KENT & MEDWAY

MULTI-AGENCY REVIEW

Mary/2018

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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1. Introduction

1.1 This Multi-Agency Review (MAR) examines how agencies responded to and supported Mary Lucas (a white British woman in her 50s), who lived in Town A, Kent prior to her death in May 2018.

1.2 Mary was not the victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

> *Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*

1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, the Chair of the Kent Community Safety Partnership decided that this criterion for a Domestic Homicide Review (DHR) had been met and that a Multi-Agency Review (MAR) would be conducted using the DHR methodology set out in the statutory guidance. The review began on the 11th June 2018.

1.4 In May 2018, a police officer went to Mary's home, having been unable to contact her by telephone. There was no reply to the front door but when the officer called Mary's mobile phone, it could be heard ringing inside the house. Police officers entered the house and found Mary was deceased. The cause of her death was established as being due to *'fatal and toxic amitriptyline consumption with therapeutic range consumption of citalopram and morphine.'* There is no record that Mary had been prescribed amitriptyline during the review period, but her son was able to explain how she had legitimate access to it in her home.

1.5 The key reasons for conducting this Multi-Agency Review (MAR) are to:

1. establish what lessons are to be learned from the death about the way in which local professionals and organisations work individually and together to safeguard victims;
2. 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;
3. apply these lessons to service responses including changes to policies and procedures as appropriate; and
4. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multiagency approach to ensure that

domestic abuse is identified and responded to effectively at the earliest opportunity;

5. contribute to a better understanding of the nature of domestic violence and abuse; and
6. highlight good practice.

1.6 This report has been anonymised and the personal names used in it are pseudonyms, except for those of the MAR Panel members. The District of Kent where Mary lived is referred to as Area A.

2. Terms of Reference

2.1 The Review Panel met first on 24th July 2018 to consider the draft Terms of Reference, the scope of the MAR and those organisations that would be subject of the review. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of this report.

3. Methodology

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

3.2. Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the MAR Panel. None of the IMR authors or the senior managers had any involvement with Mary during the period covered by the review.

4. Involvement of Family Members and Friends

4.1 The Review Panel considered who should be consulted and involved in the MAR process. The following have been contacted:

Name	Relationship to Mary Lucas
Margaret Dean	**Mother**
Darren Lucas	**Son**
Susan Tate	**Sister**

4.2 In December 2018, the Independent Chairman wrote to each of Mary's family members, explaining that a MAR was being conducted. He offered to meet with them to discuss the review and to listen to their thoughts and views.

4.3 The Independent Chairman met with Darren Lucas in January 2019 and explained the purpose and methodology of the review. Darren was able to provide valuable insight into his mother's life, details of which have been included in this report. He acted as the conduit between the Independent Chairman and other members of the family, including his stepfather, Mary's first husband.

4.4 The Independent Chairman sent Darren a copy of the final draft of the Overview Report in mid-March 2019 and met him to discuss it in detail at the end of March. A copy of the Home Office DHR leaflet for family members was given to Darren and it was explained to him that it was originally written for family members of homicide victims. The availability of independent advocacy services was highlighted to him.

5. Contributing Organisations

5.1 Each of the following organisations submitted an IMR:

- Kent Police (including Area A Multi-Agency Risk Assessment Conference)
- Centra (Domestic Abuse Service)
- GP Practice A (Mary's GP) *
- Kent Community Healthcare Foundation Trust
- Area A Council
- Kent County Council Adult Social Care and Health

* To protect the anonymity of Mary, her GP practice is not named.

5.2 In addition to the IMRs, a report was requested and received from the National Probation Service and the Independent Chairman had a discussion with the Kent County Council Superintendent Registrar.

6. Review Panel Members

6.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with Mary. It included a senior member of the Kent County Council (KCC) Community Safety Team and an independent advisor from a Kent-based domestic abuse service.

6.2 The members of the panel were:

• Kate Bushell	North Kent CCG
• Deborah Cartwright	Oasis Domestic Abuse Service
• Catherine Collins	KCC Adult Social Care and Health
• Susie Harper	Kent Police
• Lee Whitehead	Kent Police
• Kay Maynard	Kent Police
• Tina Hughes	National Probation Service
• Leigh Joyce	Centra
• Paul Pearce	Independent Chairman
• Shafick Peerbux	KCC Community Safety
• Roxanne Sheppard	Area A Borough Council
• Tim Woodhouse	KCC Public Health

6.3 Panel members had not had any contact or involvement with Mary. The panel met on three occasions during the MAR.

7. Independent Chairman/Author

7.1 The Independent Chairman and author of this overview report is a retired senior police officer who has no association with any of the organisations represented on the panel. He has never worked in Kent. He has enhanced knowledge of domestic abuse issues and legislation, and an understanding of the roles and responsibilities of those involved in the multi-organisation approach to dealing with domestic abuse.

7.2 The Independent Chairman has a background in conducting reviews (including Serious Case and Safeguarding Adults Reviews), investigations, inquiries and inspections. He has carried out senior level disciplinary investigations, presenting at and chairing discipline tribunals. He has completed the Home Office online training on conducting DHRs, including the additional modules on chairing reviews and producing overview reports.

8. Other Reviews/Investigations

8.1 Kent Police voluntarily referred Mary's death to the Independent Office of Police Conduct (IOPC). The IOPC conducted an independent investigation, which found that there were no grounds for disciplinary proceedings against any Kent Police officers or staff.

9. Publication

9.1 This overview report will be published on the websites of Kent and Medway Community Safety Partnerships.

10. Background Information

10.1 The story of Mary's life was told by her son Darren. The Review Panel is grateful to him for sharing his memories of her; he set Mary's life in a wider context of her involvement with organisations during the review period. The panel extends sincere condolences to all members of Mary's family and friends.

10.2 Mary was married to her first husband, Darren's stepfather, for nearly 30 years until they separated in early 2017. Mary had been a prison officer for about five years when, some 20 years before her death, she was taken hostage within the prison in which she was working. During what must have been an extremely frightening and traumatic event, she suffered physical injuries. As a result of her injuries, she was in pain for the rest of her life, taking medication, including morphine, as an analgesic. Her physical disabilities increased her vulnerability.

10.3 Having left the prison service, Mary worked for several years in a centre for disadvantaged young people run by a national charity. She also attended courses and qualified as a hypnotherapist and a reiki master. She described herself as a complementary therapist.

10.4 Mary's life during the review period was described by her family and set out in the records of organisations she was involved with during that time. The level and detail of personal information requested by professionals varied.

10.5 At the time of her death, Mary had been married to William Davis since early January 2018. They had previously known each other when they were at school together, aged 15-16 years. There was no contact between them for over 30 years until William contacted her via Facebook following his release from prison in November 2016. He told her of his recent release but did not disclose his full criminal past.

10.6 Shortly after Christmas 2016, Mary and her husband separated. She continued to live in the marital home and a few months later they divorced.

10.7 The first record that an organisation had of Mary and William knowing each other was when his Devon-based Probation Officer was conducting the process to establish a suitable address at which William would be directed to reside while on licence. The Probation Officer met Mary in March 2017, having previously spoken to her by telephone.

10.8 William had moved into Mary's home by the beginning of June 2017. Darren and his step-father had researched William's criminal past, details of which are available from media sources. After William moved into Mary's home, Darren visited her and told her what they had found out. Mary subsequently confronted William, who admitted his previous convictions. He said that he had not initially told her everything because he feared she might reject him.

10.9 Although Mary told William's Devon based Probation Officer that she wanted to help William and they might have a future together, she told other professionals subsequently that he had moved into her home against her wishes.

10.10 Mary and William were married in January 2018; months later she told professionals that the marriage took place against her will. Given the seriousness of the abuse she described subsequently and the length of time it had been taking place, this is not surprising. It was also indicative of the level of coercion and control she was subject to and the fear she was feeling.

10.11 The first time Mary alleged domestic abuse against William was in February 2018, when she reported it to Kent Police. She described physical, psychological and emotional abuse, which had been going on for some time. She did not disclose abuse in every subsequent contact with organisations; on one occasion she gave the cause of an injury resulting from an assault as accidental. This was almost certainly because she was the subject of coercion and control, and feared the consequences of disclosure.

10.12 Mary died during the first weekend of May 2018. She had been told in error on the Friday before, that William, who was charged with causing her grievous bodily harm with intent, had been released on bail and she was in fear for her life.

11. The Facts and Analysis of Organisations' Involvement

11.1 Introduction

11.1.1 This section sets out facts and analysis of the involvement that Mary had with organisations between 1st January 2016 and her death. The facts are based on IMRs and reports submitted by those organisations. The analysis is based on the facts, and from it come conclusions, recommendations and lessons identified.

11.1.2 Abbreviations, acronyms and references to terms familiar to professionals working in relevant organisations are included: these may need further explanation for other readers. In such cases, the reader should refer to the glossary in Appendix B, where abbreviations and acronyms are expanded,

and more detail of some terms is provided. Job titles within organisations are capitalised.

11.2 Equality and Diversity

11.2.1 Mary's disability increased her vulnerability by making her less mobile. She had received carer support from Social Services until April 2016. This stopped, not because she no longer needed it, but because she could not afford the financial contribution she was making. She said that relatives would provide the assistance she needed, but after she and her husband separated, she was alone. It may have been that she saw William moving into her home as a way of getting some support back.

11.2.2 The review considers whether those agencies that knew of her disability, understood how it increased her vulnerability and made her more exposed to coercion and control.

