

Domestic Homicide Review
Sarah/2013
Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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Domestic Homicide Review

Purpose

The key purpose of a Domestic Homicide Review (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 organisations, how and within what timescales will be acted on, and what is expected to change as a result;
- c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
- d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-organisation working.

Scope

This DHR examines the contact and involvement that organisations had with Sarah Taylor, prior to her death on 7 November 2013 at the hands of her estranged husband Robert Taylor.

The review also examines the contact and involvement the organisations had with Emma Taylor, the teenage daughter of Sarah and Robert. Emma was a victim of domestic abuse in the two months leading up to her mother's death because in accordance with S.120 of the Children Act 1989 (as amended) she potentially suffered harm from seeing or hearing the ill-treatment of Sarah.

In order to meet its purpose, this DHR also examines the contact and involvement that organisations had with the perpetrator, Robert Taylor.

Timescales

This review began on 29 November 2013 following the decision that the case met the criteria for conducting a DHR. Although Robert Taylor was arrested on the day of Sarah's death and was charged with her murder, the Crown Prosecution did not request that the review was suspended pending the criminal trial.

The review was completed on 21st January 2015.

Independent Police Complaints Commission (IPCC) Investigation

Following Kent Police's voluntary referral of the case to them, the IPCC carried out an investigation into the way in which the force responded to reports of domestic abuse made by Sarah and Emma. The investigation focused on the action of individual police officers and staff but also considered some organisational issues.

Meetings were held between the Independent Chairman of the DHR and the IPCC investigators at an early stage. There was an exchange of terms of reference. In order to complete their investigation, the IPCC needed to interview a number of police officers and staff who were also going to be asked to contribute to this review. It was agreed that the IPCC would have primacy in speaking to these people. While this inevitably built some delay into the DHR, it was felt that the potential for prejudicing the IPCC investigation by interviewing staff for the review outweighed the delay to its completion.

In order to ensure that the delay in the completion of the DHR was kept to a minimum, Kent Police produced an interim report that enabled examination of their involvement to begin. The IPCC investigation did not affect the timescale of other organisations' submissions.

The Independent Chairman of the DHR wishes to thank the IPCC for their co-operation in sharing information about its investigation, which has enabled an assessment to be made of whether areas of concern were related to individual performance or organisational issues.

Publication

This DHR report is publicly available and can be found on the websites of both Kent and Medway Community Safety Partnerships.

Anonymisation

This report has been anonymised and all the personal names contained within it, with the exception of members of the review panel, are pseudonyms.

Overview Report

1. Introduction

- 1.1 This Overview Report is an anthology of information and facts gathered from Individual Management Reviews (IMRs) prepared by, and interviews with, representatives of the organisations that had contact and involvement with Sarah Taylor, Robert Taylor and Emma Taylor between January 2001 and Sarah's death. The requirement to complete an IMR does not assume or suggest failings by an organisation.
- 1.2 An IMR is a detailed examination of an organisation's contact and involvement with any or all of Sarah, Robert and Emma. It is a written document submitted using a template. The IMR will be written by a member of staff from the organisation subject to review and will be signed off by a senior manager of that organisation before being submitted to the DHR Review Panel. Each of the following organisations completed an IMR:
- Kent Police
 - Kent Specialist Children's Services (KSCS)
 - Education, Learning and Skills Directorate, Kent County Council
 - Kent Community Health NHS Trust (KCHT)
 - East Kent Hospitals University NHS Foundation Trust (EKHUFT)
 - Kent & Medway NHS and Social Care Partnership Trust (KMPT)
- 1.3 Interviews were conducted with the following:
- The Taylor family General Practitioner (GP)
 - The Crown Prosecution Service (CPS)
 - Her Majesty's Courts & Tribunal Service (HMCTS)
- 1.4 The GP was interviewed because he was not familiar with the IMR process. The extent of his contact with Sarah, Robert and Emma, and its relevance to the enquiry, was such that the required information could be gained as effectively and in a more timely way by interviewing him rather than the submission of an IMR. There are issues about GPs' knowledge of the DHR process and who is the appropriate person to write an IMR examining their contact and involvement. In this case the interview was conducted by the Designated Nurse for Safeguarding Adults for Thanet CCG.
- 1.5 Neither CPS nor HMCTS can be required to take part in the DHR process. The CPS have produced guidance about their involvement, which they review on a case-by-case basis. In this case, they agreed to be involved. The level of their contact was such that sufficient information was obtained by a face-to-face interview with a senior CPS representative.

1.6 Although HMCTS do not have guidance about their involvement, the Clerk to Kent Magistrates agreed to be interviewed. This was done by telephone and the necessary information was obtained.

2. The Review Process

2.1 Review Panel

2.1.1 The Review Panel was made up of an Independent Chairman and senior representatives of the organisations that had relevant contact with any or all of Sarah Taylor, Robert Taylor and Emma Taylor. It also included the Kent & Medway Domestic Abuse Co-ordinator and a senior member from each of Kent County Council and Medway Council Community Safety Teams. In addition, the manager of Rising Sun, a Kent-based voluntary sector domestic abuse support organisation, sat on the Review Panel.

2.1.2 The members of the panel were:

Patricia Denney	Kent Children's and Adult Services
Andrew Coombe	NHS Medway CCG
Tim England	Medway Community Safety
Alison Gilmour	Kent & Medway Domestic Abuse Co-ordinator
Tina Hughes	Kent Probation
Anne Lyttle	Rising Sun Domestic Abuse Support Service
Paul Pearce	Independent Chairman
Shafick Peerbux	Kent Community Safety
Tim Smith	Kent Police
Cecelia Wigley	Kent and Medway NHS & Social Care Partnership Trust

2.1.3 The chairman of the panel is a retired senior police officer who has no association with any of the organisations represented on it. In particular, he did not serve with Kent Police. He has experience and knowledge of domestic abuse issues and legislation, and a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to dealing with domestic abuse. He has a background in conducting reviews, investigations and inspections, including disciplinary enquiries.

2.2 Review Meetings

2.2.1 The Review Panel met first on 18 December 2013 to discuss the terms of reference, which were then agreed by correspondence. A briefing was held for IMR writers on 17 January 2014 and the Review Panel then met on 1 April to consider the IMRs. The next meeting of the Panel was held on 1 October 2014 when the first draft of his Overview Report was considered and amendments agreed.

2.3 Family Involvement

- 2.3.1 The Review Panel considered which family members should be consulted and involved in the review process. The following have been contacted:

Name	Relationship To:		
	Sarah Taylor	Emma Taylor	Robert Taylor
Emma Taylor	Daughter		Daughter
Elizabeth BAKER	Mother	Maternal Grandmother	Mother in law
Lisa Brett (nee BAKER)	Sister	Aunt	Sister in law
Jane BAKER	Sister	Aunt	Sister in law
Rachel Grant (nee BAKER)	Sister	Aunt	Sister in law
John BAKER	Brother	Uncle	Brother in law
James Clark	Boyfriend		

- 2.3.2 The chairman wrote to family members on 7 January 2014, explaining the purpose of the review and that he would make further contact following the trial of Robert Taylor. The letters to family members living in Kent were delivered by the Kent Police Family Liaison Officer; those to members living outside Kent were sent by recorded delivery. A copy of the Home Office DHR leaflet for family members was included with the letters.
- 2.3.3 The Chairman wrote to family members again on 22 May 2014 following the trial and conviction of Robert Taylor. He offered to meet them to discuss the DHR process and listen to any views and concerns they had. The letters were sent by recorded delivery with the exception of that addressed to Emma Taylor, which was delivered by her social worker.

- 2.3.4 As a result, some very useful background information was gathered in terms of both fact and opinion. Where relevant to the terms of reference this has been included in the report but has not been attributed to an individual.

- 2.3.5 Following the completion of the Overview Report the chairman wrote to family members, offering them a further opportunity to meet and to discuss its content, conclusions and recommendations.

3. Terms of Reference

This section sets out the terms of reference for the review:

3.1 The Purpose of this DHR

- a) Establish what lessons are to be learned from the death of Sarah Taylor in terms of the way in which professionals and organisations work individually and together to safeguard victims.
- b) Identify what those lessons are both within and between organisations, how and within what timescales that they will be acted on, and what is expected to change as a result.
- c) Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-organisation working.
- d) Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-organisation working.

3.2 The Focus of this DHR

- 3.2.1 This review will establish whether any organisation or organisations identified possible and/or actual domestic abuse that may have been relevant to the death of Sarah Taylor.
- 3.2.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.
- 3.2.3 If domestic abuse was identified, this review will focus on whether each organisation's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other organisations.

3.3 Methodology

- 3.3.1 Independent Management Reviews (IMRs) must be submitted using the template current at the time of completion.
- 3.3.2 This review will be based on IMRs provided by the organisations that were notified of, or had contact with, Sarah, Robert or Emma Taylor in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Sarah, Emma or Robert Taylor, and who

is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

- 3.3.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the organisation submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual organisation 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.
- 3.3.4 Each organisation required to complete an IMR must include all information held about Sarah, Robert and Emma Taylor from 1 January 2001 (the year in which there is the first relevant agency involvement with any of those subject of the review) to 7 November 2013.
- 3.3.5 Information held by an organisation 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 Sarah, Emma or Robert Taylor. 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 2006, X was cautioned for an offence of shoplifting).
- 3.3.6 Any issues relevant to equality, for example disability, cultural and faith matters 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.
- 3.3.7 When each organisation that has been required to submit an IMR does so in accordance with the agreed timescale, each IMR will be considered at a meeting of the DHR Panel and an Overview Report will then be drafted by the Chairman of the Panel. The draft Overview Report will be considered at a further meeting of the Panel and a final agreed version will be submitted to the Chairman of the CSP.

3.4 Specific Issues to be addressed

- 3.4.1 Specific issues that must be considered, and if relevant, addressed by each organisation in their IMR are:
 - i. Were practitioners sensitive to the needs of Sarah, Robert and Emma Taylor, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
 - ii. Did the organisation have policies and procedures for the Association of Chief Police Officers (ACPO) Domestic Abuse, Stalking and

- Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Sarah, Emma and Robert Taylor (as applicable)? Did the organisation have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Sarah Taylor subject to a Multi-Agency Risk Assessment Conference (MARAC)?
- iii. Did the organisation comply with 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. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Sarah, Robert or Emma Taylor (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
 - vii. Were senior managers or other organisations and professionals involved at the appropriate points?
 - viii. Are there ways of working effectively that could be passed on to other organisations or individuals?
 - ix. Are there lessons to be learned from this case relating to the way in which an organisation or organisations worked to safeguard Sarah and Emma Taylor and promote their welfare, or the way it identified, assessed and managed the risks posed by Robert Taylor? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other organisations and resources?
 - x. How accessible were the services to Sarah, Emma or Robert Taylor (as applicable)?
 - xi. To what degree could the death of Sarah Taylor have been accurately predicted and prevented?

4. The Death of Sarah Taylor

4.1 Events Surrounding the Death of Sarah Taylor

- 4.1.1 About 1.30pm on Thursday 7 November 2013, Kent Police received a call from a member of the public who reported that she had found the body of a woman in a field in Town B.
- 4.1.2 When police arrived they found the body of Sarah Taylor. She had suffered severe head injuries and there was a ligature around her neck. She was subsequently pronounced dead at the scene.
- 4.1.3 About 3.10pm the same day, Kent Police received a telephone call from Robert Taylor, the estranged husband of Sarah, who said that he had killed his wife and left her body in a field.
- 4.1.4 A search of the area resulted in Robert Taylor being seen driving Sarah's car. He was stopped and arrested on suspicion of murder. He was taken to a police station where he was interviewed and subsequently charged with her murder.

4.2 Conviction and Sentencing of Robert Taylor

- 4.2.1 On 3 April 2014 Robert Taylor appeared at Maidstone Crown Court charged with the murder of Sarah. He admitted killing her but pleaded not guilty to murder on the grounds that he had suffered a 'loss of control'. The trial judge rejected this defence and Robert then changed his plea to guilty of murder.
- 4.2.2 He was sentenced to life imprisonment with a recommendation that he should serve at least 25 years.

5. Family History

5.1 Living Arrangements Pre-Separation

- 5.1 Sarah and Robert Taylor had been married for 17 years at the time of her death. Their only child was their teenage daughter Emma.
- 5.1.2 Sarah ran a dog walking business for several years and she was engaged in this at the time of her murder.
- 5.1.3 Robert had various jobs during his marriage to Sarah. At the time of her death he was running a business in Town C.
- 5.1.4 Robert had a criminal conviction for fraud and because of this he was unable to secure finance in the form of mortgages or loans. Both business and personal loans that the couple had were in Sarah's name.

He therefore relied heavily on her and would have been aware that their separation would have a serious financial impact on him.

- 5.1.5 The date on which Sarah and Robert separated is not known but it was in late August or early September 2013, before 7 September.

5.2 Living Arrangements Post-Separation

- 5.2.1 At the time of her death Sarah was living with Emma at the family home in Town A.
- 5.2.2 She had a boyfriend following her separation from Robert. It is not clear whether, and if so when, Robert knew this but he did not know the identity of the man.
- 5.2.3 At the time he was arrested, Robert gave his address as his business address in Town C, which was his business address.

