They found that the victim had suffocated through smoke inhalation following a fire at the house, allegedly maliciously set by George.

George was arrested for murder and was subsequently charged and remanded in custody.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 18th January 2019. It confirmed that the criteria for a DHR have been met and the Home Office informed. In accordance with established procedure this review will be referred to as DHR.

The Purpose of a DHR

The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) 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;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

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

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

f) highlight good practice.

The Focus of the DHR

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

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

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

The full subjects of this review will be the victim, Claire, Rose, Dan, Robert, and the alleged perpetrator, George.

DHR Methodology

The DHR will be based on information gathered from IMRs, chronologies and reports submitted by, and interviews with, agencies identified as having had contact with Claire in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The DHR Panel will decide the most appropriate method for gathering information from each agency.

Independent Management Reports (IMRs) and chronologies must be submitted using the templates current at the time of completion. Reports will be submitted as free text documents. Interviews will be conducted by the Independent Chairman.

IMRs and reports will be prepared by an appropriately skilled person who has not had any direct involvement with Claire, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

Each IMR will include a chronology and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/ supervision/support and training/experience of the professionals involved.

Each agency required to complete an IMR must include all information held about Claire from January 2018 to November 2018. If any information relating to Claire being a victim,

or George being a perpetrator, of domestic abuse before 1st January 2018 comes to light, that should also be included in the IMR.

Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Claire or George. 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 2014, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, sexual orientation, cultural and/or faith should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

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

Specific Issues to be Addressed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

xiv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

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

xvii. How accessible were the services to Claire and Rose?

Appendix B - Definitions

Police Information Notice (PIN)

To prove offences of harassment under Sections 2 (harassment) and 2A (stalking) of the Protection of Harassment Act 1997, the prosecution must show a 'course of conduct' by the defendant. To assist in providing evidence of this, most police forces in England and Wales introduced Police Information Notices (PIN), which some referred to as Harassment Notices.

A PIN was served on a person when it was believed that an individual act (which did amount to a criminal offence) had been committed by that person, who knew or ought to have known that the act would cause the victim harassment, alarm or distress. If the person came to notice a second or subsequent time, the PIN could be used to show that they had been warned previously and therefore, their repeated action amounted to a 'course of conduct'.

PINs had no statutory basis and their use became controversial. Her Majesty's Inspectorate of Constabulary and Crown Prosecution Inspectorate considered the use of PINs in the joint report Living In Fear, which was published in July 2017. The report recommended that *'Chief Constables should stop the use of Police Information Notices and their equivalents immediately.'*

Domestic, Abuse, Stalking & Honour Based Violence (DASH) Risk Assessments

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

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

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

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

In addition, if the victim indicates the perpetrator constantly texts, calls, contacts, follows, stalks or harasses them, 11 further questions are asked about the nature of this. This is called an S-DASH assessment.

A copy of the DASH questionnaire can be viewed here

Domestic Abuse (Definition)

The definition of domestic violence and abuse states:

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

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is:

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

Coercive behaviour is:

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

RARA

To assist in the management of incidents, officers utilise the RARA model.

Remove the risk.	By arresting the offender and obtaining a remand in custody.
Avoid the risk.	By re-housing significant witnesses or victims, re-locating to a refuge or shelter or any other place of safety, the location of which is unknown to the offender.
Reduce the risk**.**	By joint intervention/safety planning, target hardening, enforcing breaches of bail conditions, use of protective

	legislation and referring high risk cases to a Multi-Agency Risk Assessment Conference (MARAC).
Accept the risk.	By continued reference to the risk management model, continued multi agency intervention, planning and support through MARAC and MAPPA.

Storm

Storm is the proprietary name for the IT system used by Kent Police to manage incidents.

When a telephone call from a member of the public requesting police assistance is received, a Storm incident log will be created by the call handler. That log is used to record all information received and actions taken in response to the call. Storm automatically records the time an entry is made and the identity of the person making it.

Storm is a networked computer system and can be viewed by most Kent Police officers and staff. The ability to make entries on the system is dependent on a person's role within Kent Police.

THRIVE

Kent Police policy states that requests for service will be evaluated and, where relevant, 'graded' in line with guidance provided within the police service 'National Contact Management Principles and Guidance' and force policing priorities. The 'grade' given to a request for service determines whether a police response is required and if so, the urgency, speed and nature of it.

Over-arching the above, Kent Police assesses all requests for service utilising the 'THRIVE' principles. THRIVE is a mnemonic for Threat, Harm, Risk, Investigation, Vulnerability & Engagement. Where a force policy, internal working practice or national guidance suggests the grading and/or nature of our response, application of the THRIVE principles against the specific circumstances may determine that a different response is more appropriate to the individual and the investigation.

Police National Computer

The Police National Computer (PNC) contains information about people and vehicles. The information is accessible to police forces and law enforcement agencies.

Detailed guidance about the PNC, published by the Home Office, can be viewed here.

Police National Database

The Police National Database (PND) is a database that contains intelligence gathered by police forces and other criminal justice agencies across the UK. It allows the police service

and those other agencies to share local information and intelligence on a national basis. Before the introduction of the PND, this intelligence had only been stored on the intelligence systems of individual forces.

The PND supports delivery of three strategic benefits which are to safeguard children and vulnerable people, to counter terrorism, and to prevent and disrupt serious and organised crime. This information had previously only been stored on the intelligence systems of individual forces. It was developed following recommendations from the Bichard Inquiry into intelligence issues arising from the Soham case in 2002.

Genesis

This is the proprietary name for the computer system that Kent Police use to create and store crime reports, secondary incident reports and criminal intelligence. There is a comprehensive search facility on Genesis. For example, entering a person's name will retrieve all the information held about them by Kent Police. In the case of domestic abuse, it will show the whole history of police involvement including attendance, safety plans and arrests. Genesis also has the facility to store documents such as non-molestation and restraining orders, which will also be retrieved when a person's name is entered. Using a name is only one way to search Genesis; many other search parameters can be entered.

Secondary Incident Report

A secondary incident report is completed by a police officer following attendance at a domestic abuse incident in addition to the DASH risk assessment, when there is no evidence that a criminal offence had been committed.

Appendix C - GLOSSARY

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

Abbreviation/Acronym	Expansion
AAFDA	Advocacy After Fatal Domestic Abuse
CRC	Community Rehabilitation Company
CRU	(Kent Police) Central Referral Unit
DA	Domestic Abuse
DAN	Domestic Abuse Notice
DASH	Domestic Abuse, Stalking and Honour Based Violence (Risk Assessment)
DHR	Domestic Homicide Review
FLO	Family Liaison Officer
GP	General Practitioner
IMR	Independent Management Report
IMU	(Kent Police) Incident Management Unit
IOPC	Independent Office for Police Conduct
KMPT	Kent & Medway NHS & Social Care Partnership Trust
MASH	Multi Agency Safeguarding Hub
NHS	National Health Service
NPS	National Probation Service
PIN	Police Information Notice
PNC	Police National Computer
PSE	Police Staff Employee
RARA	Risk management model for domestic abuse
S-DASH	Stalking and Harassment Screening Questions
SPoA	(KMPT) Single Point of Access
STORM	Incident management system