11.3 Kent Police

11.3.1 Kent Police has records of involvement with Mary on four occasions before the review period, none of which relate to domestic abuse or include circumstances relevant to the review.

11.3.2 The first involvement Kent Police had with Mary during the review period was on 30th January 2018. She activated her Lifeline personal safety alarm and Lifeline called Kent Police on her behalf. Mary was registered as disabled resulting from the injury sustained when she was a prison officer; she had the alarm because of her disability, not because she was a victim of domestic abuse. The police response was rapid; officers arrived 15 minutes after the call was received from Lifeline.

11.3.3 Mary activated her alarm after William punched her in the face. When police arrived, she also made allegations of historical assault against him. She said he moved into her home in June 2017 having invited himself to live there. He told her about his criminal past, involving violence, which put her in fear of not letting him stay. She also stated she had been forced to marry him against her wishes.

11.3.4 She further alleged that William had stolen cash from her handbag and money from her bank account while living in her home. She added that he would spend the money on drugs for himself. During this first report she described physical, psychological and financial abuse.

11.3.5 Mary told the police officers that during the previous day, William had been to town to collect his methadone prescription. When he returned, they had an altercation, during which he punched her in the face. She suffered no visible injuries, but the punch had caused her pain. William was not present while police were at her home.

11.3.6 An officer who attended completed a DASH risk assessment and graded the risk to Mary as High. The DASH was sent to the Kent Police Vulnerability Investigation Team (VIT), which manages all domestic abuse cases, as well as cases involving vulnerable adults and children.

11.3.7 The VIT officer who picked up the DASH risk assessment submitted a Multi-Agency Risk Assessment Conference (MARAC) referral. The referral should have been sent to the Area A MARAC Administrator (see Section 12 below) and Centra, the domestic abuse support organisation that provided the Independent Domestic Violence Advisor (IDVA) service in Area A (see Section 11.4 below). The officer did not send the referral to the MARAC Administrator and sent it to the wrong domestic abuse support organisation. That organisation forwarded it to Centra without delay.

11.3.8 Not sending the referral to the MARAC administrator caused significant delay in Mary's case being considered by the MARAC. The VIT is a team that deals regularly with high risk domestic abuse victims and within it there is experience of submitting MARAC referrals. Kent Police must ensure that all VIT officers and staff know where MARAC referrals must be sent. **(Recommendation 1)**

11.3.9 Kent Police arranged for a panic alarm to be installed at Mary's house, which would send an alert to the police when activated. This was good practice.

11.3.10 The following day, 31st January 2018, there was a conversation between Kent Police and a Probation Officer, who knew about the abuse Mary had been suffering. The Probation Officer was considering whether to revoke William's licence and recall him to prison.

11.3.11 On 8th February 2018, William was arrested for the allegations made by Mary on 30th January 2018. He denied the allegations and on 9th February 2018 he was bailed to return to the police station on 3rd March 2018. Conditions were attached to his bail, prohibiting him approaching Mary or entering the street where she lived.

11.3.12 On 13th February 2018, Mary activated her police provided panic alarm. An officer responded, and Mary stated that William had been living at the home of one of her neighbours since being bailed, in breach of his conditions. A statement was taken from her and the case was referred to the officer who had attended the original call, who was also dealing with William. A vulnerable adult referral was made to Social Services, which was good practice.

11.3.13 There is no record that the possible breach of bail conditions was pursued at the time; given that officers took the statement at her home, this could have been done. However, breaching police bail conditions is not a criminal offence. The police have power of arrest but the options once an arrest is made are either to charge the person with the offence for which they are on bail, or to release them on bail with the same conditions (the law does not allow the police to vary the conditions). In practice the police rarely arrest for breach of these conditions unless they know they are able to charge the original offence.

11.3.14 On 3rd March 2018, William failed to answer bail. The officer in the case contacted his Devon-based Probation Officer, who told William to go to a police station and give himself up. There is no record that Kent Police knew this until William called them on 7th March 2018 from the telephone outside a closed police station. At that time no officer was available to arrest him. This fact was recorded, and the information passed to the officer in the case.

11.3.15 Kent Police state they were unable to deploy an officer to arrest William due to the high number of calls they were receiving at the time. They had not been told that he was intending to give himself up. William was showing a degree of cooperation; he may have responded positively to a request to go to a police station that was open or surrender at a future specified time. There is no record that he was asked to do either. Kent Police say they do not negotiate bail surrender with suspects, but the potential significance of not exploiting opportunities to arrest William at the earliest opportunity become clear with the next development.

11.3.16 On 12th March 2018, William's Devon-based Probation Officer contacted the investigating police officer to say that Mary and William were cohabiting again. The police officer contacted Mary straightaway, who said she was on the way to the police station to retract her allegations. The officer was concerned that she had been coerced into doing this. He spoke to the female friend who accompanied Mary to the police station

and asked her if Mary wanted to freely retract her statement. The friend confirmed she believed Mary did.

11.3.17 Notwithstanding Mary's retraction, the officer went to her home and arrested William, which was good practice. In contrast to previous missed chances to try to arrest him, it indicated a positive approach to dealing with domestic abuse perpetrators. William was re-interviewed about evidence that had been gathered since his first arrest, but he declined to account for this. Mary said in her retraction statement that she felt William had changed, she had missed him and wanted to continue their relationship. She added that she had exaggerated her original allegations because she had been smoking cannabis.

11.3.18 The case was reviewed by a Crown Prosecution Service (CPS) lawyer, who advised there was no realistic chance of a conviction in the light of Mary's retraction. William was released without charge. Mary was updated and advised about her personal safety. The investigating officer also contacted the KCC Area A Safeguarding Adults Coordinator to tell her about the situation. This information sharing was good practice and showed an understanding of the importance of keeping other relevant organisations updated.

11.3.19 On the same day, the officer in the case forwarded the referral he had previously submitted to the IDVA service, to the MARAC Central Coordinator. This resulted in Mary's case being considered by the MARAC on 17th April 2018. Had the referral been submitted to the MARAC Central Coordinator on 5th February 2018, when it was sent to the IDVA service, Mary's case would have been heard at the February meeting. The only action allocated to Kent Police at the MARAC meeting was to update its operational information.

11.3.20 On 2nd May, Mary again activated her Lifeline alarm and police were called. There was no one at her home, but a police officer traced her via her mobile phone. She reported that William had assaulted her the previous week resulting in her attending hospital with broken ribs. She detailed other incidents where he had beaten her and held his hands to her throat. She also stated he had withdrawn money from her bank account to buy drugs and used her car without permission.

11.3.21 Later the same day, William was arrested at Mary's home. He was charged with causing her grievous bodily harm with intent. Bail was refused, and he was remanded to appear before magistrates on 4th May. The magistrates granted him conditional bail, but the CPS appealed this decision and William was remanded into police custody pending the

appeal being heard. Appealing a bail decision made by magistrates is rare and was an example of good practice by the CPS prosecutor.

11.3.22 Kent Police policy was that due to Mary being a domestic abuse victim, a Witness Care Officer (WCO) would contact her and advise her of the court outcome before the end of the working day.

11.3.23 At the conclusion of the hearing on Friday 4th May, a Hearing Record Sheet (HRS), completed by a CPS lawyer, was submitted to the Witness Care generic email account. The allocated WCO read the form but was unclear of the outcome of the case. She believed William had been released on bail by the Magistrates, albeit this was being appealed.

11.3.24 The WCO consulted her supervisor who agreed the outcome was that William had been released on bail. The WCO called Mary about 3.15pm that afternoon and told her William had been released; she recalled Mary was distressed by this news. When Mary spoke to the Centra IDVA later that day, she said she had told the WCO that *'…it was as though the magistrates had signed her death warrant'*.

11.3.25 The CPS's decision to appeal to the Crown Court reflected the seriousness of the charge and the strength of evidence. The detailed procedure that must be followed when such an appeal is made is set out in Part 14.9 of the Criminal Procedure Rules. Sub-Section 3 was key in this case and states:

> *The court which has granted bail must exercise its power to remand the defendant in custody pending determination of the appeal.*

11.3.26 This means that when the CPS appeal a magistrates' decision to grant bail, the magistrates must remand the defendant in custody pending the appeal (which the Crown Court must hear as soon as practicable and, in any event, no later than the second business day after the appeal notice was served). The HRS stated clearly that William had been released on conditional bail, but this decision was being appealed. Cases of appeals against bail are rare. The WCO and her supervisor did not know that an appeal negated the bail decision and that William must have been remanded in custody.

11.3.27 Kent Police must ensure that its Witness Care staff know that when the Crown Prosecution Service appeal a decision made by magistrates to grant bail, the defendant will be remanded in custody pending the outcome of the appeal. **(Recommendation 2)**

11.3.28 Kent Police's witness care policy and procedures must state clearly that if Witness Care staff have any doubt about the outcome of a court case, they must contact the court for clarification at the earliest opportunity and advise victims and/or witnesses of the uncertainty until it is resolved. **(Recommendation 3)**

11.3.29 Late in the evening of 4th May, the National Offender Management Service contacted Kent Police to arrange William's recall to prison. Because of his remand in custody that afternoon, he was already in prison, having been taken there from court.

11.3.30 The investigating police officer went off duty for the bank holiday weekend after William was charged, so was not at work when he appeared before magistrates on 4th May. When she returned, she received the incorrect information that William had been released on bail, but she established eventually that this was not the case. During the afternoon of 8th May, the officer went to Mary's home to discuss the case with her. She got no answer but when she called Mary's mobile phone, she could hear it ringing inside. Police officers gained entry and found Mary deceased.