6 The Facts and Analysis of Organisations' Involvement

6.1 Introduction

- 6.1.1 This section sets out in detail the facts and analysis of the contact and involvement that Sarah, Emma and Robert Taylor had with organisations during the period covered by the terms of reference. The facts are based on IMRs submitted by, and interviews with, organisations. It includes information gathered from discussions with family members and/or friends.
- 6.1.2 Each IMR included a detailed chronology of contact and involvement with Sarah, Emma and Robert, an anonymised version of which is submitted with this Overview Report. This section examines the entries in the chronology that are relevant to the terms of reference.
- 6.1.3 The analysis is based on the facts and from it come the conclusions, lessons learned and recommendations.
- 6.1.4 The facts and analysis make references to processes and procedures that will be familiar to professionals in the relevant organisation but which may need further explanation for other readers. Where such references are made, the reader is referred to the glossary in [Appendix A](#) where more detail is provided.

6.2 Organisation Involvement – Sarah Taylor

6.2a Kent Police Facts

- 6.2a.1 During the period covered by the terms of reference Sarah had one recorded contact with Kent Police prior to 7 September 2013.
- 6.2a.2 On 22 May 2002 she was arrested on suspicion of having obtained property by deception. This related to a complex fraud concerning the sale of a house. Robert was also arrested for the same offence on the same day and he was subsequently charged and convicted of it. No further action was taken against Sarah.
- 6.2a.3 From 7 September 2013 to her death, exactly 2 months later, Sarah had numerous contacts with Kent Police, all related to the domestic abuse that she suffered at the hands of Robert.
- 6.2a.4 Sarah's involvement with Kent Police on 7 September followed two 999 calls made by Emma, the first of which was abandoned. These calls, like all the others made to Kent Police in this case, were received at the

[Force Control Room \(FCR\)](#). Police officers were sent to Sarah's home where she, Emma and Robert were present when they arrived.

- 6.2a.5 Sarah told the officers that her marriage to Robert was over but he would not accept this. He had begun shouting at Sarah and had threatened her. He said that she had ruined his and Emma's life. The police were made aware that Robert had threatened to stab Sarah in the heart, although he had not been in possession of a knife at the time. The officers were told that a few nights previously he placed a knife to his throat and threatened to take his own life. It is unclear whether Sarah or Emma told the police officers this.
- 6.2a.6 As a result of the police attendance, Robert agreed to leave but they saw him subsequently return to the house. They spoke to him and he then gave an officer his house key, which they in turn gave to Sarah. The officers then escorted Robert to a hotel which he booked into. It is unclear whether he and Sarah were already living apart at this time.
- 6.2a.7 In common with all other police forces in England & Wales, Kent Police use the [Domestic Abuse Stalking & Harassment \(DASH\)](#) risk assessment to classify and manage the risk to domestic abuse victims. This will be referred to in this report as DASH. The DASH that was completed on this occasion was classified as 'Medium'.
- 6.2a.8 This classification was subsequently confirmed by the [Central Referral Unit \(CRU\)](#) and a safety plan was recorded on the [Secondary Incident Report](#). In addition, a [Domestic Abuse Notification \(DAN\)](#) was submitted to Kent Specialist Children's Services (KSCS) because of Emma's presence.
- 6.2a.9 On 13 September Emma again made a 999 call to Kent Police, during which Sarah also spoke to the call handler. Emma made the call because Robert had turned up at a restaurant where she and her mother were dining with friends. He had attempted to establish whether Sarah was there with a man and had left prior to Emma calling the police.
- 6.2a.10 As well as telling the police call handler that she was scared of Robert, Sarah said that he had stolen petrol and that he had left a restaurant without paying for a meal. She added that he was playing mind games with her.
- 6.2a.11 At Sarah's request police did not attend the restaurant but an arrangement was made for them to go to her home later that evening. When Emma and Sarah arrived home, Emma made two further calls to Kent Police. In the first she apologised for her and her mother being late home, thinking that they may have missed officers attending. In the second she said they were scared to leave the car because Robert might be in the house.

- 6.2a.12 A police officer arrived at about 2am the following morning. Sarah explained that she had separated from Robert six weeks previously and that he was extremely jealous. He had sent her several text messages saying that he could not live without her. A DASH was completed and graded as 'Standard'. The case was filed at the CRU without being reviewed. There is no record that any action was taken in response to the information that Robert had failed to pay for a meal and that he was drink driving. No action was taken in relation to these offences.
- 6.2a.13 On 15 September Emma made two 999 calls to Kent Police, and both she and Sarah spoke to the call handler. Sarah had received a text message from Robert stating that he had been drinking and was coming round. She said that she was scared and requested immediate police attendance as he was nearby. She described him as unstable and asked '*...that he should be breath tested*'.
- 6.2a.14 Sarah was given security advice by the call handler and a police officer was dispatched. When he arrived, she described Robert's recent behaviour and the text messages she had received from him. A DASH was completed, which again included the information that Robert had threatened to kill her and himself, and that she believed this threat. This risk assessment was graded as 'Standard'. Again, no action was taken about the information that he was drink driving.
- 6.2a.15 On 19 September Sarah made a 999 call to Kent Police stating that Robert had approached her while she was dog walking on a beach. She also said that he kept coming to her address. She gave the call handler background information and explained that she was applying for a non-molestation order. She added that he was saying things to her such as '*I hope you die*'.
- 6.2a.16 Police officers were not sent on this occasion despite the call initially be graded as 'High Priority'. An appointment was made for Sarah to be visited but it is unclear whether this method of contact was at her request, as it had been on a previous occasion.
- 6.2a.17 A police officer visited Sarah the following day, 20 September, and took details. A secondary incident report was created on which it was recorded that there were 'no offences disclosed'. A DASH risk assessment was completed and classified as 'Standard'.
- 6.2a.18 The same day Sarah applied for, and was granted, a non-molestation order at her local county court. A non-molestation order is granted by a civil court and there is no police involvement. However, breaching such an order is a criminal offence and Robert was arrested on two occasions for doing so. The conditions attached to the non-molestation order were that:

1. *The respondent Mister Robert Vincent Paul Taylor, date of birth 1958, is forbidden to use or threaten violence against the applicant Mrs Sarah Taylor and must not instruct, encourage or in any way suggest that any other person should do so.*
2. *The respondent Mister Robert Vincent Paul Taylor, date of birth 1958, is forbidden to intimidate, harass or pester the applicant Mrs Sarah Taylor and must not instruct, encourage or in any way suggest that any other person should do so.*

6.2a.19 A court official personally served a copy of the non-molestation order on Robert at 7.15pm on the day that it was granted. At the time he was in the road where Sarah lived. A non-molestation order does not prohibit contact with the applicant, so by being there Robert was not in breach of it. The police had no involvement in the service of the order or knowledge of it at that time.

6.2a.20 At 9:01am on 21 September Sarah made a 999 call to Kent Police. She was in a park in Town B and explained that she had obtained a non-molestation order the previous day and that Robert was breaching it. He had followed her in his car and had been asking her for money. He then drove away having left a copy of the non-molestation order (which had been served on him the day that it was issued) on her car.

6.2a.21 Sarah said that Robert was stalking her and that she needed to get away. She was asked to wait and told that someone should be with her within an hour. She said that she was intending to go to Eastbourne but would wait in order to speak to a police officer.

6.2a.22 At 4.49pm, almost eight hours after her call, a police officer became available. When Sarah was contacted she said that she was already in Eastbourne. She asked if she could be visited at her home the following afternoon.

6.2a.23 At 3.35pm the following day, 22 September, an FCR call handler tried to telephone Sarah about the incident at the park in Town B. There was no reply and at 6.45pm Sarah contacted the FCR to say she was at home and would be available until 10pm.

6.2a.24 By 9.37pm the police had not attended. Emma made a 999 call to them and said that Robert kept coming to the house and was behaving in a threatening way. Sarah also spoke to the call handler, saying that Robert was in the back garden and had been drinking. She also mentioned the non-molestation order. She asked for police to attend as soon as possible because Robert was looking through a back window as she was making the call.

- 6.2a.25 A police officer attended promptly and took details from Sarah. These were subsequently entered on a [Crime Report](#), which set out a number of breaches of the non-molestation order and described Robert's intimidating behaviour. The crime recorded was stalking.
- 6.2a.26 The police officer left but was immediately called back because Robert had been seen in the back garden again. He was found hiding there by the officer, who arrested him. Robert said *'I know I've done wrong. I'd never hurt them. I love them'*.
- 6.2a.27 After his arrest the crime report was reviewed by a Detective Sergeant in the CRU who produced a comprehensive safeguarding plan. One of the items on the plan is recorded as *'permission to refer to an [IDVA](#) [Independent Domestic Violence Advisor]'*. He also asked that KSCS be notified about Emma so they could consider safeguarding issues.
- 6.2a.28 The safeguarding plan was given to a [Neighbourhood Policing Officer](#) (NPO1) to implement and was supervised by a Sergeant. There appears to have been a misunderstanding over who was going to make the referral to the IDVA service as it was never made. NPO1 gave Sarah information about the service but did not refer her.
- 6.2a.29 On 29 September Sarah went to Town C police station and spoke to a police staff [Enquiry Officer](#). She reported that she had seen Robert that morning driving his van close to her house. She said that this had been happening every morning for the last nine days, which was in breach of the non-molestation order (it was also in breach of his bail conditions). She showed the order to the enquiry officer, who identified that the breach amounted to a criminal offence. Both a crime report and a [STORM](#) report were raised by the enquiry officer. The enquiry officer also identified that a DASH was required. Enquiry officers are not trained to complete DASH assessments.
- 6.2a.30 The crime report completed by the enquiry officer was reviewed by a Detective Sergeant in the CRU. He did this before the DASH had been completed but he suggested it was *'... likely to be a standard risk case as there were no threats of violence and no communication between the parties'*. He also endorsed the report that *'This is a Standard risk no threat of violence and communication between parties.'* He also recorded that there were no children who required child protection.
- 6.2a.31 Simultaneously, a Neighbourhood Policing Officer (NPO2) was allocated to make contact with Sarah and complete the DASH, provide safety advice and seek the arrest of Robert.
- 6.2a.32 On 30 September Sarah contacted Kent Police using the non-emergency number. She said that she had been to Town C police Station the previous day. She went on to describe how Robert had

since been to her address and had sat in the back garden. The call handler told Sarah that she would '*...email the officers dealing with the incident.*'

- 6.2a.33 Sarah telephoned Kent Police again later that day using the non-emergency number because she had not heard from them since her previous call. She was told by the call handler that an officer would be with her within the next four hours, but 10 minutes later the same call handler phoned Sarah and said this was not correct. She was also told that the information had been passed to NPO2 and that the officer would contact her '*at some point*'.
- 6.2a.34 Another Neighbourhood Policing Officer (NPO3) met Sarah the following day, 1 October, and completed a DASH risk assessment which was graded as 'Standard'. The answer to the question '*Has he ever threatened to kill you and you believed him?*' was recorded as '*Yes, me and someone else*'. *No other details. [Robert] said if she was to get anyone he would be willing to kill them and do time*'.
- 6.2a.35 During this meeting with NPO3, Sarah added that she was concerned about Emma because Robert kept leaving messages for her to contact him. This information was included on the DASH risk assessment but did not result in a further referral to KSCS.
- 6.2a.36 Later that day Sarah called Kent Police to ask if Robert had been arrested for breaching the order. She was told that her query would be passed to NPO2 who was on duty the next day.
- 6.2a.37 The following day, 2 October, Sarah called Kent Police and said that Robert was breaching the non-molestation order. She added that she was becoming confused about all the appointments being made and felt that nothing would be done. She was told that efforts would be made to contact NPO2 and that she should dial 999 if she felt threatened.
- 6.2a.38 Robert was arrested at 9.48am on 3 October for breaching the non-molestation order. Following this, Sarah called Kent Police to ask what was happening and she was told that NPO2 was off duty and could not be contacted. This was not relevant as NPO2 was not the arresting officer. She was also told that an email would be sent to NPO4, who was the arresting officer.
- 6.2a.39 Robert was remanded in custody and appeared before East Kent Magistrates Court on 4 October. He pleaded guilty to breaching the non-molestation order. He received a 12 month conditional discharge and a restraining order. Sarah was told the result of Robert's court appearance by the court on 7 October. It was entered on [Genesis](#) the same day.