11.4 Centra

11.4.1 Centra are the supported housing department of Clarion Housing Group, a regulated housing association and registered social landlord. From April 2017, Centra has held the Kent County Council (KCC) contract to provide domestic abuse support services in the part of Kent that includes Area A. Centra provides refuge and outreach services, as well as the Independent Domestic Violence Advisor (IDVA) service.

11.4.2 When Mary was referred to Centra, and throughout its involvement with her, management of IDVA cases in Area A was sub-contracted by Centra to SATEDA. SATEDA are a specialist domestic abuse service working in that area; its title is an acronym for Support & Action To End Domestic Abuse. IDVAs employed by Centra had their caseloads managed by a qualified IDVA case manager working for SATEDA.

11.4.3 The IDVA assigned to Mary transferred to Centra when it was awarded the contract; she had over five years' experience in the role. She was supported by a Centra Project Manager, who was also a qualified IDVA. The IDVA had fortnightly case management sessions with the SATEDA Case Manager; at those meetings each case the IDVA was involved in was discussed. Risk assessments and risk management plans agreed with clients were reviewed by the Case Manager. If needed, actions to

further reduce risk would be discussed and agreed. Decisions to close cases were also made at case management meetings; the SATEDA Case Manager would make the final decision to do this.

11.4.4 Centra's involvement with Mary began on 5th February 2018, when the IDVA received a MARAC referral submitted by a Kent Police officer. It followed an incident of domestic abuse at Mary's home the previous day. This section considers the actions taken by Centra on receipt of the MARAC referral relating to Mary; the referral process in general is considered in sections 11.3 and 12.

11.4.5 The IDVA contacted Mary by telephone on 7th February and completed a DASH risk assessment with her. This resulted in a score of 14 based on Mary's replies to the questions. This DASH score made her a High-risk domestic abuse victim, as it had when conducted by the police officer who made the MARAC referral.

11.4.6 The DASH risk assessment is a pivotal part of ensuring that a domestic abuse victim receives the appropriate level of support. The DASH grade is based on a combination of answers given to a set of questions, and the judgement of the professional completing it. 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 if, based on professional judgement, the person completing it believes the victim is at that level of risk.

11.4.7 All 27 DASH questions are closed, although there is an additional *'Is there anything else you would like to add to this?'* question. Within the yes/no questions, there are two categories. First, questions of fact which, following the first occasion the victim answers 'Yes', should in subsequent assessments always be answered 'Yes'. An example is *'Has [Name] ever threatened to kill you or someone else and you believed them?'* Other questions are based on the victim's feelings at the time of completion and can elicit a different answer each time they are asked, depending on changing circumstances. For example, *'Are you very frightened?'*

11.4.8 If a victim answers a question of fact 'No', having previously answered it 'Yes', this would be significant because on the subsequent occasion when they answered 'No', they may have done so because they feel under duress to give that response. This may have been relevant in Mary's case, as this section will highlight.

11.4.9 DASH grades that change, with risk going either up or down, may reflect changes in circumstances or the way the victim feels. However,

professionals completing the DASH must be aware that although a reduced score may indicate decreased risk, the true risk might be increasing.

11.4.10 Some DASH questions include a section for the victim to provide additional detail and others expect the professional to add information. Although the answers to individual questions are important, it is the risk grade (High-Medium-Standard) that influences most the subsequent course of action. It is 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.

11.4.11 The DASH risk assessment is an important element in deciding the initial level of safeguarding that a domestic abuse victim receives, and the professional curiosity and judgement of the person completing it is important. The ability to make sound judgements can be based on numerous factors as diverse as the professional's understanding of the DASH process to the victim's perception of the threat they face. In every case, assessing the risk correctly is only part of safeguarding domestic abuse victims; of itself it delivers nothing. It is how the identified risk is managed that helps to safeguard the victim.

11.4.12 During the conversation when the DASH was completed, Mary told the IDVA about the assaults William had subjected her to and confirmed that she wished to support police action. The IDVA completed a safety plan with her. There is no record that the IDVA contacted Kent Police to discuss what action was being taken.

11.4.13 The following day, 8th February 2018, the IDVA called Mary again. She had been to her GP, who had prescribed her medication for anxiety. She added that she thought William was hiding in a neighbour's property. Safety planning was reviewed with Mary, and she was advised to download the Hollieguard mobile telephone app, which sends a person's locations and audio/video from their device to their nominated contact.

11.4.14 At the time of this telephone conversation with Mary, the IDVA was working in a multi-agency Community Safety Unit (CSU). Following the call, the IDVA heard police officers talking about William. She told them that she had spoken to Mary, who said that William was breaching his bail conditions. The officers confirmed it was planned to arrest William at an Area A Council office, where he was due to attend a housing appointment that afternoon. In addition to Centra, The CSU was staffed by Kent Police, Area A Anti-Social Behaviour Team, a local Housing Association

and SATEDA. This is a good example of multi-agency working at practitioner level.

11.4.15 The next day, 9th February, the IDVA again called Mary and following her agreement, made a referral to the Freedom Programme. This is an intensive course that examines the role played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors.

11.4.16 The IDVA next called Mary on 12th February. Mary described feeling upset because William had been arrested and released on bail. He had a bail condition not to enter the street where she lived, but she believed he was staying with a neighbour. She gave the IDVA the number of the neighbour's house. There is no record that the IDVA notified the police or that she asked Mary if she would agree to this information being shared. This should have been done and was a missed opportunity.

11.4.17 On 20th February, the IDVA received the case list for the February meeting of the Area A MARAC. Mary's case was not on it, but the IDVA did not contact the MARAC administrator to query this. Centra point out that Kent Police sometimes withdraw cases from the MARAC because a referral does not meet the threshold. For this reason, a previously referred case not appearing on the list would not in itself raise concerns. However, there is no record that the IDVA contacted police to establish whether and why Mary's case had been withdrawn.

11.4.18 Between the 12th and 28th of February the IDVA did not contact Mary. There is no record that the IDVA sought or received updates from any other organisation during that period and no evidence that the risk to Mary was reducing. The IDVA should have been in frequent and regular contact with Mary. Centra accept this was a failing.

11.4.19 On 28th February, the IDVA completed another DASH risk assessment with Mary during a telephone conversation. The score had reduced from 14 to 8 in three weeks. On this basis, the risk grade was Medium. At a case management meeting between the IDVA and her SATEDA supervisor that day, the supervisor decided that Mary's case should be closed to the IDVA service. Her case would be referred to SATEDA for outreach support. There was no case management note of the rationale for the decision.

11.4.20 Centra has reviewed the DASH risk assessment carried out on 28th February and accepts it did not reflect the risk Mary was facing, which was still High. The reduction in the score was significant in a short period (3 weeks); there was no record of any events or developments that would

have resulted in this reduction, or that professional judgement was applied. The possibility that Mary was subject to coercion and control that may have influenced her answers should have been explored, both with her and other agencies. There is no record that this was done. This demonstrated a lack of professional curiosity. The risk assessment influenced the decision to close her case, which with hindsight was wrong.

11.4.21 Centra should consider adopting the Kent Police policy that results in a domestic abuse victim who has been assessed at being at High risk, remaining High risk for at least 12 months, regardless of whether one or more subsequent risk assessments results in a lower grade. **(Recommendation 4)**

11.4.22 Centra's records show that between the 2nd and 15th March, SATEDA attempted to contact Mary four times without success and then closed her case. Centra state that the volume of cases that SATEDA were dealing with meant it was impractical for them to notify Centra of closures. It was therefore unaware that SATEDA had closed Mary's case. SATEDA are no longer sub-contracted to Centra. In order to monitor performance of its current sub-contractor more rigorously, Centra have introduced a process of random audits of closed cases.

11.4.23 On 9th April 2018, the IDVA received the Area A MARAC case list for the April meeting. It showed Mary's case for the referral that had been made by Kent Police to the IDVA on 5th February.

11.4.24 The IDVA attended the MARAC meeting on 17th April. There is no record that the she attempted to contact Mary or any other agency to get an update prior to the meeting. Arising from the MARAC meeting, it was agreed that the KCC ASCH Safeguarding Adults Coordinator (SAC) and the IDVA would have a joint meeting with Mary.

11.4.25 This meeting, organised by the SAC, was held on 3rd May at Mary's GP surgery. The IDVA attended and recorded that Mary made disclosures about forced isolation, physical abuse, threats to kill her and harm others. The IDVA carried out another DASH risk assessment, the score for which was 19, the highest of the four that had been conducted. The DASH risk assessment has a question relating to suicidal thoughts; on this occasion, in answer to the question, Mary said she felt anxious and depressed but did not say she felt suicidal. The IDVA made another MARAC referral because of the DASH result. Kent Police were aware of this because an officer was party to the meeting by telephone.

11.4.26 The meeting demonstrated that Mary was willing and able to meet professionals face to face. When her case was open to Centra, the IDVA did not attempt to arrange a meeting with her. The professional judgement applied to risk and vulnerability will be better informed by a face to face meeting. Apart from the potential evidence of physical injury, in Mary's case, the extent of her disability would have been clear, and her body language may have given away the fear she was experiencing.

11.4.27 Centra state that the caseload that IDVAs have is such that it is not possible to meet every client. In addition, in some cases it may not be appropriate because it could increase risk. IDVAs should record their rationale when deciding whether to meet victims, and this should form part of the case discussions with their manager. If a victim is suffering from a disability that increases their vulnerability, this should be a factor in the rationale.

11.4.28 Centra must instruct their IDVAs to record the rationale for their decision whether to meet a victim face to face. **(Recommendation 5)**

11.4.32 On Friday 4th May 2018, the IDVA received an email from the SAC explaining that William was in custody and appearing before magistrates that day via video link. The SAC also set out the actions she had taken to attempt to safeguard Mary if William was released on bail. The IDVA carried out another DASH risk assessment, which was graded High.

11.4.33 Mary told the IDVA she did not know whether she would be told if William had been released on bail. The IDVA advised her to ring 101 (the police non-emergency number) and ask to speak to the relevant custody suite for the outcome.

11.4.34 The IDVA advised a high risk, vulnerable victim, who the previous day had described to her a catalogue of serious abuse, to make their own enquiries about whether their abuser has been remanded in custody or released on bail. This is something the IDVA should have done for Mary, not least because in her professional capacity, she would be more likely to have been given the information.

11.4.35 The same day, the IDVA completed a MARAC referral due to the result of the DASH risk assessment she had completed with Mary the day before.

11.4.36 About 6pm on Friday 4th May, Mary telephoned the IDVA, who had remained at work, although her shift should have finished at 3.30pm. She said she had been told by a Witness Care Officer that William had been released on bail. The IDVA recorded that Mary was very upset and

distressed, noting that she said the magistrates had signed her death warrant. Mary said she had spoken to William's Probation Officer, who told her he was *'…submitting papers to have William recalled on licence.'*

11.4.37 The IDVA then discussed with Mary how she could stay safe over the weekend. Mary said she had talked to her mother and had been back in contact with a friend, so she had places to go if she did not want to be alone. The IDVA encouraged her to use her alarm if William came to her home and to have an escape route planned. The IDVA arranged to call Mary on Tuesday 8th May 2018, after the bank holiday weekend.

11.4.38 On Tuesday 8th May, the IDVA attempted to contact Mary four times between 11am and 3.20pm without success. She then spoke to a police officer who had also been trying to make contact. The police officer told the IDVA that William was on remand in a prison. The IDVA updated the SAC about this by email.

11.4.39 On 9th May, the IDVA received an email from Kent Police telling her that Mary had died during the weekend. She emailed the MARAC Coordinator to tell her to withdraw the referral relating to Mary from the case list, a purely administrative action.

11.4.40 Centra have agreed that the way they dealt with Mary raises concerns. There was lack of proactive work to gather information from her or share information with other organisations. There was a two-week period when there was no contact with Mary. When contact was made, it was on the day that the IDVA would have needed to provide current information to her supervisor in a case management meeting. There was no rationale recorded for closing Mary's case. If there was any professional curiosity or concern about the reduction in the DASH 'score' on 28th February, it was not recorded. Despite her distress, Mary was advised to make her own enquiries about whether William had been released from custody.

11.4.41 Kent County Council must, as part of the performance monitoring of its contract with Centra, consider how the concerns identified in this report are being addressed by Centra to ensure that the service provided to high risk victims of domestic abuse is improved. **(Recommendation 6)**

11.5 GP Practice A

11.5.1 GP Practice A (GPP A) is in Town B, about three miles from Mary's home. She was registered there throughout the review period. During that time, she had consultations with three GPs, but all those relevant to the review were with the same one.

11.5.2 Prior to November 2016, when William contacted Mary via Facebook following his release from prison, none of the entries in her GP notes relate to domestic abuse. She suffered from fibromyalgia, which caused her chronic pain, for which she was prescribed analgesic medication, including morphine. She also suffered from non-epileptic stress seizures, which may be associated with fibromyalgia.

11.5.3 On 4th December 2017, Mary had a face to face consultation with the GP, during which she told him she was getting married soon. The notes made of this consultation were brief and somewhat unclear, *stating 'Lower mood – anxious and paranoid about everything. Accusing partner of things knows not true – that he's against her – going to "rip me off" – previous abusive marriage. Socially withdrawn.'* The GP concluded *'Likely stress related as getting married with lots of previous abuse [in a former relationship].'* The GP was aware of issues in a previous relationship.

11.5.4 The GP listed the treatment options as *'Brief CBT, counselling and regular promethazine.'* The notes are not clear as to whether he offered to facilitate the first two options, but he prescribed promethazine. This drug may be prescribed for numerous ailments, and as a sedative or sleep aid.

11.5.5 The GP asked Mary about the issues she was having with her current partner, but she declined to expand on this. It is reasonable to assume she was referring to William, because he was living with her at the time and she married him less than a month later.

11.5.6 The next consultation Mary had with the GP was on 7th February 2018. Again, the notes made by the GP were brief, stating *'Abuse from partner, police, victim support and SATEDA involved but acute distress'.* Mary and William were married by this time, but it is not clear whether she told the GP this because the notes refer to her *'partner'*.

11.5.7 The GP asked Mary about the nature of the abuse, but she again declined to expand on this, saying that she was no longer in contact with her partner (William had left her home three days earlier after she reported abuse by him to the police). For this reason, and because other organisations were already involved, the GP did not consider it necessary to share the information. Confirming with Mary that she was being supported by other organisations was good practice, but the value of further information sharing about domestic abuse should always be considered. Medical confidentiality is a factor, but the patient can be asked for consent to discuss their case with other organisations.

11.5.8 On 3rd March, Mary saw her GP again. He asked about her domestic situation and she told him that issues involving the police had been dealt with. Her notes state *'…other family relationship stress – but settling practically and coping better with stress improving.'* She added that promethazine was helping to reduce her stress and a friend was also helping her. The GP carried out a medication review for the analgesia that had been prescribed historically. This was the last occasion that Mary visited the GP.

11.5.9 On 19th April, the GP was contacted by the KCC Safeguarding Adults Coordinator (SAC), who explained that she wanted to organise a meeting with Mary on 3rd May, using GPP A as a venue. She asked the GP if he could contact Mary to try to facilitate this.

11.5.10 The record of this conversation in Mary's GP notes states *'[The SAC wants] to check re; weight loss (Not mentioned as a concern by patient)'* These notes do not record what the GP's view of Mary's weight loss was but the SAC recorded that *'[The GP] had no real concerns about her weight loss and stated that she had been a large lady and losing weight was in fact advantageous and unlikely to be linked to health condition.'* If this was an accurate reflection of the GP's response, it does not show an appreciation that the weight loss could have been linked to domestic abuse, something the GP was aware of.

11.5.11 On 26th April, the GP contacted Mary by telephone, after ensuring she was alone and that it was safe for her to speak. This was good practice and showed an understanding of the risks of unguarded interactions with domestic abuse victims. He told her about the proposed meeting, which she agreed to attend. This was the last time Mary spoke to the GP.

11.5.12 Later the same day, the GP spoke to the SAC and confirmed that Mary would attend the meeting. The GP explained that he was unavailable to attend. He added that Mary had recently attended the local Minor Injuries Unit with a suspected rib fracture, which she claimed had been due to a fall following a seizure. The GP was not convinced by this version of events because the type of seizure Mary has suffered historically, would not cause loss of consciousness or a falls risk. This was significant because at the meeting on 3rd May, when asked again about it, Mary disclosed that the injury had been caused by William punching her.

11.5.13 The GP's opinion may have prompted a question to Mary about the injury at the meeting, which shows the value of information sharing. It also demonstrated that the GP had considered Mary's injury in the context of

her medical history and concluded that her explanation was unlikely. This was good practice.

11.5.14 GPP A subsequently received from Kent Police, an authorisation signed by Mary, allowing the disclosure of any medical records relating to the incident where she suffered a suspected broken rib.

11.6 Kent Community Healthcare NHS Foundation Trust

11.6.1 Kent Community Health NHS Foundation Trust (KCHFT) provides a wide range of NHS care for people in the community. Services are delivered in a range of settings including: people's own homes, nursing homes, health clinics, community hospitals, minor injury units and mobile units.

11.6.2 KCHFT provides its services across Kent as well as parts of East Sussex and London. It employs more than 5,000 staff, including doctors, community nurses, physiotherapists, dieticians and many other healthcare professionals. KCHFT became a foundation trust on 1st March 2015.

11.6.3 Prior to William contacting her in late 2016, Mary had several interactions with KCHFT during the review period. In July 2016, it was recorded that she presented at her local Minor Injuries Unit (MIU) with her then husband following a fall. In August that year, she attended a follow-up appointment at the MIU, when it was recorded that she used a wheelchair rather than walking long distances, due to her back problems.

11.6.4 Mary attended the Muscular Skeletal Physiotherapy Service (MSK) in September 2016, when it was recorded that she was registered disabled and suffered from Post Traumatic Stress Disorder as a result of being taken hostage when she worked as a prison officer. It was also noted that she said she was a complementary therapist. At a subsequent appointment at the MSK during the same month, it was recorded that her father had recently died.

11.6.5 In September 2017, after William had moved into her home, Mary went to the MIU, following what she described as a slip in her bathroom the previous evening, which had resulted in a twisted ankle. There were no concerns about the way she presented, and it was not recorded if anyone attended with her.