- 6.2a.40 The next record of Sarah contacting Kent Police was on 2 November when she made a non-emergency call at 11.12am. She said that she was receiving contact from Robert and he was stalking her. She was offered an appointment to see a police officer and it is recorded that she '*...was happy with that*'. The appointment was set for 5pm on 4 November.
- 6.2a.41 At 4.10pm on 4 November Sarah telephoned the police to say that she could not make the appointment that day. A further appointment was made for 6pm on 7 November.
- 6.2a.42 At 6.56pm the same day Sarah made a second call to Kent Police, telling the call handler that Robert was sending her text messages. She added that he was going to see her mother, family and friends to try to find out what she was doing.
- 6.2a.43 She told the call handler that Robert would '*kill her if he saw her with anybody else*'. She added that she wished she had not cancelled the appointment for that evening and Robert was constantly pestering her. No additional police action was taken in response to this second call.
- 6.2a.44 At 8.30am on 7 November, the day of her death, Sarah made a 999 call to Kent Police. She said she had let her dog out into the garden, where she found Robert hiding in a cupboard. He had jumped out in front of both her and Emma, following which he climbed over a fence and ran away without saying anything. Although Sarah did not tell the call handler, her boyfriend was in the house at this time but it is not believed that Robert was aware of this.
- 6.2a.45 She explained that Robert was in breach of a non-molestation order and that he must be arrested. She said that he was driving a white Renault van and gave the registration number. She added that she was about to take Emma to school and was happy to see the police by way of appointment. It was recorded that a diary appointment was made for her to be seen, although a previous appointment for 6pm that evening had already been made.
- 6.2a.46 There is no record that any action was taken to arrest Robert following this call.
- 6.2a.47 At 1.33pm that day Sarah's body was found in a field in Town B.

Analysis

- 6.2a.48 The first time Kent Police were told that Sarah was a victim of domestic abuse was when Emma made a 999 call to them on 7 September. Sarah was murdered exactly two months later.

- 6.2a.49 During that short time, Sarah's contact with Kent Police was separated into two discrete periods. The first was from 7 September to 4 October; the second from 2 November to 7 November.
- 6.2a.50 The period of almost a month when Sarah had no contact with Kent Police was due to her feeling that, following Robert's court appearance and sentence, she may have been too hard on him. It was not because his stalking and harassment of her stopped after his court appearance; it continued unabated. This information was provided by a friend of Sarah.
- 6.2a.51 To establish what Sarah disclosed about the domestic abuse she was suffering, this review relies on the recordings of telephone calls made to Kent Police, the subsequent records made by officers attending calls and her witness statement prior to Robert's second arrest. However, information provided by a friend is that the level of stalking and harassment by Robert was concerted and intense, and that he breached the non-molestation order, and later the restraining order, more times than Kent Police were aware of.
- 6.2a.52 Following Sarah's death Kent Police responded quickly. They identified individual and organisational issues, and suspended a number of FCR call handlers before they referred the case to the IPCC. The introduction to this report details how the DHR and the IPCC investigation ran concurrently.
- 6.2a.53 The IPCC investigation into the conduct of Kent Police officers and staff has been exhaustive. Their recommendations to Kent Police are based on evidence gathered by experienced independent investigators, including interviews conducted under the rules governing disciplinary investigations. IPCC investigators have also met with family members and kept them updated on the progress of their investigation.
- 6.2a.54 The IPCC have recommended that a number of officers and staff should be given advice and/or further training but that none should face misconduct proceedings. This review does not revisit the actions of individuals but considers the overall support and safeguarding action by Kent Police in an organisational context. Therefore, no recommendations are made about individuals; those that are made refer to Kent Police.
- 6.2a.56 The facts of Kent Police's involvement as set out earlier in this subsection identify three themes under which the analysis will be made:
- Initial response and attendance.
 - Victim care.
 - DASH.

- 6.2a.56 Initial response is the contact that Sarah had when she called Kent Police by telephone and spoke to FCR staff. Attendance is the deployment of police officers following those calls.
- 6.2a.57 In common with all police forces, Kent Police grade calls dependent on the urgency of the response required. There are five call grades (other police forces may have the same, more or less); the criteria for which are set out in [Appendix B](#).
- 6.2a.58 Call grading is not an exact science and the call handler's professional judgement is an important element in deciding the appropriate grade. It is the call handler who records the grade on STORM but dispatchers and FCR team leaders, who are senior to call handlers, can change it.
- 6.2a.59 In addition to the call grading policy, FCR staff can refer to guidance on specific subjects using a facility on STORM known as [PAGES](#). The PAGES section relating to domestic abuse states that '*There must be an attendance at all domestic abuse incidents.*' The section goes on to explain the procedure when a victim '*...does not wish to engage with the police...*' This did not apply to Sarah.
- 6.2a.60 At the time of the contact with Sarah and Emma, guidance relating to the response to breaches of non-molestation and restraining orders was in the section of PAGES relating to stalking and harassment and was not directly linked to the section relating to domestic abuse. This has now been changed to ensure the guidance is available when viewing the domestic abuse section.
- 6.2a.61 In summary, Kent Police have clear guidance on incident grading. There is a degree of professional judgement required, which is inevitable. Supervisors can amend any grades that are clearly wrong. Having now addressed the issue outlined in the preceding paragraph, the domestic abuse guidance for FCR staff is comprehensive and in line with Kent Police domestic violence policy.
- 6.2a.62 Police officers attended a number of domestic abuse incidents following calls made by Sarah and Emma. Where the calls were graded as 'Immediate' the officers attended in an appropriate time.
- 6.2a.63 In the first period of contact that Sarah had with Kent Police, between 7 September and 3 October, some of the work done by officers who attended and by the Neighbourhood Policing Team was positive. The importance of DASH in dictating what action the police take following their attendance at domestic abuse incidents is discussed below in this sub-section and the arrests of Robert are also considered in sub-section [6.4a](#).

- 6.2a.64 On the one occasion that Sarah went to a police station, the member of staff she spoke to correctly identified the relevant issues and the implications of what she told them. This resulted in the case being allocated to an NPO. This too was positive.
- 6.2a.65 The response overall during the first period of contact is perhaps summed up by Sarah's comment on 2 October, that she was '*confused*'. She related this specifically to the number of appointments being made but it could have applied equally to the number of officers she had seen.
- 6.2a.66 The referral to an NPO was a positive step in so far as they took action in gathering evidence to arrest Robert the second time. However, Sarah probably never knew who the 'officer in the case' was as she had contact with four different NPOs in just over a week. Action was taken more quickly using a team approach than if one officer had done everything, but it was confusing.
- 6.2a.67 In addition, the situation arose where a call that should have been attended promptly was deferred to an NPO who was not available to do this. There was an over reliance on NPOs to support Sarah in every circumstance.
- 6.2a.68 In summary, during that first period of contact, Kent Police did some things well. What appears to have been unintentionally lacking was an empathy with how frightened and vulnerable a domestic abuse victim feels. This is linked to a failure to keep Sarah informed of what action was being taken in a way that was clear and reassuring. This is further discussed in this sub-section below.
- 6.2a.69 Between 2 November, when Sarah made her first call to Kent Police for almost a month, and her murder on 7 November, there was no police attendance. During that period she made four calls.
- 6.2a.70 There was a restraining order in force against Robert in addition to a non-molestation order, so Sarah was describing criminal offences. There was a history recorded on Genesis, which was available to the call handlers. During that period, on 4 November, it is recorded on STORM that she said to a call handler that Robert would '*...kill her if he saw her with anybody else.*'
- 6.2a.71 Call handlers do not complete DASH; their risk assessment relies on their professional judgement and the guidance in PAGES. During this period Sarah was allowed to select the police response by agreeing to appointments and then cancelling them. Although it was not known that Robert's stalking had continued during the weeks when she had not contacted Kent Police, it should have been recognised that she

was a vulnerable, frightened person and there was a child living with her.

- 6.2a.72 The actions of the call handlers and other FCR staff during this period have been investigated by the IPCC, which has made recommendations. Notwithstanding that, Kent Police must examine this period carefully and establish whether there are organisational issues that resulted in Sarah not receiving an appropriate level of response. [\(Recommendation 1\)](#)
- 6.2a.73 In summary, Kent Police's standard of response both in call handling and attendance was inconsistent during the first period that she was contacting them and poor in the second.
- 6.2a.74 The second theme is whether Kent Police achieved the correct balance between seeking to bring Robert to justice and providing the appropriate level of victim care – safeguarding and support – to Sarah.
- 6.2a.75 Robert was arrested twice. On the first occasion he was found in the act of breaching the non-molestation order. He was arrested, charged and released on conditional bail. On the second occasion he was arrested for the same offence after Sarah made a statement about his actions. He was charged, remanded in custody and convicted of breaching the non-molestation order. He received a 12 month conditional discharge and a 12 month restraining order.
- 6.2a.76 Details of the arrests and subsequent action are considered in more detail in sub-section 6.4a below but overall this was a positive aspect of safeguarding action taken by Kent Police.
- 6.2a.77 Arresting perpetrators is something that only the police have the power to do and the evidence gathering stage of bringing them to justice is their responsibility. Providing victim care is the responsibility of all organisations that deal with domestic abuse victims.
- 6.2a.78 Kent Police's domestic abuse policy, which is published on the internet, has more references to victims than to perpetrators. It lists the overriding priority for dealing with incidents of domestic abuse as:
- *To protect the lives of adults and children who are at risk of domestic abuse;*
 - *The first priority of the police in responding to a domestic abuse incident is to protect the victims and any other persons at risk, including children and police officers;*
 - *The immediate response to a report of a domestic abuse incident is key to protecting victims, children and police officers;*
 - *To investigate all incidents of domestic abuse;*

- *To facilitate effective action against offenders so they can be held accountable through the criminal justice system;*
- *To adopt a proactive multi-agency approach in preventing and reducing domestic abuse.*

- 6.2a.79 The first three priorities concern victims; the offender is only mentioned once, in the fifth bullet point. The policy is indicative of an organisation that understands the importance of victim care when dealing with domestic abuse. That is not to underestimate the importance of their core function of dealing with perpetrators: arrest removes the risk the perpetrator poses to the victim, if only temporarily, and is part of safeguarding.
- 6.2a.80 However, in this case the victim care given to Sarah and Emma fell short of what they were entitled to expect. When she called Kent Police on 21 September and was told that an officer would be with her within an hour, it was nearly eight hours before one became available. During that time she was not updated about the delay. She said she thought nothing would be done at a time when action was being taken to arrest Robert. If she had been kept updated, her concerns may have been allayed.
- 6.2a.81 Keeping victims informed about the progress of their case in a timely way is something that all organisations in the criminal justice system have wrestled with for many years. There have been attempts to resolve the problem, including national charters and standards. How well organisations do this seems to ebb and flow; it is during times of heavy demand or financial constraint, such as that be experienced currently, that it becomes less of a priority.
- 6.2a.82 It is particularly important that domestic abuse victims are kept informed because they are likely to be living in fear of an ongoing pattern of behaviour. Knowing what action is being taken to support them can alleviate that fear. A mechanistic ‘once a month’ or ‘proforma letter’ approach will not achieve this; it must be tailored to need. It is most likely to be achieved when there is clear ownership of a case.
- 6.2a.83 It may be that for some crimes the decision has to be taken that keeping a victim informed is not a priority due to a shortage of staff time. This must not be the case for domestic abuse victims for the reason given; they must be kept updated. Kent Police must ensure that the importance of keeping domestic abuse victims informed of police action is seen as a priority. ([Recommendation 2](#))
- 6.2a.84 In addition to not being kept informed, Sarah received conflicting information about who was dealing with her case and became

confused by the number of appointments that were made. This is linked to the issue discussed in paragraph 6.2a.67 above.

- 6.2a.85 To summarise, Kent Police brought Robert to justice effectively but did not engage with Sarah in a way that would have reassured her that they were taking action to safeguard her.
- 6.2a.86 The shortcomings, which Kent Police have accepted, relate to victim care. This review recognises that this case may not be representative of the service given to domestic abuse victims. However, Kent Police must review its domestic abuse policy regularly to ensure that it accurately describes the service that victims can expect and that it does not become aspirational. Having done so it must ensure that the policy and associated guidance are complied with. [\(Recommendation 3\)](#)
- 6.2a.87 The third theme is DASH. It governs the ongoing safeguarding of adult victims and of children who are present in households when the police attend domestic abuse incidents. DASH plays a pivotal role in the level of safeguarding that victims receive.
- 6.2a.88 The classification of DASH is usually based on a combination of answers given to a set of standard questions and the professional judgement of the police officer completing it. However, if 14 or more questions (from a total of 27, i.e. over 50%) are answered 'Yes', the classification must be 'High'. A DASH may be graded 'High' if this criterion is not met but the officer believes other factors make it appropriate.
- 6.2a.89 All 27 questions are closed; they require a yes/no answer. However, there are two categories:
- i) Questions of fact which, following the first occasion when answered 'Yes', should then always be answered 'Yes'. For example, 'Has [Name] ever threatened to kill you or someone else and you believed them?'
 - ii) Questions that are subjective and could elicit a different answer each time they are asked. For example, 'Are you very frightened?'
- 6.2a.90 Without taking into account an officer's professional judgement, the answers to the subjective questions can reduce or increase the risk classification following successive completions of the DASH. Therefore, changing classifications within a short time period are not necessarily indicative of inconsistency by the officer(s) completing the form – they may reflect the changing answers given by the victim.