11.6.6 On 20th April 2018, about two weeks before she died, Mary attended the MIU with a man described as her partner. His name was not recorded, but it is now known it was William. She had an injury to the left side of her chest, which she said happened following a stress seizure. She walked

into the MIU unaided and there was no bruising or swelling visible. The diagnosis was of a possible fractured rib. Mary was advised to take pain killers and gentle exercise. She was given advice relevant to aiding recovery from chest injuries.

11.6.7 The nurse who saw Mary said there were no concerns about her presentation or the dynamics of the relationship with her partner. There was no investigation of the cause of the stress resulting in the seizure or how often she suffered such seizures. This would have been good practice.

11.6.8 Mary attended the MIU twice in seven months. The injuries were different, as were the causes she gave for them. She suffered back problems and had a history of seizures, so her explanations on both occasions appeared consistent with her description of previously diagnosed conditions.

11.6.9 At a multi-agency meeting on 3rd May 2018, Mary disclosed that the chest injury she had attended the MIU with two weeks previously had not been the result of a stress seizure. She said it happened when William punched her in the chest, so hard she was almost unable to breathe. He had gone to the MIU with her to ensure that she attributed the injury to a seizure.

11.6.10 Injured people frequently attend medical facilities with relatives, who provide care and support. If the clinician has no concerns about the way a patient presents, relative to the person accompanying them, they may decide it is appropriate to speak to and examine the patient with that person present. The nurse who treated Mary used professional judgement and recorded there were no concerns at the time. This was good practice.

11.7 Area A Council

11.7.1 Town A, where Mary lived, is covered by Area A Council (AAC), a second-tier local authority. The council's statutory remit combines a responsibility for a wide range of local government services within a geographical area of Kent. The services that AAC are responsible for providing or commissioning includes housing, which is the one relevant to this review.

11.7.2 AAC has a Housing Options Team, which manages homelessness and housing applications. Its Revenue & Benefits Team which deals with payment of rent, as well as council tax and entitlement to housing benefit.

Although both teams deal with housing issues, the roles of each are separate.

11.7.3 AAC uses two computer systems to manage its housing services. First Locata, which is accessed and used by staff in the Housing Options Team. It contains confidential personal information about residents in AAC-provided housing and those making housing applications. Locata cannot be accessed by staff in the Revenue & Benefits Team. The other computer system is Academy, which is primarily used by the Revenue & Benefits Team. It contains information about a person's entitlement to benefits and council tax relief, as well as family composition and address history. Academy can also be accessed by Housing Options Team staff.

11.7.4 Mary lived in a house provided by ACC through a social housing provider, Hyde Housing. After separating from her first husband shortly after Christmas 2016, she had been living alone in the house. In September 2017, AAC's housing Revenue & Benefits Team received an automated notification from the Department for Work and Pensions (DWP) stating that Mary's Employment Support Allowance (ESA) was ending *'…due to William Lucas moving into her property.'* Mary and William were not married at this time, but it appears he was using her surname.

11.7.5 A Benefits Advisor from the Revenue & Benefits Team interviewed Mary. AAC has a duty to investigate a change in a person's circumstances that might affect their benefit claim and council tax relief. The interview with Mary took place 10 days after the notification from the DWP.

11.7.6 During the interview, Mary said William was not her partner, but was *'…a friend made homeless.'* She added that he had moved into her home on 1st June 2017, having previously lived in a hostel following his release from prison. A change of circumstances form was completed, and Mary discussed the benefits that she and William were receiving. The relevant entries were made on Locata.

11.7.7 During the interview, Mary did not talk about any issues that would have raised concerns about her safeguarding. She did not suggest she was unhappy with William moving into her house or that he had coerced her into allowing this. She added that her ESA had been reinstated.

11.7.8 On 8 February 2018, a Housing Officer from the Housing Options Team spoke to a Kent-based Probation Officer, who was caretaking William's case, about an application William was making for housing. The reason for the application was that William said he had split up with his wife of five weeks and was homeless.

11.7.9 The Probation Officer explained William's history of firearms offences and that he was being managed by the Multi-Agency Public Protection Arrangements (MAPPA). She also told the Housing Officer that Mary had recently told William's Probation Officer in Devon that William had been abusive towards her. She added the police were investigating this, and a panic alarm had been fitted in Mary's house.

11.7.10 Having been given this information, the Housing Officer contacted Kent Police, who confirmed William was liable to arrest for assaulting Mary. The Housing Officer told the police that William was attending a housing meeting at the AAC building that afternoon; as a result, police officers went there and arrested him. This was a good piece of proactive work by the Housing Officer, whose action directly facilitated the arrest of William for domestic abuse.

11.7.11 The next involvement with Mary was in February 2018, when the Revenue & Benefits Team were told by the Housing Options Team that she and William had been in a relationship, but he had moved out of her house. The Housing Options Team had been told of this by William when he made a housing application. Due to this change in Mary's circumstances since the interview in September 2017, she was sent an Entitlement Review Form (ERF) by the Revenue & Benefits Team.

11.7.12 A month later, in March 2018, the ERF had not been returned and Mary was sent a letter, telling her that her benefit claim had been suspended. She returned the completed ERF in mid-April, again stating William was just a friend. She gave no indication he had moved out of her house. The Revenue & Benefits Team then wrote to her asking why William would say they were in a relationship and why he would have advised that he no longer lived at the property.

11.7.13 A member of AAC's housing department attended the Area A Multi-Agency Risk Assessment Conference (MARAC) on 17th April, when Mary's case was discussed. The minutes do not record if any information was provided by the AAC representative and there were no actions allocated to her.

11.7.14 On 25th April, about a week after the Revenue and Benefits Team sent the letter to Mary, she was interviewed by a Benefits Advisor (not the same person who interviewed her in September 2017). She reiterated that she and William were not in a relationship, and said he was no longer living in her house. The National Probation Service are co-located in the AAC building with the Revenue and Benefits Team, where they operate a 'reporting centre'; Kent caretaking Probation Officer was working there on

this date and overheard this interview. After Mary had left, the Probation Officer told the Benefits Advisor it was a condition of William's licence that he reside at an address approved by his Probation Officer, and that he and Mary were married.

11.7.15 As a result of this information, on 25th April, the Revenue & Benefits Team raised a fraud referral to the DWP. The aim was to try to establish whether Mary and William were married and/or living together, which may have impacted on their housing benefits. Mary's housing benefits and council tax support were not suspended as a result of the fraud referral, and there is no record that she would have known about it. The Revenue & Benefits Team did not receive a response from the DWP before Mary's death and had no further contact with her.

11.7.16 AAC knew that Mary was a victim of recent domestic abuse from the information received by the Housing Options Team in February 2018 and attendance at the MARAC two months later. It is unclear whether this information was known to the Benefits Advisor who interviewed her on 25th April, but she would not have had access to the Locata system on which it was stored. Had the Advisor have had access to Locata, she would have been able to see that Mary had been the victim of domestic abuse, for which her husband had been arrested.

11.7.17 AAC should ensure that Revenue & Benefits Team staff seek all the relevant safeguarding information known within AAC about a client they are interviewing. **(Recommendation 7)**

11.7.18 All AAC staff complete an e-learning module about safeguarding adults. Since May 2018 they have been required to complete a further module relating specifically to domestic abuse. Those staff who have regular engagement with vulnerable people are also required to have completed a face to face domestic abuse training session. This includes all Housing Options Team staff. In this case it was Revenue & Benefits Team staff who met with Mary; Housing Options Team staff had no interaction with her.

11.7.19 AAC should consider and decide whether, in the light of this case, Revenue & Benefits Team staff should attend the face to face domestic abuse training module. **(Recommendation 8)**

11.8 National Probation Service

11.8.1 The National Probation Service (NPS) is a statutory criminal justice service that supervises high-risk offenders released into the community.

NPS had responsibility for supervising William during the review period, following his release from prison.

11.8.2 On 25th April 2013, William was sentenced to seven years and four months imprisonment for armed robbery. He was released from prison on licence in November 2016.

11.8.3 Following his release, William was directed to reside in an NPS Approved Premises (AP) in Devon. Offenders may be placed in APs for a variety of reasons; in William's case it was because he was classed as a high or very high-risk offender. His placement in the AP was for three months, ending in February 2017.

11.8.4 When William was in prison, he was allocated a Probation Officer (PO1) in Devon, who was to be responsible for his offender management until his licence expired. Having been given notice to leave the AP, William had to find an address approved by PO1 as somewhere he could be directed to reside. William proposed living in Kent with his partner, Mary Lucas, while they looked for suitable accommodation in Devon.

11.8.5 PO1 spoke to Mary first by telephone. She stated she was willing for William to live with her. She added she would attend his fortnightly NPS appointments in Devon with him. PO1 directed that William should reside at Mary's home. Mary's disclosures to other agencies several months later were that she did not want him to live with her, but PO1 had no reason to think this was the case when he made the decision.

11.8.6 On 14th March 2017, PO1 met Mary for the first time when she accompanied William to an NPS meeting. She said she knew about his offending history, but she wanted to help him. She felt they might have a future together but did not want to rush things. She explained that they had known each other as teenagers but had lost touch. William contacted her via Facebook after his release from prison.

11.8.7 In most cases, a person on licence attends regular meetings with their Probation Officer at an NPS office local to where they live. In William's case he travelled from Kent to Devon because it was thought he and Mary might soon find a property in Devon. In September 2017, they were still living in Kent. Although William said they were actively seeking accommodation in Devon, PO1 requested William's case be caretaken by the NPS office in Town C, Kent. From then, William attended NPS meetings in Kent where he had an allocated caretaking Kent-based Offender Manager, although PO1 continued as his Offender Manager.