- 6.2a.91 Some questions include a section for the victim to provide additional detail and others expect a police officer to add information. Although the answers to individual questions are important, it is the risk classification (High-Medium-Standard) that most influences the subsequent course of action. It is the officer's professional judgement that increases the element of subjectivity and because of this, two DASH assessments with the same questions answered 'Yes' and 'No' may result in different classification.
- 6.2a.92 In the two weeks following the first police attendance at a domestic abuse incident involving Sarah, six DASH assessments were completed. Two of them, the first and last, were classified as 'Medium'; the remainder were 'Standard'. This may either have been due to Sarah giving different answers to some of the questions or because the same answers were given but the professional judgement of the officers completing the DASH differed.
- 6.2a.93 Kent Police domestic abuse policy includes a requirement that when six DASH assessments have been completed within 12 months (regardless of their classification) a Detective Inspector in the [Combined Safeguarding Team](#) (CST) should examine the case. However, there is no IT system or process that has the facility to flag up a case that fits this criteria; for this reason the requirement cannot be met.
- 6.2a.94 This review does not revisit the classification of each DASH; to do so would simply add another professional judgement. The important points are that the DASH is the single most important element in deciding the overall level of support and safeguarding that a domestic violence victim receives, and that it relies on the professional judgement of the officer completing it. The ability to make sound judgements can be based on numerous factors as diverse as the officer's understanding of the DASH process to the victim's perception of the threat they face.
- 6.2a.95 When the police are the first agency to deal with an incident of domestic abuse as they were on every occasion that Sarah sought help, the involvement of other organisations that might provide support and safeguarding will depend on the DASH classification.
- 6.2a.96 This does not apply only to adult victims of domestic abuse. Sub-section 6.3b below explains how the criteria for notification and referral to KSCS of children who are party to domestic violence are linked to the DASH classification.
- 6.2a.97 This review is not critical of the DASH process; its combination of objective facts and subjective opinion should ensure that when used

properly by those who understand its application, it will provide an accurate risk classification in most cases.

- 6.2a.98 However, getting the classification right is only part of the DASH process and in itself delivers nothing. It is managing the identified risk that will help to safeguard the victim.
- 6.2a.99 If a DASH is classified as 'High', the case will be referred to the MARAC (see [6.6a](#) below). This did not apply to the any DASH completed with Sarah. However, victims subject of the MARAC receive the highest level of multi-agency protection, safeguarding and support. In particular, officers from Kent Police's CST will generally only become involved in domestic abuse cases that have been classified as 'High'.
- 6.2a.100 The CRU will do the following if a crime report or secondary incident report is submitted with a 'Medium' DASH classification:
- *Review all DASH risk assessments categorised as 'High' or 'Medium' and this should take place within 24 hours whenever practicable.*
 - *Review the risk category.*
 - *Formulate safeguarding plans and allocate to a nominated officer or department in relation to 'Medium' risk incidents.*
- 6.2a.101 These actions were completed when the DASH classification relating to Sarah was 'Medium'.
- 6.2a.102 Based on the information available to this review, the standard level of action, i.e. that given to domestic abuse victims when the DASH risk classification is 'Standard', is minimal and it is unlikely to engage other organisations unless there are wider factors that are relevant to the specific service they provide.
- 6.2a.103 In the CRU secondary incident reports (SIRs) are rarely reviewed when the DASH classification is 'Standard'. Once a report is over three weeks old it will be filed. At this point there will have been no check on the DASH risk classification unless this was done by the reporting officer's supervisor prior to the report being submitted to the CRU.
- 6.2a.104 The Kent Police Domestic Abuse Policy requires the CRU to review all 'Standard' SIRs when there are children in the household. In practice, only one in five are checked for this and only then will they be reviewed. This is relevant in this case.
- 6.2a.105 Kent Police is breaching its own policy and the reason given is that the volume of submissions is too great to comply with it.

- 6.2a.106 If Kent Police believe their current policy is correct but there are insufficient staff to implement it, they must increase the staffing. If this cannot be done and the policy cannot be complied with, the policy must be changed. Inserting 'whenever practicable' is an honest if disingenuous option. The Kent Police Domestic Abuse Policy is publicly available, at least through Freedom of Information Act requests, and it tells victims the level of service they can expect. It must reflect what the force is delivering.
- 6.2a.107 When a crime report, as opposed to an SIR, arising from domestic abuse is submitted and the DASH classification is 'Standard', the policy is complied with. All are checked to determine whether there are children in the household and if so the report is reviewed.
- 6.2a.108 Kent Police, like all organisations in Kent that deal with domestic abuse, cannot provide all victims with the highest level of safeguarding. If organisations could do this, there would be no need for a risk assessment. The safeguarding provided should be commensurate with the identified risk.
- 6.2a.109 If when a DASH classification is 'Standard', no further action will be taken beyond that taken by the attending officer in line with policy, victims must be left in no doubt of this. Kent Police must be open and transparent about the minimum level of service that domestic abuse victims will receive from each of the three risk classifications.
[\(Recommendation 4\)](#)
- 6.2a.110 There is no evidence that previous incidents of domestic abuse involving Sarah were used to inform the second and subsequent DASH classifications. The time period within which the six DASH were completed was short but the frequency of calls was in itself a relevant factor that does not appear to have been recognised.
- 6.2a.111 Domestic abuse is usually, and certainly was in this case, a pattern of behaviour by a perpetrator towards a victim. It must be viewed as such, not as a series of isolated incidents that have happened to the same person by coincidence. The history must form part of the risk classification and management because it is the indicator of how a pattern of abuse is developing and whether it is escalating.
- 6.2a.112 The fact that a 'Standard' DASH will be filed without any scrutiny in the CRU suggests that the classification is the overriding factor and that previous history is not always considered. While the officer attending should check on the history, this does not always happen. There should be a 'backstop' to ensure that the classification is considered in the context of historical events.

- 6.2a.113 If a victim has ever received a 'High' or 'Medium' DASH risk classification, there must be some additional scrutiny of any subsequent 'Standard' risk classification to ensure that the history of the abuse has been taken into account when classifying the risk as 'Standard'. It is for the CRU Management Board to consider how this is achieved. [\(Recommendation 5\)](#)
- 6.2a.114 In summary, DASH provides a sound means of classifying the risk to domestic abuse victims. The management of the risk is the responsibility of Kent Police and any other organisations that become involved. In the case of a 'Standard' risk it is unlikely any other organisation will be notified.
- 6.2a.115 The analysis of Kent Police's involvement in this case, has raised a number of organisational issues. There were also issues with the way in which a number of individuals dealt with calls from Emma and Sarah, and these have been investigated by the IPCC investigation. The manner in which the force dealt with Robert was positive.

6.2b Kent Specialist Children's Services (KSCS) Facts

- 6.2b.1 There is no record of Sarah having any contact with KSCS prior to her separation from Robert. On 16 September 2013, following a notification from Kent Police received on 14 September, a KSCS Senior Practitioner (SP1) telephoned her.
- 6.2b.2 Sarah explained that she had separated from Robert and did not want him to return home. She said that she intended to see her solicitor about obtaining a non-molestation order and had changed her locks. She added that police had given her relevant information and she was not requesting further support.
- 6.2b.3 No further action was taken by KSCS on the basis that this was the first reported incident of domestic abuse and that Sarah was taking appropriate action.
- 6.2b.4 The KSCS electronic case file dated 20 September records that a non-molestation order had been granted.
- 6.2b.5 On 4 October another KSCS Senior Practitioner (SP2) made a telephone call to Sarah following the second notification from Kent Police, which was dated 28 September. The KSCS electronic case file records that Sarah said that there was no more stalking at the present time. She described herself and Emma as relieved.
- 6.2b.6 KSCS took no further action following the second contact because Sarah had '*...taken all necessary steps, including taking out a non-*

molestation order to protect herself and her daughter, and Robert Taylor had been arrested and bailed in relation to the breach.'

6.2b.7 There was no further contact between KSCS and Sarah.

Analysis

6.2b.8 Sarah's contacts with KSCS were the result of two notifications from Kent Police that followed visits police officers made to her home after Emma made 999 calls. Emma was present on both occasions when the officers attended.

6.2b.9 There is a difference between the terms 'notification' and 'referral' as they are used in the Kent Police matrix for referral to KSCS in domestic abuse cases ([Appendix C](#)). A notification is made using a non-statutory Domestic Abuse Notification (DAN). One of the circumstances in which a DAN is submitted to KSCS is when police attend a domestic abuse incident and find there is a child living in the household.

6.2b.10 'Referral' means a referral under S.17 or S.47 of the Children's Act 1989, which relate to safeguarding children. The circumstances that give rise to referrals cover all aspects of safeguarding; in many cases domestic abuse might not be an issue.

6.2b.11 A notification by means of a DAN will be specific to domestic abuse; a referral is specific to safeguarding a child or children. While there may be overlaps, the importance of the distinction between the two terms will become clear in this sub-section.

6.2b.12 Following both DANs made by Kent Police, KSCS contacted Sarah by telephone. Neither DAN mentioned that Emma had made calls to Kent Police and KSCS were unaware of this. In addition, the second DAN specifically said that there were no child protection issues.

6.2b.13 The telephone calls to Sarah were made by KSCS Social Workers, both of whom were Senior Practitioners based in the CRU. An electronic case file system was used to input details and make a non-verbatim record of the calls. SP2, who made the second call, would have been aware of the content and result of the first from the electronic case file record.

6.2b.14 Having spoken to Sarah, the decision was made in both cases to take no further action. One of the reasons given following the first call was that it was the first reported incident of domestic abuse.

6.2b.15 There is no evidence or information available to this review that Sarah was a victim of domestic abuse before her separation from Robert. Therefore, this first report may have related to the first incident that she

suffered, but it is rare for this to be the case. Research suggests that domestic abuse victims do not make their first report until they have been subjected to abuse numerous times or when an ongoing cycle of abuse has been taking place for some time.

- 6.2b.16 In Sarah's case it may be that her separation from Robert gave her the confidence to begin reporting domestic abuse, although the first three calls were made by Emma.
- 6.2b.17 The first DAN in this case resulted from a first reported incident of domestic abuse but this should not have been a factor in deciding whether further action was taken. It would have been more victim focused, and in this case more child centred, to assume that although it was the first report, it was not likely to have been the first incident.
- 6.2b.18 KSCS does not have a policy of taking no further action because a DAN relates to a first reported incident of domestic abuse. The record that it was a factor in deciding to take no further action in this case may reflect more on the individual than on the organisation. However, the decision was reviewed and ratified by a Team Leader, and there is no record of that reason being queried.
- 6.2b.19 When training staff in how to deal with DANs, KSCS must emphasise that being a first notification should not in itself be a reason for taking no further action. [\(Recommendation 6\)](#)
- 6.2b.20 The action that Sarah was taking, such as changing the locks and obtaining a non-molestation order, appears to be the main factor in reaching a decision to take no further action in relation to both DANs.
- 6.2b.21 In neither case is there a record that KSCS updated Kent Police with the result of the DAN and this is not a requirement. Staff in the two organisations do not have access to each other's IT systems.
- 6.2b.22 The volume of DANs from Kent Police to KSCS and the workload on staff in both organisations are reasons given for not providing updates in such cases. This is pragmatic: recommending a change to updating the results of all DANs would create a system that would become overloaded and unworkable.
- 6.2b.23 However, in cases of domestic abuse where an adult is the primary victim, the police are the lead organisation in investigating criminal offences. They need to know what, if any, new and relevant information has been obtained and/or is held by other organisations in order to have the best chance of safeguarding the victim.
- 6.2b.24 When KSCS staff make contact with adults or children following a DAN, there should be a workable process that enables them to pass back to

Kent Police any new information that they gather from the contact which may be relevant to the way Kent Police deal with future incidents involving that victim. How this is best achieved should be agreed between Kent Police and KSCS. ([Recommendation 7](#))

- 6.2b.25 The remainder of this sub-section considers whether the KSCS responses to the two DANs relating to Emma Taylor were child centred in accordance with *Working Together to Safeguard Children 2013* and with KSCS and Kent Safeguarding Children Board (KSCB) policies. In order to do this it is necessary to explain the process that Kent Police use to decide whether to make a notification or a referral to KSCS following their attendance at an incident or ongoing issue involving a child.
- 6.2b.26 KSCB have agreed and published a document entitled Kent & Medway Inter-Agency Threshold Criteria for Children in Need. This describes four tiers of risk to children (1 to 4 in ascending order of risk) with criteria that define whether a child meets the threshold for a tier. A child who meets the threshold for Tier 3 is a 'Child In Need' as defined by S.17 of the Children's Act 1989. Meeting the threshold for Tier 4 means that a child is in need of 'protection' as defined in S.47 of the Act.
- 6.2b.27 A matrix describes features that would place a child in a given tier and contains illustrative examples. These examples describe '*...how need might present itself, rather than an exhaustive list of fixed criteria that must be met*'. The matrix also sets out the assessment process for each tier. Domestic abuse appears as an illustrative example under 'Family and Environmental Factors' in tiers 2-4. Within Tier 3 the illustrative example is:
- Domestic Abuse where the risk to the victim is assessed as standard/medium risk (DASH) and the child is present within the home during the incident.*
- 6.2b.28 On this basis Emma fell into Tier 3 on both occasions when a DAN was submitted by Kent Police to KSCS, which in turn requires a [Common Assessment Framework \(CAF\)](#) to be completed.
- 6.2b.29 A CAF is a more lengthy and comprehensive document than a DAN and in practice it is likely that the requirement to complete one would be identified in the CRU following the submission of a DAN. A CAF can only be undertaken with informed and explicit consent from the child and/or their parents/carers.
- 6.2b.30 When KSCS receive a CAF from Kent Police, they should decide on their response based on the information in it. They will undertake an initial assessment and if appropriate complete a Child In Need Plan. Following that the case may be closed, actioned or lead to a fuller assessment.

- 6.2b.31 The KSCS SPs who received the DANs and contacted Sarah were knowledgeable about the risks of domestic abuse. They had considerable experience in dealing with DAN contacts. On neither occasion was it recorded that the Tier 3 domestic abuse criterion was met and why the decision was taken not to implement the Tier 3 assessment process.
- 6.2b.32 When a decision is taken that appears to be contrary to policy and/or guidance, rationale for it must be recorded. If it is not, the decision becomes harder to justify in any subsequent enquiry, review or complaint investigation, particularly if there has been a considerable time lapse and the decision maker cannot recall the rationale.
[\(Recommendation 8\)](#)
- 6.2b.33 Professional judgement will play a part in deciding what action to take in safeguarding cases. For example, there will be cases where the criteria for a particular course of action as set out in policy and guidance are not met but a professional will use their judgement to recommend that it is necessary.
- 6.2b.34 In order to take a course of action when the criteria are not met, a professional would need to record the reasons leading to their decision. The same must also apply when the criteria are met but a decision is made not to take action. Every opportunity must be taken to ensure that all the available evidence and information is gathered and considered before such a decision is taken.
- 6.2b.35 In neither call made by KSCS to Sarah is it recorded that Emma was spoken to, nor that there were requests to speak to her. Had she been a baby or a very young child this would have been understandable, but she was a teenager. Speaking to Emma would have provided an opportunity to reach a decision on further action in a more informed way. It was noted in the electronic case file that the police record indicated that Robert Taylor had previously threatened to hurt Emma. Speaking to her might have established what that threat amounted to, whether it had escalated beyond a threat and whether Emma currently felt threatened.
- 6.2b.36 In addition, following both calls, the decisions were based primarily on the fact that Sarah was taking action that would help to safeguard Emma. This suggests an over-reliance, particularly in the second case, on Sarah's ability to protect Emma. The failure to speak to Emma was a missed opportunity to establish whether she felt safe following her mother's actions.
- 6.2b.37 In the case of a contact made on the basis of a DAN rather than a statutory referral, a child can only be spoken to following parental consent being obtained. In the case of these two DANs there is no

record that this was sought. When KSCS staff speak to a child's parent(s) about domestic abuse they should request to talk to the child, if the child is old enough to speak for themselves. Where a request is not made, the reason why should be recorded. [\(Recommendation 9\)](#)

6.2b.38 There is no record that Sarah was asked about child access arrangements. If Robert had access to Emma and was able to take her out alone, the protective arrangements that her mother had put in place, on which the decision to take no further action was based, would not have applied. When KSCS staff speak to a child's parent(s) about domestic abuse and the parents have separated, they should query child access arrangements. [\(Recommendation 10\)](#)

6.2a.39 Notwithstanding the comments and recommendations made about the DAN process, the review acknowledges that there is no statutory requirement to have such a process in place. Its existence is an example of good practice and reflects positively on multi-agency child safeguarding arrangements in Kent and Medway.

6.2b.39 No contact was made with Emma's school following the second notification. If it had been, KSCS could have updated the school that domestic abuse was continuing and the school might have been able to provide them with additional information.

6.2c Health Services Facts

6.2c.1 There are two records of Sarah having involvement with health services: first when she visited her GP, second when she attended hospital.

6.2c.2 On 12 November 2003 she went to see her GP. She told him that she had taken an overdose of Brufen, which is now better known by its retail name of Ibuprofen. She said that she had taken nineteen 200 mg tablets. Her medical record states that this was an impulsive act and that she was *'regretful and little tearful'*.

6.2c.3 The GP was unable to recall what action, if any, he took as a result of this disclosure and Sarah's medical records do not assist. Similarly there is no recollection or record of whether he asked her why she had taken an overdose.

6.2c.4 On 25 October 2011 Sarah went to the out patients department of her local hospital for treatment of a medical condition.

6.2c.5 She had no contact with health services between the time she separated from Robert and her death.

Analysis

- 6.2c.6 Sarah's contact with her GP following her overdose in 2003 is the only contact with health services that is subject of analysis.
- 6.2c.7 The GP practice that Sarah visited was in her hometown. It was and is a single GP practice, which is still run by the doctor who saw her following her overdose.
- 6.2c.8 The GP records contain very little information. They do not show the time period that had elapsed between Sarah taking the tablets and attending the surgery, whether she was asked about her reason for taking an overdose or what, if any, action the GP took. Unsurprisingly, given the time lapse between the event and this review, he had no recollection of the visit.
- 6.2c.9 The reason why Sarah took the overdose related to the fraud perpetrated by Robert, for which he was subsequently convicted. At the time he had been arrested for this and he wanted the family to move overseas and start a new life, presumably to avoid a criminal trial and possible prison term. This information was provided by a friend of Sarah and it is not known whether she shared it with her GP.
- 6.2c.10 Plans for this move were progressing but Sarah was strongly opposed to it. She took an overdose in the hope that it would convince Robert how unhappy she was and to change his mind about the move. Her action was not a suicide attempt and it is not known whether the overdose was the reason or even a contributory factor to the move not taking place.
- 6.2c.11 There is nothing in Sarah's medical records to suggest that she was a victim of domestic abuse, although taking an overdose might have been an early sign that Robert was controlling her and that she had to take an extreme measure to draw attention to her plight.
- 6.2c.12 The lack of detail in the GP records in such a case is surprising and means that it is not possible to know whether Sarah disclosed domestic abuse to him. Accurate records are not simply important to inform reviews; they are essential in ensuring that any subsequent events can be dealt with in the light of the history – particularly as those events may be dealt with by a different clinician.
- 6.2c.13 The fact that one consultation, that took place over 10 years ago and was not well recorded is insufficient evidence to conclude that this GP consistently fails to keep proper records. However, NHS England should consider whether to explore this further. [\(Recommendation 11\)](#)

6.3 Organisation Involvement – Emma Taylor

6.3a Education (School) Facts

- 6.3a.1 At the time of her mother's death, Emma was attending a secondary school in Town A where she had been a pupil since September 2009. Prior to that she had attended a primary school in Town B for the duration of her primary education.
- 6.3a.2 Staff at the primary school knew about Robert's imprisonment for fraud and gave Emma additional pastoral support during that time.
- 6.3a.3 The head teacher at her primary school recalled Emma being very ill during her final year there, during which time she appeared to need a lot of additional support.
- 6.3a.4 The primary school also knew that Emma's parents were estranged for a period. It is not known when this separation happened or how long it lasted for but it could not have been the period of estrangement in the two months prior to Sarah's death.
- 6.3a.5 The first time that the secondary school were aware of Emma's parents' relationship difficulties was on 16 September 2013 when the Designated Child Protection Coordinator recorded that *'Mum and dad have split up. Mum is getting an injunction. Her solicitor has advised that if dad comes to school to take Emma out, she doesn't have to go and we will contact mum. I have ensured that Emma has the school phone number in case of any issues at lunchtimes as dad has been hanging around at the end of the day.'* Emma also asked that the school recognise her change of surname to Baker (her mother's maiden name), although there is no record of written confirmation of this being received from Sarah or any contact being made with her about it.
- 6.3a.6 On the same day, her secondary school records show that a telephone call was received from KSCS SP1. She asked the school to provide Sarah's telephone number because Kent Police had made a notification about domestic abuse. No more information was offered and none was requested by the school.
- 6.3a.7 Following Emma telling the school about her parents' separation and KSCS telling them about domestic abuse, there is no record of the secondary school taking any specific action. School records show that in the half term from 3 September to 28 October Emma's attendance was almost complete, with one day's absence for illness and attendance at a medical appointment.

6.3a.8 The secondary school were not told about the second notification to KSCS. The next record that school staff were aware of any further issues relating to Emma's domestic circumstances was when they were told about the death of her mother. Emma was at school at the time.

Analysis

6.3a.10 The secondary school were told on the same day that Emma's parents had separated and that there was domestic abuse taking place. In the former case they were told by Emma, in the latter by KSCS.

6.3a.11 It is unclear whether SP1, who had received the first DAN from Kent Police, contacted the school primarily to inform them of the situation or to find out Sarah's telephone number. On the basis that KSCS did not contact the school after the second notification from Kent Police, it would seem more likely to be for the latter reason.

6.3a.12 Parental separation is not a rare event for a school to become aware of and unless there are additional factors, it is unlikely to trigger significant action beyond any additional pastoral support that may be required.

6.3a.13 In this case there was additional information, referring to domestic abuse, provided on the same day and although Emma's school attendance did not suffer it would be reasonable to have expected the secondary school to have demonstrated at least a little more professional curiosity, perhaps by contacting Sarah.

6.3b Kent Police Facts

6.3b.1 There is no record of Emma having contact with Kent Police before her parents separated in the weeks before her mother's death.

6.3b.2 As detailed in sub-section 6.2 above, the first five calls that Kent Police received about domestic abuse were 999 calls made by Emma. She subsequently made a further three such calls.

6.3b.3 Those calls appear to have been made on behalf of her mother and do not refer to threats against her (Emma). Following the calls she made on 7 September, Emma was present when police officers responded. As part of their response Kent Police made a notification by means of a DAN to KSCS.

6.3b.4 The second notification came after Robert's first arrest when a Detective Sergeant in the CRU completed a safeguarding plan for Sarah.

6.3b.5 There is no record of whether police officers spoke to Emma when they attended reports of domestic abuse and she was present.

Analysis

- 6.3b.6 Emma made six 999 calls to Kent Police in a period of 10 days about the domestic abuse being suffered by her mother at the hands of her father. The calls were made on four separate days; on two of which she made two calls. Five of the calls that Emma made, in the course of three separate days, were made before Sarah contacted the police herself.
- 6.3b.7 On each day that Emma made calls, Kent Police officers attended. They knew that she was present when the action that prompted her calls took place. There is no record that Emma was spoken to by police officers when they attended.
- 6.3b.8 Kent Police have, as part of the domestic abuse policies and procedures, a matrix which set out the criteria for making a notification or a referral to KSCS when a child is affected by domestic abuse. A copy of the matrix is included at [Appendix C](#).
- 6.3b.9 The criteria in the matrix are based on the classification of the DASH. On the first occasion when police officers attended following Emma's call, the DASH was graded 'Medium'. On the three subsequent occasions it was graded 'Standard'.
- 6.3.10 Applying the criteria in the matrix, the first call would require a notification to KSCS because of the 'Medium' classification and the serious threat made to Sarah. The three 'Standard' classification would not have required a notification or referral to KSCS unless there were unspecified 'wider factors'. The second notification was made after the second time when a DASH was classified as 'Medium'.
- 6.3b.11 The matrix criteria mean that the appropriate classification of the DASH is essential to safeguarding children who are living in households where domestic abuse is taking place.
- 6.3b.12 There may be many calls to such a household and if on each occasion the risk is graded as 'Standard', there may never be a notification or referral to KSCS. 'Standard' secondary incident reports are generally filed at the CRU without further scrutiny and the check of one in five to see whether a child was present is not being undertaken.
- 6.3b.13 There are two anomalies in the matrix. First, it does not specify whether a notification or referral should be made when the risk is graded as 'Medium' without any other factors.
- 6.3b.14 Second, where there have been four domestic abuse incidents within a 12 month period, a referral to KSCS need only be made when the latest risk assessment is graded 'Medium'. If the first three incidents were graded 'Medium' and the last one 'Standard', no notification or referral

would be required. Given that the DASH process has a strong element of professional judgement, i.e. subjectivity, the reduction in the classification would be no guarantee that the risk had reduced.

- 6.3b.15 Kent Police, in consultation with KSCS, should review the matrix to ensure that there are no anomalies and that it provides the right criteria for safeguarding children who are living in households where domestic abuse is taking place. [\(Recommendation 12\)](#)
- 6.3b.16 As well as the occasions when she called Kent Police, Emma may have been present at other times when they attended. There is no record of whether they spoke to her. Had they done so, she may have provided them with information that would have assisted in assessing the risk to both her and Sarah. It may also have influenced their decision as to whether a notification or a referral to KSCS was required.
- 6.3b.17 When training officers and staff in dealing with domestic abuse incidents, Kent Police should emphasise the importance of speaking to children who are old enough to speak for themselves. [\(Recommendation 13\)](#)

6.3c Health Services Facts

- 6.3c.1 Emma's medical records show that she had only routine appointments with Kent Community Healthcare Trust (KCHT) during her childhood for vaccinations and developmental assessments.
- 6.3c.2 On 13 June 2009 Emma was transferred from a local hospital to one in London for emergency surgery and she received two further periods of outpatient and inpatient treatment in hospital for a medical condition during 2011 and 2012.
- 6.3c.3 There is no record of Emma having any involvement with health services between her parents' separation and her mother's death. There is no evidence or information in her medical records that she was a victim of domestic abuse or that she had witnessed abuse at home prior to that separation.