11.8.8 It is unusual for a person on licence to bring their partner or other family member to NPS meetings, even more so in the case of William, because of the long distance involved, and Mary's disability. There is no record that the reason for this was discussed or that it raised any concerns about coercion and control.

11.8.9 On 31st January 2018, the Kent-based Probation Officer (PO2) who was caretaking William's case emailed PO1 with information that William had threatened Mary. PO1 made enquiries and found out William was on police bail. He considered revoking William's licence but decided not to. He would have had the grounds to do so; revocation does not require a person to have been charged with a criminal offence.

11.8.10 During February, PO1 was on leave and another Devon-based Probation Officer (PO3) was assigned to William's case for this period. She had contact with him and Kent Police during this time.

11.8.11 On 8th February, as set out in Section 11.7 above, PO2 received an enquiry from ACC Housing Options Team about William. She told the Housing Advisor about Mary's allegations of domestic abuse by William and this led to his arrest the same day. This demonstrates the value of sharing relevant and appropriate information between organisations.

11.8.12 On 21st February, following his return from leave, PO1 applied for a variation to William's licence to include a night curfew to his son's address outside Kent. This was because one of William's bail conditions was not to go to Mary's home.

11.8.13 PO1 was told by the police officer dealing with the assault on Mary that on 3rd March, William had failed to surrender to police bail. PO1 then contacted William, who agreed to surrender to bail. There is no record that PO1 asked Kent Police whether there was any information that would have increased the harm, risk and imminence posed at that time, which could have led to a reassessment of whether he met the recall requirements.

11.8.14 As detailed in Section 11.3 above, on 7th March, William went to a police station in Kent to surrender, there was no police officer available to arrest him. PO1 immediately contacted William, who then agreed to hand himself in on 12th March. PO1 emailed the police officer to this effect.

11.8.15 On 12th March, PO1 was told that Mary had collected William from his son's house. She had withdrawn the statement she had made alleging

acts of domestic abuse and said she was happy for William to stay with her.

11.8.16 On 20th March 2018, William and Mary attended an NPS meeting with PO3 in Kent. They appeared 'OK' and there was a further meeting on 17th April.

11.8.17 On 2nd May, William was arrested and charged with an offence of causing Mary grievous bodily harm with intent. He was remanded in police custody to appear before magistrates on 4th May. NPS were made aware of this and William's prison release licence was revoked. Mary was not contacted about this. His sentence is due to expire on 8th July 2020.

11.8.18 PO1 met Mary several times when she accompanied William to meetings. This was in the first few months of their relationship and her demeanour did not cause him to believe she was being subjected to coercion and control. PO1 considered recalling William to prison when he was first arrested for domestic abuse in late January 2018. He decided not to do this and there is no record that he asked whether there was any information that might have affected the risk William posed at the time he failed to surrender to police bail. Revocation is based on a Probation Officer's assessment of risk, which must also be endorsed by a Senior NPS Manager.

11.9 Kent County Council Adult Social Care and Health

11.9.1 Adult Social Care and Health (ASCH) is the directorate within Kent County Council that has responsibility for adult safeguarding in the county. It employs Social Workers and other staff to discharge its duties under the Care Act 2014.

11.9.2 ASCH was involved with Mary throughout the review period. Prior to February 2018, this had centred on financial assessment for social care being provided to her at home, as a result of her disability. In April 2016, she decided she could not afford to pay the client contribution towards this and that relatives would provide the assistance she needed.

11.9.3 While not directly relevant to the review, this indicates that Mary had social care needs. Her separation from her first husband shortly after Christmas 2016 may have increased her feelings of vulnerability. Following the cessation of the contribution to her social care payments, the only service being provided to Mary by ASCH was a Lifeline personal alarm.

11.9.4 On 15th February 2018, ASCH received a Kent Adult Safeguarding Alert Form (KASAF) relating to Mary from Kent Police. The KASAF referred to an incident that had taken place on 9th February. It was sent following William failing to surrender to police bail in the course of an investigation into allegations of abuse against Mary.

11.9.5 On 16th February, a Senior Practitioner working in the ASCH Older Persons and Physical Disability Team contacted the Anti-Social Behaviour Officer at Area A Council to request any information held about Mary. The ASB officer advised she would make enquiries and reply by 19th February.

11.9.6 Following the receipt of an KASAF, ASCH should complete a risk assessment and agree actions within 24 hours (1-2 working days). The document that should be completed to record the decisions made is known as a KASAF 2 (KASAF 1 being the form on which the KASAF is submitted).

11.9.7 On 1st March, two weeks after ASCH received the KASAF in respect of Mary, its Area A Safeguarding Adults Coordinator (SAC) saw, when checking a spreadsheet, that the KASAF 2 had not been completed. This meant that no decisions or action had been taken on the KASAF. Two issues arise from this: first why the KASAF process was delayed; and second, why it took two weeks to identify this.

11.9.8 It appears that the former was because the KASAF was received during a period of adverse weather, including heavy snow, which prevented ASCH staff from being able to travel to the Area A office. This resulted in the Senior Practitioner who received that KASAF having to cover another area in addition Area A, causing additional workload.

11.9.9 There will be exceptional circumstances when processes are delayed, and it may take time to catch up. It is not clear what the process is for prioritising KASAFs that have been delayed. The spreadsheet was not an effective way to highlight outstanding KASAFs – had it been, it would not have taken two weeks to realise that it had not been progressed.

11.9.10 KCC ASCH must ensure that when completion of a KASAF 2 is delayed due to exceptional circumstances, the fact that it is outstanding cannot be overlooked. **(Recommendation 9)**

11.9.11 Having identified that the KASAF process had not been progressed in this case, the SAC took responsibility for it and completed the KASAF 2 retrospectively that day. She also contacted a colleague, who had dealt

with Mary's social care financial assessment, to get further background information.

11.9.12 The SAC also contacted Kent Police to find out the name of the officer who submitted the KASAF; the MARAC Administrator to confirm that Mary's case was still listed; and SATEDA (a domestic abuse charity) to enquire whether an Independent Domestic Violence Advisor (IDVA) was involved in Mary's case. In addition, she obtained a copy of the information provided by the Area A Council ASB Officer.

11.9.13 The SAC telephoned Mary the same day, leaving her a brief message worded in a way that recognised the risk that the message might have been picked up by someone else.

11.9.14 Having taken on the KASAF after such a long delay, the SAC quickly made relevant enquiries to inform how it should be progressed. She took ownership of the KASAF, which was good practice.

11.9.15 The following day, 2nd March, Mary returned the SAC's call and they spoke by telephone. She provided detailed background information about her relationship with William, confirming that he had contacted her via Facebook following his release from prison (in November 2016). Her father had died shortly before and she described herself as being vulnerable because of this. She stated that she believed that William had *'taken advantage of her'* at this that time.

11.9.16 Mary said that she had not wanted William to move in with her, and she detailed the abuse she had suffered since then. Most of her allegations were of psychological abuse but included William having driven a car, which she was passenger in, into a parked lorry to cause her injury. She said she had lost five stones in weight since she had married William, only two months earlier.

11.9.17 Mary then described the assault that resulted in William's arrest and release on police bail. It was his failure to surrender to bail that had resulted in the KASAF made by Kent Police. She said she believed he was living with one of her neighbours. She confirmed an IDVA, who she named, had been allocated to her and a safety plan had been completed. She added that she had a panic alarm, provided by Kent Police. She knew a MARAC referral had been made and understood what this meant. She had been offered and agreed to enrolment in the Freedom Programme, a nationally recognised programme that aims to improve the knowledge and skills of domestic abuse victims to protect themselves and understand what constitutes abuse.

11.9.18 The SAC explained the actions she was planning to take. She ensured that Mary knew who to call in an emergency and gave her the relevant social services contact number.

11.9.19 The detail that Mary was able to give showed she was able to understand and recall what actions had been taken to safeguard her. It also indicated that she had engaged with the support offered by organisations. Her clarity may have masked how frightened and vulnerable she must have been feeling.

11.9.20 Mary declined any further input from ASCH *'…because everything was in place and being done.'* It was good practice that despite this, on the same day, the SAC made enquiries with other organisations that Mary had mentioned. She spoke to a Senior Worker at SATEDA, who said that Mary's case was closed to the Centra IDVA and had been passed to SATEDA (see Section 11.4 above). The police officer investigating Mary's case told the SAC that William was bailed to 3rd March, and it was hoped he would then be charged with an offence of coercion and control. On 9th March, the SAC was told William had not answered bail and that attempts to arrest him were continuing.

11.9.21 On 12th March, the SAC received an email from the MARAC Central Coordinator, telling her that Mary's case was not on the list for the March meeting and would be considered at the following meeting on 17th April.

11.9.22 The next day, the police officer dealing with Mary's case told the SAC in an email that Mary had retracted her statement, William had moved back in with her and the Crown Prosecution Service had decided not to charge him.

11.9.23 On the same day, the Senior Worker from SATEDA contacted the SAC to say she had made four attempts to contact Mary without success. The Centra IDVA had decided not to become involved with Mary again because William was living with her and further involvement might put her at more risk. Further details of the Freedom Programme, which Mary had been offered and which was due to start in April, were not being provided to Mary due to the lack of success in contacting her.

11.9.24 The same day, the SAC spoke to her supervisor (the ASCH Safeguarding Services Manager) about Mary's case and the decision was taken that the KASAF would be closed because Mary *'…had been clear in her wishes and making her own choices and there was no evidence that she lacked the capacity to make such decisions that she did not want to engage with*

social services.' However, it was agreed that the SAC would attend the MARAC meeting in April.

11.9.25 On 16th March, Mary's case was discussed in a formal supervision meeting between the SAC and her supervisor (the ASCH Safeguarding Services Manager). It was suggested that the SAC should contact Mary's GP to discuss her self-disclosed weight loss and chronic health condition, and the potential link to domestic abuse. The SAC made this call, which is considered in Section 11.5 above.

11.9.26 On 23rd March the KASAF was closed. The rationale was described thus: *[Mary] had engaged initially with the IDVA, safety planning was in place and she had enrolled in the Freedom Programme. However, she had withdrawn her support of the police enquiry and allowed Mr Davis back in to her home which had significantly increased her risk. She had not engaged further with SATEDA who had closed her case. Her case was still going forward to the MARAC in April where further discussions would take place regarding risks and safeguarding plans. Ms Lucas was clear on 02/03/2018 when she spoke to [the SAC] that she did not want any further social services involvement.*

11.9.27 The SAC had done some good work in establishing the facts from Mary's perspective and confirming what each organisation she was involved with was doing. The KASAF process is not one in which the SAC (or whoever is managing the enquiry) becomes the central point in providing ongoing support for a person in Mary's situation. It is to enquire into whether a person for whom there are safeguarding concerns, is receiving the appropriate support.

11.9.28 On that basis, closure of the KASAF was appropriate, but although the rationale recorded was factually accurate, its wording suggests a lack of understanding of the nature and impact of coercion and control suffered by domestic abuse victims. It intimates Mary was withdrawing from services willingly and was partly the author of her own suffering by allowing William back into her home. Both actions can be (and with hindsight in this case were) indicators that the risk to domestic abuse victims is increasing. The use of the word '*allowed'* suggests this was not considered or understood.

11.9.29 KCC ASCH must ensure that staff dealing with the safeguarding of high-risk domestic abuse victims understand and act on the fact that apparent reconciliation between a victim and alleged perpetrator may be because of coercion and control, and indicative of the victim being at increased risk. **(Recommendation 10)**

11.9.30 On 17th April, the SAC attended the MARAC. It was agreed that a joint meeting between Mary and the IDVA would be arranged *'to discuss concerns that her decision to drop charges and allow [William] back into her home may have been due to coercive and controlling behaviour'.* As described in Section 11.5 above, the meeting was arranged at Mary's GP Practice. It took place on 3rd May and lasted over two hours. Mary told the SAC and IDVA about the assault on her by William, for which he was now in police custody. She also explained why William was living in her home again, reasons that amounted to serious coercion and control. It was clear that the abuse she was suffering was increasing, as was her fear and vulnerability. Further actions taken by the IDVA are described in Section 11.4.

11.9.31 The following day, 4th May, the SAC raised a new KASAF. She also contacted a senior manager (the ASCH Service Manager) to get approval for an out of hours referral given Mary's high risk of domestic abuse. She was then able to give Mary advice about how to contact ASCH if she needed urgent out of hours help, for example relocation. This was another example of good practice by the SAC.

11.9.32 On the same day, the SAC received an email update from the IDVA about the charges William faced at court that day, following his remand in custody. The SAC then contacted Kent Police and confirmed that William was in custody. This indicated a thoroughness in her approach to Mary's safeguarding.

11.9.33 The SAC then contacted Mary and gave her details of the Out of Hours Referral service, which would allow her to contact social services during what was a bank holiday weekend. The reason why the SAC had arranged the out of hours referral was in case William was not remanded in custody and she needed immediate support.

11.9.34 The SAC then made a referral to Kent and Medway Social Services Out of Hours Team. She provided details of the KASAF, the contingency plan in place, other circumstances that may have required the intervention of the out of hours team, a risk assessment and confirmation that this had been authorised by the ASCH Service Manager.

11.9.35 Tragically, Mary died during the weekend, but the work done by SAC in trying to ensure that she would have been protected had William been released was commendable. Overall, the service provided to Mary by the SAC while KASAFs were open was professional, thorough and conscientious. She demonstrated an understanding of the key aspect of

multi-agency working; that information should be shared to ensure Mary was getting help from the most appropriate organisations.

11.10 Kent County Council Libraries, Registration and Archives

11.10.1 Mary and William were married in a civil ceremony on 2nd January 2018. The wedding was attended by two witnesses and two guests. None of Mary's family attended, but a friend who did told Darren subsequently that she looked 'petrified'.

11.10.2 Members of staff from KCC's Registration Service, who conduct marriage ceremonies, see the bride and bridegroom separately at least twice before the wedding. First, when notice of the marriage is given, and then immediately before the ceremony. This applied in the case of Mary and William.

11.10.3 One of the staff who conducted the marriage of Mary and William cannot recall anything about the ceremony. The other recalled it and said there was nothing significant about it. The Superintendent Registrar explained that it is not unusual for parties to a marriage to appear nervous.

11.10.4 Prior to the date of the wedding, William had difficulty in producing documentation proving he was divorced. He became agitated to the point of verbal aggression. This is not unusual because people who do not understand how important proof of freedom to marry is can become frustrated. The date of the wedding was postponed from 30th November 2017 because William did not have necessary paperwork.

11.10.5 All staff who conduct marriage ceremonies in Kent have been trained in dealing with cases where a bride or bridegroom says they are being forced into marriage. The person will be offered the opportunity to call the police or the Forced Marriage Unit in private. The emphasis is on facilitating the person to take the action they want, not on stopping the wedding. Mary did not give an indication that she was being forced to marry William or that she did not want the ceremony to proceed.

12. Multi-Agency Risk Assessment Conference (MARAC)

12.1 A Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared between representatives of relevant statutory and voluntary sector organisations about victims of domestic abuse who are at the greatest risk. Victims do not attend MARAC meetings; they are represented by their Independent Domestic Violence Advisor (IDVA).

12.2 There are 13 MARACs covering Kent and Medway. Each is coterminous with a local authority boundary; district and borough councils in Kent, and Medway unitary authority. In Area A, MARAC meetings are held monthly.

12.3 Kent Police are responsible for managing MARAC meetings and receive funding to employ MARAC Coordinator and Administrator posts. In some areas of Kent and Medway, the role of chairing the MARAC is shared by organisations; in Area A Kent Police provide the Chair. There are seven MARAC Administrators, each covering between two and four MARACs.

12.4 Kent Police also employ a MARAC Central Coordinator, who is responsible for ensuring that the MARACs provide a consistent level of support to high-risk domestic abuse victims. The Central Coordinator deputises for absent Administrators at MARAC meetings.

12.5 The Central Coordinator is also responsible for ensuring that the Kent and Medway MARAC Operating Protocol and Guidelines (OPG) are updated and that each MARAC adheres to them. A further responsibility of the Central Coordinator is to provide training for MARAC members and chairpersons.

12.6 Each MARAC has an optimum caseload at each meeting; for Area A it is 21. This takes account of how often the meeting is held and the time available to deal with cases. In general Area A works close to its optimum caseload. If the optimum number of cases is exceeded at a meeting, all referrals should still be considered – on only one occasion has the number of excess cases meant some were deferred to the next meeting. This recognises the need to consider referrals expeditiously.

12.7 In general, there is good attendance at Area A MARAC meetings. Attendance is important because an organisation cannot be assigned an action unless they attend, even if their activity could be key to safeguarding a victim.

12.8 Mary's case was initially the subject of a MARAC referral made by Kent Police on 5th February 2018. Referrals should be made to the appropriate MARAC administrator, who is responsible for ensuring that the case is listed for discussion at the next meeting. At the time of this referral the MARAC administrator post covering Area A was vacant and this remained the case for some months. When an administrator post is vacant, it increases the workload on the Central Coordinator.

12.9 As described in Section 11.3 above, the police officer making the referral sent it to an IDVA who worked for a domestic abuse organisation that did

not cover Area A. This IDVA realised the error and forwarded it to Centra IDVA without delay. The police officer should also have sent the referral to the Area A MARAC Administrator. Although that post was vacant, the Central Coordinator was monitoring all emails sent to the Area A MARAC.

12.10 Because the referral was not sent to the MARAC Administrator, the case missed the February meeting. When Kent Police realised the error, the referral was sent, and received by the Central Coordinator, on 14th March. By this time, it had missed the cut-off date for submissions to the March meeting. The cut-off date is not set in stone; a case involving a particularly vulnerable victim can be added after the cut-off date. There is no record that this was considered in Mary's case. It was heard at the meeting held on 17th April – two and a half months after the referral.

12.11 The meeting at which Mary's case was considered was chaired by a Kent Police Detective Inspector. In the absence of an administrator for the Area A MARAC, the Central Coordinator was planning to attend to take minutes. For justifiable reasons she was unable to, which resulted in the minutes (which use a standard template) being completed by the meeting Chair.

12.12 MARAC minutes are brief: they do not record detailed discussions. They set out what information is shared by whom and from which agency. The actions arising from the meeting are also listed, with the name and organisation of the attendee responsible for each.

12.13 The minutes of the meeting were available to the review. They contain one very brief piece of information about Mary's case, provided by her IDVA. The actions are identifiable as relating to Mary's case but are inaccurate and incorrectly allocated. These issues are not a criticism of the meeting Chair – it is unreasonable to expect a person chairing a meeting of almost 20 people discussing about 20 complex cases, to accurately record what is said and the actions allocated.