Analysis

- 6.3c.4 There is no analysis made of Emma's contact with health services as it is not relevant to the terms of reference of this DHR.

6.4 Organisation Involvement – Robert Taylor

6.4a Kent Police Facts

- 6.4a.1 Robert had one criminal conviction during the period covered by the terms of reference. On 4 February 2005 he was sentenced to 3 years imprisonment for obtaining over £60,000 by deception. This related to

a complex fraud concerning the sale of a house. He was released from prison on licence on 24 March 2006.

- 6.4a.2 Robert was dealt with by Kent Police on a further five occasions as a potential offender during the period covered by the terms of reference and prior to 7 September 2013. None of the incidents were related to domestic abuse. Two involved him being a suspect for minor violent crime but in both cases the victims declined to support a prosecution and no further action ensued.
- 6.4a.3 In addition, during the period covered by the terms of reference, Robert was a victim of crime on a number of occasions. In one of these he was assaulted. This was not related to domestic abuse.
- 6.4a.4 The remainder of this sub-section deals with the three occasions that Robert had contact with Kent Police in the period between his separation from Sarah and him murdering her.
- 6.4a.5 The first contact was on 7 September 2013 and is set out in sub-section 6.2a above. The detail of the attending police officers' interaction with Robert is not recorded but he agreed to leave the house for the night.
- 6.4a.6 His second contact with Kent Police was on 22 September when he was arrested in the back garden of the family home for breaching the non-molestation order.
- 6.4a.7 Following his arrest, he was charged with breaching the order and bailed to appear at Canterbury Specialist Domestic Violence Court (SDVC) on 29 October. The following bail conditions were imposed by the police:
- *Not to go or enter the housing estate, Town save on one occasion in company with a uniformed officer to collect bags of personal effects from the matrimonial home.*
 - *Not to contact or interfere with, either directly or indirectly, any prosecution witness, namely and Sarah Taylor, save through a solicitor, Social Services or agreed third party for the purpose of arranging child contact and resolving financial matters.*
- 6.4a.8 His third contact with Kent Police was when he was arrested on 3 October, again for breaching the non-molestation order. On this occasion he was charged and remanded in custody to appear before East Kent Magistrates Court the following day.
- 6.4a.9 The next time that Robert had contact with Kent Police was when he telephoned them at 3.09pm on 7 November to tell them that he had killed Sarah.

Analysis

- 6.4a.10 This sub-section examines the contact that Robert had with Kent Police between 7 September and 7 November 2013. None of the previous contact was relevant to the terms of reference of this DHR.
- 6.4a.11 On 7 September Robert was present when police officers arrived at Sarah's home following the 999 call made by Emma, who was also present. While Sarah's allegations about his behaviour are recorded in some detail, the officers' interaction with Robert is not. What is recorded is that Robert '*...agreed to leave the house for the night.*' although he was separated from Sarah and not living there by this time.
- 6.4a.12 Couples who are separated, as with couples who are still cohabiting, may have heated disputes that do not meet the definition of domestic abuse. Police may be called and the resolution of such incidents of conflict by one party leaving the scene may be appropriate.
- 6.4a.13 However, on this occasion Robert had made a threat to kill Sarah and this was an incident of domestic abuse.
- 6.4a.14 There is a statutory offence of Threats to Kill contrary to Section 16 of the Offences Against the Person Act 1861, which is punishable by a maximum prison term of 10 years. The key points to prove are that the threat was made and that the person making it did so '*intending that the other would fear it would be carried out.*' Although straightforward, the first point may be hard to prove if only two people were present when the alleged threat was made. In any circumstances where the alleged threat was made verbally in the heat of a conflict, the required intent may also be difficult to prove.
- 6.4a.15 The detail of the conversation that the police officers attending had with Sarah and Robert is not recorded so a judgement on whether they ought to have arrested him for making the threat cannot be made.
- 6.4a.16 Arrest, which is an early step towards a potential prosecution, requires sufficient grounds and this is not always provided by an unsupported allegation that something was said. It is known with hindsight that Robert carried out this threat but there is no evidence or information of physical violence in the relationship between Sarah and Robert, nor did he have a history of serious and/or escalating violence. If the officers were aware of this, and they may have been, it would have been reasonable for them to take it into account when considering whether to arrest him.
- 6.4a.17 Robert's next recorded contact with Kent Police was on 22 September when he was arrested for breaching the non-molestation order, having been found in the back garden of the family home. He was

subsequently charged with the breach and bailed to appear at a Specialist Domestic Violence Court (SDVC) on 29 October with bail conditions that were imposed by the police.

- 6.4a.18 Those bail conditions were more restrictive than the conditions placed on him by the non-molestation order. In particular they prohibited him from contacting Sarah, which the non-molestation order did not.
- 6.4a.19 Robert's arrest, bail conditions and the fact that he was bailed to an SDVC were examples of positive action against a domestic abuse perpetrator. The fact that he never appeared for the SDVC was because he was arrested again before the court date.
- 6.4a.20 His next recorded contact with Kent Police was on 3 October when he was arrested for breaching the non-molestation order a second time. He could have been arrested for breaching his bail conditions, although unlike the breach of the non-molestation order this is not a substantive criminal offence.
- 6.4a.21 On this occasion Robert was charged and remanded in custody to appear in court the following morning. Again, this was positive action against a domestic abuse perpetrator.
- 6.4a.22 The way in which Kent Police dealt with Robert is inextricably linked to the service they gave to Sarah because any action against him was aimed at safeguarding her. Overall, the way in which they dealt with him was the most positive aspect of the service they gave to Sarah.

6.4b Health Services Facts

- 6.4b.1 The first record of Robert having involvement with health services during the period covered by the terms of reference was on 19 August 2004 when he went to the family's GP, stating that three weeks prior to the visit he had fallen through a loft hatch. He said that he had injured his shoulder, knee and head, and that he had been knocked out for 30 to 40 minutes. He also complained of blurred vision and that he could not sleep.
- 6.4b.2 The GP referred him to the Accident & Emergency department of the hospital local to Town A, where he had a CT scan, which found no abnormalities.
- 6.4b.3 He returned to see his GP on 24 August stating that he had fractured vertebra in his neck, as well as repeating that he was suffering from loss of vision, having sleeping problems and headaches.

- 6.4b.4 He again attended his GP surgery two days later, and his medical records indicate that he said that he was '*...off to Cyprus and needs a letter to get out of court appearance.*'
- 6.4b.5 He went to the GP again on 2 September 2004, the day before he was due to appear at Canterbury Crown Court in relation to the offence for which he was subsequently imprisoned. He was described by the GP as being '*all over the place*', musing on whether he should go to court or on holiday. The GP referred him for a private appointment with a neurologist.
- 6.4b.6 Robert visited the neurologist at the Chaucer Hospital, Canterbury on 16 November 2004, where in addition to the symptoms that he had described to his GP, he complained of irritability, loss of concentration lethargy and depression. In particular, he said that he became irritable and angry, and sometimes had to leave the room, when dealing with colleagues. There is no record that he mentioned any difficulties at home or that he was becoming aggressive there.
- 6.4b.7 Medical records held by Kent & Medway Partnership Trust (KMPT) dated 23 November 2004 show that a letter was received from the consultant neurologist who had seen him at the Chaucer Hospital, Canterbury. He requested that Robert be offered psychological management.
- 6.4b.8 A letter was sent to Robert telling him that he had been referred to a neuropsychologist and that he would receive an appointment within 12 weeks. Letters were then sent to him on three occasions offering appointments: 12 January, 27 January and 14 February 2005. No response was received to any of these letters and his case was closed.
- 6.4b.9 There are no further entries in Robert's medical records relating to the symptoms he complained of following his fall from the loft.
- 6.4b.10 On 31 January 2005, during the period that he was failing to respond to letters, he visited his GP after having attended hospital on 27 September as a result of being assaulted. Sarah had contacted the GP the previous day seeking advice and Robert attended as a result of this. He was prescribed painkillers.
- 6.4b.11 He attended hospital on two further occasions during the period covered by the terms of reference. The first was in 2008 for investigation and treatment of a medical condition, the second was in 2011 following a sports injury.
- 6.4b.12 There is no record of Robert seeking medical advice during the period between his separation from Sarah and her murder.

Analysis

- 6.4b.13 The head injury suffered by Robert is described above in some detail. When the DHR started prior to his trial, it was felt that this was an event that might, despite it happening nine years before he murdered Sarah, feature in his defence case. It also gives the only insight into Robert's character prior to him separating from Sarah.
- 6.4b.14 He did not use this event in his defence and a friend of Sarah has said that the injury was not as he described but that he sought to use it in an attempt to postpone his court appearance for fraud. This is corroborated by the comment to his GP about whether he should go on holiday or to court.
- 6.4b.15 The treatment that Robert received for this episode might be different today but it was appropriate at the time, and it is not relevant to the terms of reference of this review. Nothing else in his medical history is relevant.

6.5 Other Organisations' Involvement

- 6.5.1 This sub-section deals with two organisations - The Crown Prosecution Service and HM Courts & Tribunal Service - that did not have direct personal contact with Sarah, Emma or Robert Taylor but whose involvement is relevant to this DHR.

6.5a Crown Prosecution Services (CPS) Facts

- 6.5a.1 The CPS were involved on both occasions when Robert was arrested for breaching the non-molestation order.
- 6.5a.2 Following his arrest on 22 September, CPS made the decision that he should be charged with the breach and then bailed. They advised Kent Police on the appropriate bail conditions.
- 6.5a.3 When Robert was arrested on 3 October, CPS again decided that he should be charged with breaching the non-molestation order. On this occasion they decided that he should be remanded in custody to appear at East Kent Magistrates Court on 4 October. They also prosecuted the case.

Analysis

- 6.5a.4 CPS *Policy for Prosecuting Cases of Domestic Violence* applies to all offences arising out of domestic abuse. There is also separate and specific guidance for prosecuting the breach of a non-molestation order. Such a breach is contrary to Section 1 of the Domestic Violence, Crime and Victims Act 2004.

- 6.5a.5 The guidance for prosecuting breaches on non-molestation orders states that '*By the very nature of this offence, prosecutors should refer to our policy statement and guidance on prosecuting Domestic Violence and apply the principles contained therein*'. This clearly links breaching a non-molestation order to the domestic violence policy.
- 6.5a.6 When the police arrest a suspect for breaching a non-molestation order and believe that they have sufficient evidence to charge the offence they must contact CPS, who will make the charging decision. There will be a detailed consideration of the evidence in each case and a suspect will only be charged if there is a reasonable prospect of conviction and a prosecution is required in the public interest.
- 6.5a.7 The detailed considerations are set out in the *DPP's Guidance on Charging* and *The Code for Crown Prosecutors*.
- 6.5a.8 In all but the most serious cases the police contact CPS Direct to get a charging decision. CPS Direct is a nationwide 24/7 telephone service staffed by CPS lawyers. The police officer explains the evidence and the lawyer decides whether the charging criteria have been met. The lawyer might request copies of documents such as statements to be sent to them.
- 6.5a.9 After Robert's first arrest, the CPS Direct lawyer advised that he should be charged with breaching the non-molestation order. There was a further discussion about whether he should be remanded in custody or on bail. The lawyer advised that he should be bailed with conditions and gave further advice on those conditions.
- 6.5a.10 The lawyer recorded the rationale for both the charging decision and bail advice on the CPS electronic case management system.
- 6.5a.11 When Robert was arrested on 3 October for the second breach, a police officer contacted CPS Direct as previously. On this occasion the lawyer's decision was that Robert should be charged with breaching the non-molestation order and remanded in custody to appear before East Kent Magistrates Court the following morning.
- 6.5a.12 In cases where a person is remanded in custody to appear before the first available court, CPS Direct also provide briefing and advice for the CPS lawyer who will be prosecuting the case. This is recorded on the CPS electronic case management system, which the prosecutor will access before the hearing.
- 6.5a.13 The advice to the prosecuting lawyer from the CPS Direct lawyer was that if Robert pleaded not guilty, a request should be made to the magistrates that he be remanded in custody until the next court

hearing. However, Robert pleaded guilty and was sentenced at the first hearing.

- 6.5a.14 On both occasions when Robert was arrested there was potential to charge him with an offence of harassment or stalking contrary to the Protection from Harassment Act 1997. Section 6 of the *CPS Code for Crown Prosecutors* deals with selecting charges and the decision to only charge the breach of the non-molestation order complies with this.
- 6.5a.15 When Robert was arrested the second time he was also in breach of the conditional bail that he had been granted by the police following his first arrest and charge. Breaching the conditions of bail imposed by the police is not a criminal offence. When a person breaches such conditions they can be brought before a court, which can only consider whether to vary the conditions or remand the person in custody. It cannot impose a sentence for the breach.
- 6.5a.16 In conclusion, CPS involvement following Robert's two arrests was in accordance with their policies and was appropriate.

6.5b HM Courts & Tribunals Service (HMCTS) Facts

- 6.5b.1 HMCTS were involved with Robert when he appeared before East Kent Magistrates Court on 4 October charged with breaching the non-molestation order.
- 6.5b.2 He pleaded guilty to the charge and was dealt with at the first hearing. He was sentenced to a 12-month conditional discharge and a 12-month restraining order was imposed. A restraining order is essentially a non-molestation order that is imposed by a criminal court with the important difference that a restraining order can prohibit contact with other persons.
- 6.5b.3 The conditions imposed by the restraining order were that Robert was prohibited from:
1. Contacting Sarah Taylor either directly or indirectly save through a solicitor, social services or Elizabeth Baker [*Sarah's mother*] for the purpose of child contact and through a solicitor for the purpose of financial matters and personal effects.
 2. Entering housing estate, Town A.

Analysis

- 6.5b.4 Some background about how those charged with offences arising out of domestic abuse are dealt with in Kent is relevant to this DHR.

- 6.5b.5 HMCTS in Kent host Specialist Domestic Violence Courts (SDVCs). A person who is charged with an offence arising out of domestic abuse, and who is bailed by the police with or without conditions, should be bailed to an SDVC. It is likely that the time between a person being charged and their first court appearance will be shorter when this is done. One of the aims of the SDVC process is 'fast track' defendants once they have been charged.
- 6.5b.6 It is unlikely that a person will appear before an SDVC if they are charged and remanded in custody. This is because there is a requirement that a person remanded in custody must appear at the first available court after charge and SDVCs are only held at pre-determined times and locations. In addition, the demand on SDVCs is such that that it would be unlikely there would be a vacant slot at such short notice.
- 6.5b.7 When a suspect is charged and remanded in custody in Kent & Medway, their appearance before the court can either be in person or by video link. HMCTS Kent are an early adopter of the video link system, which is also referred to as a 'virtual court'.
- 6.5b.8 If an appearance is by video link, the case will be heard at Medway Magistrates Court, which has the necessary facilities. If it is in person, it will be heard at the magistrates' court nearest to the police station where the suspect has been held in custody.
- 6.5b.9 The default position is that a suspect remanded in custody will appear by video link. On occasions this may not be possible because of the limited capacity at Medway Magistrates Court to hear cases this way.
- 6.5b.10 The police can also decide how a suspect remanded in custody will make their first court appearance. The reasons for them deciding that a person will appear in person could be, for example, that the defendant refuses to co-operate with the video procedure or that there are insufficient police resources available to supervise them during the procedure. In the case of video link, it is the responsibility of the police to supervise the defendant. If they are taken to court for a personal appearance, this is done by a private contractor.
- 6.5b.11 It is not recorded why Robert appeared in court in person but it is not relevant to the result of his case.
- 6.5b.12 All magistrates in Kent receive induction and refresher training in dealing with domestic abuse cases. There is no additional training for magistrates sitting in SDVCs: any magistrate who has received the standard training can sit in these courts but magistrates should be encouraged to ensure that their understanding of domestic abuse

remains current. This can be achieved by attending the refresher training provided.

- 6.5b.13. The CPS prosecutor at an SDVC will have received enhanced domestic abuse training, there are separate waiting areas for victims and perpetrators, and there will be an Independent Domestic Violence Advisor (IDVA) present in court.
- 6.5b.14 When a person is remanded in custody for an offence arising from domestic abuse and appears either personally or by video link at their first hearing, it will only be by chance if a CPS prosecutor with enhanced domestic abuse training presents the case. It is unlikely that an IDVA will be in court because there is no process for notifying them that a person has been remanded in custody.
- 6.5b.15 If a defendant pleads not guilty at the first hearing following a remand in custody, they will not be bailed to an SDVC because trials are not heard in these courts. SDVCs are for first hearings only but at subsequent hearings an IDVA will be present if a need is identified at the first SDVC hearing.
- 6.5b.16 If, as Robert did, a defendant pleads guilty at the first hearing, the magistrates may bail them to the next available SDVC. However, if they are satisfied that they are in possession of all the information that they need to dispose of the case, they are likely to do so as they did on this case.
- 6.5b.17 In short, the enhanced facilities to support victims and prosecute perpetrators that are provided by SDVCs in Kent are unlikely to be available when a suspect is remanded in custody to appear before the first available court. If the defendant pleads guilty at their first hearing and is sentenced, as in Robert's case, they will not appear before an SDVC.
- 6.5b.18 This is an anomaly because a person is likely to be remanded in custody by the police for more serious cases or because it is a second or subsequent offence.
- 6.5b.19 There is pressure on HMCTS and other agencies to reduce the time taken to reach the conclusion of a criminal case. The government publication *Delivering Simple, Speedy, Summary Justice (2013)* emphasises the need to make '*...the first hearing effective every time...*' and states that one of the four ways of achieving this is to ensure that '*where defendants plead guilty, they are dealt with there and then.*'
- 6.5b.20 The principles of delivering justice expeditiously and effectively can benefit victims, including those of domestic abuse. However, [Kent Criminal Justice Board \(KCJB\)](#) should consider whether there is any

way in which the facilities available in an SDVC could be provided in cases where the defendant appears after having been remanded in custody. ([Recommendation 15](#))

- 6.5b.21 In the longer term the Department for Constitutional Affairs (DCA) should consider whether domestic abuse should be excluded from the general principle of cases being disposed of at first hearing where this means that offenders are less likely to appear for SDVCs. ([Recommendation 16](#))
- 6.5b.22 In 2006 the Sentencing Guidelines Council published definitive guidance for the sentencing of offenders convicted of breaching protective orders, which includes non-molestation orders and restraining orders. The guidance sets out the starting point for sentencing, which is dependent on the nature of the breach. It also lists additional aggravating and/or mitigating factors that might increase or reduce the sentence respectively.
- 6.5b.23 Robert appeared before the court twice, having breached the non-molestation order on two occasions. The sentencing guidelines define the nature of the breach in this case as *'More than one breach involving no/minimal contact or some direct contact.'* The starting point for sentencing in these circumstances is *'Medium range community order.'*
- 6.5b.24 In Robert's case none of the aggravating or mitigating circumstances that are listed in the guidelines applied. The sentence he was given is less severe than the starting point but not to a significant extent. Some credit may have been given for an early guilty plea.

6.6 Multi-agency Working

- 6.6.1 The multi-agency working that happened in this case has been examined as it arose in the analysis of each organisation's role. This sub-section explains the formal processes that are in place to identify domestic abuse victims who are most at risk (MARAC) and perpetrators who present the greatest threat (MAPPA - Multi-Agency Public Protection Arrangements). It considers whether Sarah and Robert should have been subject of those processes.
- 6.6.2 This sub-section also refers to domestic abuse support agencies in Kent and whether there was a missed opportunity to provide additional support to Sarah.

6.6a MARAC

- 6.6a.1 Those victims who are most at risk of significant harm from domestic abuse are identified through the Multi-agency Risk Assessment

Conference (MARAC). This is a meeting at which information about high risk domestic abuse cases is shared amongst representatives of local police, health, child protection, housing practitioners, IDVAs and other specialists from the statutory and voluntary sectors.

- 6.6a.2 Kent has a well-established MARAC process with a detailed protocol and guidelines document, and a separate information sharing protocol. Sarah was never assessed as meeting the [MARAC criteria](#). Given the tragic result, the question of whether there should be a recommendation that the criteria should be changed has been considered.
- 6.6a.3 To work effectively there must be sufficient resources to manage the cases that are referred to the MARAC and ensure effective interventions. This will guarantee that those most at risk are carefully examined and appropriate action is taken to protect them. Given that resources will always be limited, there is a need for referral criteria.
- 6.6a.4 Changing the criteria to admit more cases would dilute the support given to those at demonstrably the greatest risk. The death of Sarah is not evidence of a failure in the MARAC process and does not provide evidence that the criteria are too restrictive.

6.6b MAPP

- 6.6b.1 The potentially most dangerous offenders are identified and managed using multi-agency Public Protection Arrangements (MAPP). This is not a statutory body; it is a mechanism through which organisations can better discharge their statutory responsibilities and protect the public in a co-ordinated manner. MAPP is not restricted to domestic abuse perpetrators.
- 6.6b.3 The decision on whether a person is a MAPP offender is based on their previous offending behaviour. A person who has never been cautioned for or convicted of a criminal offence will not become a MAPP offender.
- 6.6b.4 Robert did not fall into any of the [categories](#) that would have made him a MAPP subject. If every person with his offending history fell into the process there would be insufficient resources to manage it effectively. As with MARAC, Sarah's murder is not evidence that the MAPP process is ineffective.

6.6c Domestic Abuse Support Agencies

- 6.6c.1 There are four third-sector domestic abuse support organisations that collectively form the Kent Domestic Abuse Consortium (KDAC). The consortium are commissioned by a group of statutory agencies to deliver a domestic abuse service, which includes IDVAs.

- 6.6c.2 In this case, there was one occasion where a Detective Sergeant in the CRU authorised contact with an IDVA. Such authorisation is necessary because if police officers attending domestic abuse incidents contact or refer victims to IDVAs directly, the service would become overloaded. Neither Kent Police nor the organisation covering the area where Sarah lived have a record that referral was made.
- 6.6c.3 With hindsight, this was a significant missed opportunity because Sarah would have been contacted by an IDVA. The service aims to make contact within 48 hours of a referral. Every victim that is contacted will receive advice. The IDVA service is funded to provide support to 'High' risk victims and the volume of referrals is such that 'Medium' risk victims will not get ongoing support.
- 6.6c.4 In this case there is no criticism of the domestic abuse support organisation: they would only have known about Sarah if she had been referred to them.
- 6.6c.5 There is an IDVA assigned to each of the four SDVCs in Kent and each SDVC sits once a week. Domestic abuse cases make up about 20% of all cases in Kent Magistrates Courts. Each full-time equivalent court based IDVA has the capacity to support a maximum of 120 victims, so they also have to risk assess victims and prioritise those at the greatest risk.
- 6.6c.6 In summary, Sarah was not referred to a domestic abuse support organisation because there was a misunderstanding about who in Kent Police was going to do this. Had she been referred she would have been contacted, almost certainly within 48 hours.

7. Conclusions

- 7.1 Conclusion: - None of the organisations involved in this review had evidence or information that Sarah Taylor was a victim of domestic abuse prior to 7 September 2013.
- 7.2 Conclusion: - None of the organisations involved in this review had evidence or information that Sarah Taylor was a victim of physical violence prior to the incident that led to her death. Family and friends who have been spoken to as part of this review support this.
- 7.3 Conclusion The safeguarding, support and victim care that Kent Police provided to Sarah fell below the standard that its policies aspired to.
- 7.4 Conclusion Kent Police did not fully implement aspects of its Domestic Abuse Policy and Sarah did not receive the service she was entitled to.
- 7.5 Conclusion Kent Police did not keep Sarah updated with the work they were doing in response to her concerns and therefore failed to provide reassurance that action was being taken.
- 7.6 Conclusion Kent Police did not appreciate that the history of domestic abuse must inform risk classification and management.
- 7.7 Conclusion Kent Police dealt well with the aspect of victim safeguarding that comes from taking positive action against perpetrators.
- 7.8 Conclusion: - Kent Police and KSCS paid insufficient attention to the safeguarding of Emma Taylor.
- 7.9 Conclusion: - Kent Police and KSCS missed opportunities to gain information from Emma Taylor about the domestic abuse that she and her mother were subject to.

8. Lessons Learned

8.1 *The risk of domestic homicide may increase after the parties separate.*

- 8.1.1 It is not known whether Robert exercised control over Sarah while they lived together, i.e. whether she was a victim of domestic abuse. It may have been that separation triggered his coercive and controlling behaviour. He began to harass and stalk her and the fear that generated in her was the control he exercised.
- 8.1.2 Domestic abuse may be triggered or increase as a result of separation and this happened in Sarah's case. That it is more likely and predictable if there was domestic abuse in the relationship when the partners cohabited, but in the event that abuse begins after separation, it must not be assumed that it will simply stop or reduce as time passes.
- 8.1.3 When parties separate, particularly when that is instigated by the victim, the perpetrator can still exercise control but the separation may lead a change in the nature of, or an increase in the level of, domestic abuse.

8.2 *Domestic abuse is a pattern of behaviour, not a series of isolated incidents.*

- 8.2.1 Organisations that have experience in dealing with victims and/or perpetrators of domestic abuse know this. When the approach to incidents that are reported separately is not coordinated, the chance of identifying a victim at significant risk decreases.
- 8.2.2 When the victim is assessed as high risk, coordination is provided by the MARAC process. A multi-agency approach to protecting, safeguarding and supporting the victim is initiated and any further incidents are managed in line with a well-established process. The level of support given to high risk victims through this process is not and cannot be given to every domestic abuse victim, not only because there are insufficient resources available but also because it would be inappropriate.
- 8.2.3 Ideally, in all cases where more than one incident of domestic abuse is reported by a victim, their case would be allocated to one member of staff who would gain an in-depth understanding of the issues. However, this is not practical and organisations should seek to have systems in place that allow those responding to incidents to be provided with the previous history to enable them to provide the best support to the victim, and assess the incident in the light of a developing pattern of behaviour.

8.3 *Acts of physical violence are not always a precursor to a domestic homicide.*

8.3.1 Sarah's death confirms that physical violence is only one indicator of the risk that domestic abuse victims face. It is believed that she was not subjected to physical violence prior to the event leading to her death.

8.3.2 After their separation, Robert subjected Sarah to coercive and controlling behaviour. He constantly stalked and harassed her, which can be as abusive as physical violence because of the fear that creates in the victim's mind. It can also be harder to prove in court because there is no physical evidence.

8.3.3 It is therefore important that all indicators of potential serious harm are identified. In the relatively short period between Sarah first reporting domestic abuse and her death, it cannot be said conclusively that the level of stalking and harassment escalated but it was certainly persistent, including during the month long period when she did not report it.

8.4 *Policies, however well researched and thorough, only have value if they are applied consistently.*

8.4.1 Organisations must ensure that their staff understand the need to comply with domestic abuse policies and procedures on every occasion.

8.4.2 There must be no ambiguity about what staff are required to do. The language of strategy used by senior management is of little help to service deliverers who need to know exactly what it is they are to do, how, when and where.

8.5 *Policies must be reviewed regularly to ensure that the commitments made in them can still be delivered.*

8.5.1 The policies of organisations, particularly those in the public sector, are now accessible on the internet and through Freedom of Information Act requests. This means that it is easy for service users to see what level of service they are entitled to expect.

8.5.2 For the public sector organisations that dealt with Sarah, domestic abuse is one of many issues they have to deal with. They must decide where it ranks in their priorities and assign the level of resource that they believe matches that.

8.5.3 Policies are often written or revised when there is increased public interest in an issue or there has been a high profile failure by an

organisation. The writing or revision may be linked to a concurrent increase in resources in order to raise the standard of service they are providing in that area. When preparing policies in these circumstances, organisations must consider whether the commitments that are making are sustainable in the long term, in the knowledge that priorities can change.

8.5.4 In the past few years there has been increasing pressure for organisations to become more efficient: specifically 'to do more with less'. Pressure on budgets has increased this focus. This comes at a time of rising awareness about the risk to victims of domestic abuse and encouragement for them to report. In short, demand is increasing while resources are decreasing.

8.5.5 Policies that were written in the anticipation of a certain level of resource being sustainable are becoming more difficult to deliver. These policies must be reviewed if the difficult decision is taken to reduce the level of service provided. The policy must reflect the current level of service. Organisations will always be criticised if they promise more than they deliver: policies must not become aspirational.

8.6 Risk assessment must involve professional judgement; it is not all about numbers

8.6.1 Whilst an element of objectivity such as the DASH criteria that over 50% of questions answered 'yes' will ensure a 'High' risk classification, the judgement of professionals is an essential element in risk assessment.

9. Recommendations

9.1 The following recommendations arise from this DHR:

	Recommendation	Organisation
1.	Kent Police must examine its initial response to calls made by Sarah between 2 November and 7 November and amend policies and guidance in order to ensure that the lessons learned from this review are incorporated.	Kent Police
2.	Kent Police must ensure that importance of keeping domestic abuse victims informed of police action is seen as a priority.	Kent Police
3.	Kent Police must review its domestic abuse policy regularly to ensure that it describes the service that victims can expect. Having done so it must ensure that the policy and associated guidance are complied with.	Kent Police
4.	Kent Police must be open and transparent about the minimum level of service that domestic abuse victims will receive from each of the three DASH risk classifications.	Kent Police
5.	If a victim has previously received a 'High' or 'Medium' DASH risk classification, Kent Police must ensure there is additional scrutiny of any subsequent 'Standard' risk classification to ensure that the history of the abuse has been taken into account when making that classification.	Kent Police
6.	When training staff in how to deal with DANs, KSCS should clarify that being a first notification should not in itself be a reason for taking no further action.	KSCS
7.	When KSCS staff make contact with adults or children following a DAN, there should be a workable process that enables them to pass back to Kent Police any new information that they gather from the contact which may be relevant to the way Kent Police deal with future incidents involving that victim.	Kent Police KSCS
8.	When a decision about child safeguarding is taken, which appears to be contrary to policy and/or guidance, the rationale for the decision must be recorded.	KSCS

9.	When KSCS staff speak to a child's parent(s) about domestic abuse they should ask for consent to talk to the child, if the child is old enough to speak for themselves. Where a request is not made, the reason why should be recorded.	KSCS
10.	When KSCS staff speak to a child's parent(s) about domestic abuse and the parents have separated, they should query child access arrangements.	KSCS
11.	NHS England should consider whether there is a need to check the quality of records made by the GP visited by Sarah following her overdose.	NHS England
12.	Kent Police, in consultation with KSCS, should review the domestic abuse child referral matrix to ensure that there are no anomalies and that it provides the right criteria for safeguarding children who are living in households where domestic abuse is taking place.	Kent Police KSCS
13.	When training officers and staff in dealing with domestic abuse incidents, Kent Police should emphasise the importance of speaking to children who are old enough to speak for themselves.	Kent Police
14.	Kent Criminal Justice Board (KCJB) should consider whether there is any way in which the facilities available in an SDVC could be provided in cases where the defended appears having been remanded in custody.	KCJB
15.	The Department for Constitutional Affairs (DCA) should consider whether domestic abuse should be excluded from the general principle of cases being disposed of at first hearing following a guilty plea, when this means that offenders are less likely to appear before SDVCs.	DCA
16.	The training given to professionals who come into contact with domestic abuse victims must emphasise that control and behaviour (such as stalking and harassment) suffered by victims, other than through physical violence, must be carefully considered when assessing the risk to domestic abuse victims.	All Organisations

GLOSSARY

This glossary contains explanations of terms that are used in the main body of the Overview Report. The terms are listed in the order that they first appear in the report.

Force Control Room (FCR)

The FCR is a call centre where Kent Police receive emergency (999) and non-emergency telephone calls from the public and other organisations. It is also a dispatch centre from which police officers and staff are deployed, usually by radio, in response to those calls. All telephone calls made to or from the FCR, including those made on Kent Police's internal telephone system are recorded. Radio messages both to and from the FCR are also recorded.

The staff who receive telephone calls are referred to as call handlers. Those who deploy police officers and staff, and who otherwise manage the calls received, are referred to as dispatchers.

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

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model has been agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of pre-set questions will be asked of the victim, 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.

Central Referral Unit (CRU)

The CRU contains staff from Kent Police, Kent Social Services, Health and Education. Its main purpose is to manage safeguarding referrals, facilitate the sharing of information with partner agencies and to conduct initial strategy discussions relating to child and adult safeguarding.

Kent Police staff in the CRU examine crime reports and secondary incident reports relating to domestic abuse and assess the DASH risk classification to ensure that it is appropriate and that there is a protection plan in place.

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.

Domestic Abuse Notification (DAN)

A DAN is submitted by Kent Police to KSCS on each occasion that a child is present when police officers attend an incident of domestic abuse. In more serious cases where, for any reason, it is believed that the child is at risk as a result of domestic abuse, a referral under S.17 or S.47 of the Children's Act 1989 will be made instead of a DAN. The criteria for deciding whether a DAN or a referral is appropriate are set out in a matrix, a copy of which is at [Appendix C](#).

Crime Report

This is the report that must be completed when an officer attends an incident where there is evidence that a crime has been committed. It is recorded electronically on Genesis (see below) and contains details of the crime, including the victim(s) and suspect(s)/offender(s).

Independent Domestic Violence Advisor (IDVA)

IDVAs are professionally trained independent specialists who provide support to domestic abuse victims. They can advise victims on their safety and that of their children.

Neighbourhood Policing Officers (NPO)

NPOs work in teams that cover a defined geographical area. They deal with ongoing 'slow time' problems in that area, which can include domestic abuse. NPOs do not generally respond to emergency calls. The nature of their work means that they do not normally work 24/7.

(Kent Police) Enquiry Officer

A member of police staff who works at the enquiry desk in a police station dealing with issues raised by members of the public.

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 in the FCR, 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.

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. 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.

PAGES

This is the name given to the guidance for FCR staff that is stored on STORM. There are specific PAGES of guidance for domestic abuse and this includes the questions that call handlers should ask victims.

Combined Safeguarding Team (CST)

The CST are a team of Kent Police Officers who have received enhanced training in dealing with all aspects of safeguarding. This includes child, vulnerable adult and domestic abuse. Kent Police previously had separate teams dealing with each of those three disciplines. The specialists in those areas now deal with all three and there are no officers in Kent who specialise in, or deal only with, domestic abuse cases.

Common Assessment Framework (CAF)

A CAF is a detailed assessment, the aim of which is to help identify, at the earliest opportunity, a child or young person's additional needs which are not being met by the universal services and to provide timely and co-ordinated support to meet those needs.

Kent Criminal Justice Board (KCJB)

KCJB is a board made up of senior representatives of organisations that are involved in the criminal justice process. It is a forum that can, through discussion and agreement, make decisions affecting the way the criminal justice system in Kent delivers a service to victims and perpetrators.

MARAC Criteria

A domestic abuse victim will be referred to the Kent MARAC if any of the following criteria are met:

1. Professional Judgement: if a professional has serious concerns about a victim's situation, they should refer the case to the MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour' based violence. This judgment would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and 3 below. or,
2. Risk Indicator: as determined by DASH. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC threshold, or
3. Escalation: this criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at the MARAC.

MAPPA Categories

To be referred to MAPPA a person must be in one of the following three categories:

Category 1 – Registered sexual offender

Category 2 – Murderer or an offender who has been convicted of an offence under Schedule 15 of the Criminal Justice Act and:

- who has been sentenced to 12 months or more in custody; or
- who has been sentenced to 12 months or more in custody and is transferred to hospital under s.47/s.49 of the Mental Health Act 1983 ("MHA 1983"); or

Appendix A

- who is detained in hospital under s.37 of the MHA 1983 with or without a restriction order under s.41 of that Act.

Category 3 – Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for an offence under Schedule 15 of the CJA 2003.

Kent Police Incident Classification

Calls made to Kent Police are prioritised under the following categories:

Immediate

Calls are identified as 'Immediate' when an incident is taking place and life is in danger, or where violence is being used, or there is an imminent risk of its use. Such grading's will generally result in a 'blue light' response.

High

When:

- Those where the informant is vulnerable.
- Prompt attendance is required to identify or locate the offender.
- Attendance is required to reduce a current risk to a person or property and/or prevent a crime.

'High' is sub-divided into:–

- High Priority - when it is aimed to attend the call within 1 hour, and is used where risk or vulnerability is identified but the call is not classified as 'Immediate'.
- High - when it is aimed to attend the call within 4 hours e.g. traffic offences such as parking on a pavement or regular missing persons.

Appointment

'Appointment' grade incidents are those where attendance is required but do not fall within the 'Immediate' or 'High' criteria.

An FCR document entitled 'Managing Appointment and Local Calls' describes procedures to be adopted in relation to appointment calls. This document makes some reference to domestic abuse, which includes a requirement that at least a two hour slot be allocated to such calls. It also states that when the victim is unable to arrange an appointment within 72 hours, the FCR may book an appointment outside of this time period.

The 'early turn' Neighbourhood Policing Supervisor is responsible for checking the e-mails and managing the STORM incidents that have been given an appointment time outside of 72 hours. The early turn Neighbourhood Policing Supervisor is also responsible for checking the e-mails and managing the STORM incidents that have been given a 'Local' grading overnight.

Local

This is a STORM grading used internally to identify and segregate incidents that fall within the 'Appointment' criteria, but have not received that grading because the diary function has no appointment time slots available, or where the incident falls within the criteria for allocation to the Reactive Investigations Department.

Resulted Without Deployment (RWD)

Some calls can be dealt with by FCR staff talking to the caller over the telephone and can be resulted without despatching a patrol; these will be classified as 'Resulted Without Deployment' (RWD).

When more than one call is received about the same incident and the first call has been graded in one of the other four categories, subsequent calls will be classified as RWD and all details related to the incident will be recorded on the first STORM log.

Kent Police Domestic Abuse Matrix

Police Manage Information	Notification To KSCS (DAN)	Referral To KSCS (S.17/S.47)
<p>Where the adult victim of domestic abuse is Standard risk and there is a child living in the household.</p>	<p>Where information indicates that the case meets Standard or Medium risk, but the child is open to KSCS, e.g.</p> <ul style="list-style-type: none"> • Child in Need • Subject to Child Protection Plan • Child Looked After (including subject to proceedings) 	<p>Where the child is normally resident and the adult victim of domestic abuse is identified as High risk or child is assaulted or injured during the incident.</p>
<p>Where the risk is Standard but there are wider factors that impact on the risk to children then a referral to KSCS (S.17/S.47) should be made.</p>	<p>Where it is the first report of domestic abuse but the victim details historic abuse with children normally resident that indicates Medium level of risk.</p>	<p>Where the latest incident is Medium risk and there has been 3 or more previous incidents occurring within the last 12 month period.</p>
	<p>Where risk is deemed as Standard but a child is under 1 year or unborn regardless of whether present or not, even if a single incident.</p>	

	<p>Medium Risk - Where incident is assessed as Medium risk but wider factors surrounding the circumstances indicate increased risk for children e.g.</p> <ul style="list-style-type: none">• Significant drug/alcohol misuse, mental health• Serious threats against the victim or child.	
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