12.14 There is reference in the minutes to information provided by, and an action assigned to, the Forward Trust, but no representative of that organisation appears on the attendance list. They may have been present, but this is unclear. In addition, because the MARAC Coordinator was not present to take minutes, the action summary sheet, which would confirm if an action was implemented, was not completed. This is an important document because if a person is re-referred to the MARAC, it would show what had been done on the previous occasion.

12.15 A previous Kent DHR made a recommendation about minuting MARAC meetings:

The Kent and Medway Domestic Abuse and Sexual Violence Group (DASVG) should agree a process that ensures minutes are taken at all MARAC meetings and include this in the OPG.

12.16 In addition, the same DHR made a recommendation about the management of MARAC actions:

DASVG must establish a process that ensures all MARAC actions from the previous meeting have either been implemented or if not, the reasons why. A record must be kept of the results.

12.17 This DHR shows that there are still issues relating to minuting and management of actions. Accurate and complete minutes, clearly setting out the actions, are essential to ensure that information about victims is recorded, and actions are correctly allocated and implemented. The purpose is not to ensure a tidy administrative process; it is central to the aim of safeguarding victims of domestic abuse who are at the highest risk.

12.18 The review panel attaches no criticism to MARAC staff in this case; the Area A administrator post was vacant and if, as is inevitable on occasions, the Central Coordinator cannot attend a meeting, there is no further resilience. The panel acknowledges the difficulty in recruiting and training new staff in the event of an unexpected vacancy arising. However, the highest risk domestic abuse victims must attract the highest priority from organisations (not only Kent Police) that have responsibility for safeguarding adults. Where difficulties arise in staffing MARAC meetings, there should be a multi-agency contingency to ensure the administration of the meetings is managed effectively.

12.19 Kent and Medway Domestic Abuse and Sexual Violence Group must agree a process that ensures all MARAC meetings are accurately minuted and that the allocation and implementation of actions are recorded. The agreed process should be included in the Kent and Medway MARAC Operating Protocol and Guidelines. **(Recommendation 11)**

13. How Organisations Worked Together

13.1 If organisations involved with domestic abuse victims work well together, the risk of harm is reduced by sharing information and ensuring support is provided by the most appropriate organisation(s). It also makes the best use of limited resources. The success of inter-agency working relies on effective communication to ensure that each organisation knows when its services are required and has the information on which to base decisions about action it might take.

13.2 Section 11 highlights areas of good practice when an organisation has shared relevant information with another or others. It has also identified occasions when an organisation could have done so but did not.

13.3 It is positive to note that information sharing by practitioners, particularly those working for agencies that feature regularly in DHRs, was noticeably better than in most previous reviews. This is hopefully a sign that the value of information sharing is now widely recognised and that professionals feel empowered to contact other organisations both to impart and enquire about potentially relevant information.

14. Conclusions

14.1 In late 2016, William contacted Mary using Facebook, having previously known her when they were at school together. Why he chose to contact her is unclear, but at the time she was physically and emotionally vulnerable. She suffered from a physical disability for which she needed support and was living alone for the first time in over 30 years, having recently separated from her husband. In addition, her father had died earlier in 2016. Within a few months of contacting Mary, William was living in her home.

14.2 Mary first reported domestic abuse by William at the end of January 2018, by which time they were married. She said the abuse had been going on for some months. Although he moved out following his arrest a week later, he coerced her into withdrawing her allegations and moved back into her home. He was subjecting her to physical, psychological and emotional abuse, which escalated to a point where he was again arrested and charged with serious assault. He remained in custody and his prison release licence was revoked. Mary was told on a Friday afternoon that he had been released and she died during that weekend.

14.3 It is significant that when she was told William had been released on bail, Mary said *'…it was as though the magistrates had signed her death warrant'*. What she meant by this was not explored, but it is a possibility that she was intimating an intention to take her own life. A professional who had received suicide prevention training may have asked Mary to clarify the statement with a view to identifying if she was at risk of suicide.

14.4 The risk of a victim of domestic abuse taking their own life has been recognised; it is why reviews using DHR methodology, such as this one, are conducted. Some recent research into the risk is contained in a study carried out jointly by Refuge and Warwick Law School:

https://www.refuge.org.uk/wp-content/uploads/2018/07/domestic-abuse-suicide-refuge-warwick-july2018.pdf

Some statistics about the increased risk were included in a prestation given at an Advocacy After Fatal Domestic Abuse conference about Suicide and Domestic Abuse, held on 21st March 2019:

https://aafda.org.uk/2019presentations/eleanor-stobart-dhrs-and-suicide-aafda-conference-21-march-2019/

14.5 Free to access suicide prevention training is available in Kent and Medway. Adult suicide prevention training for KCC staff can be accessed at:

http://www.maidstonemind.org/suicide-prevention-awareness-training/

A 20-minute e-learning package is available at:

https://www.zerosuicidealliance.com/

14.6 Kent County Council to consider using their commissioning relationship with the domestic abuse service providers to require that all front facing staff (IDVAs, outreach workers etc) complete face to face suicide prevention training. **(Recommendation 12)**

14.7 All agencies involved in this review should add suicide prevention training to their directory of training available to staff and encourage take up. **(Recommendation 13)**

14.8 Several examples of good practice, based on individual performance and organisational practices, have been highlighted in this review. Information was shared between organisations to an extent not seen in many earlier reviews, indicating its value is better understood.

14.9 Organisations knew for three months before Mary's death that she was a victim of domestic abuse, although the abuse had been taking place for months before anyone became aware of it. She was identified as a high-risk victim, but a chain of events began that raises concerns about how organisations responded. In some cases, this was individual error, in some a more worrying indication of cultural shortcomings. The review panel understands that professionals are human and make mistakes; this review does not seek to apportion blame to them, but to learn lessons for the future. It is important however, to identify clearly each issue of concern.

14.10 The MARAC referral from Kent Police was made promptly but was not sent to the correct destination. This delayed, by two months, Mary's case being heard. It was just over three months from the date when organisations first knew Mary was a domestic abuse victim to her death, which shows how

important it is that processes which seek to safeguard high-risk victims are implemented expeditiously, with a degree of urgency.

14.11 A lack of available police officers meant William was not arrested when he tried to surrender to bail; this was significant. During the period between then and his eventual arrest, he told Mary he had information about her family that he would disclose if she did not retract her allegations and allow him back to live in her home. She did both, which resulted in further abuse, compounded by a failure by organisations to consider why she might have done this.

14.12 The decision not to recall William to prison after his first arrest was based on assessment of the risk he posed, based on the criteria for revocation of risk, harm and imminence. There is no record of such an assessment when he failed to surrender to police bail. To have deprived him of his liberty at that point would have changed the course of Mary's suffering.

14.13 The Review Panel accepts that there is greater certainty in hindsight about why Mary made the decisions she did. However, there is concern that there was a lack of consideration and understanding about why a high-risk domestic abuse victim might withdraw allegations, and apparently reconcile with an alleged abuser. It should have been recognised that these decisions were indicative of Mary suffering increased coercion and control, putting her at higher risk. In common with separation, resumption of cohabiting and withdrawal of complaint, are factors that should cause professionals to become concerned and curious.

14.14 There is little evidence that Mary's vulnerability due to her physical disability formed part of professionals' considerations. As well as the practical consideration that it made her less able to resist physical abuse, her reliance on care in her home day to day might have made her reluctant to report abuse at an early stage.

14.15 When Mary failed to engage with SATEDA, this did not raise any recorded concerns that it might have been because she was being subjected to coercion and control. There were no recorded attempts to establish why she could not be contacted or why she did not respond to calls.

14.16 The rationale recorded by KCC ASCH when closing the KASAF showed a lack of understanding that a consequence and sign of coercion and control is for domestic abuse victims to make decisions that are contrary to their best interests. It concluded with reasoning that bordered on victim blaming - Mary had withdrawn her allegations and allowed William back into her home.

14.17 On the day William was appearing in court, Mary expressed to her IDVA, her fear that he might be released on bail. The IDVA told her to ring the police custody suite to find out the court result. This demonstrated a lack of empathy and understanding; it was something that should have been done for her.

14.18 There can be little doubt that Mary's death was influenced by her belief that William had been released on bail. The information she was given was wrong because Witness Care staff did not know that an appeal against bail granted by magistrates must result in the defendant being remanded in custody.

14.19 Each of these issues had consequences, and recommendations have been made to try to ensure that in future, the culture and practices of organisations prevent a repetition. Mary was identified as being vulnerable and assessed as being at high risk. There is value in assessing risk only when the appropriate action is taken. High risk victims must be given high priority to ensure their safeguarding as far as possible.

15. Lessons Identified

15.1 Professionals dealing with victims of domestic abuse must look at issues through the eyes of the victim.

15.1.1 This is necessary to ensure that responses are appropriate to individuals and not simply the result of adherence to policy. An appreciation of the level of fear and vulnerability relies on understanding the circumstance of the individual.

15.1.2 Consideration of all aspects of equality and diversity are essential, which may require professionals to consult with others who have experience and understanding of issues.

15.2 If a domestic abuse victim withdraws allegations and/or accepts an alleged perpetrator back into their home, professionals must be aware that this could be because the victim is being subjected to coercion and control.

15.2.1 The circumstances described are one of the potential indicators, along with separation, that a domestic abuse victim may be at increased risk. It must not be assumed that the victim has willingly reconciled with the alleged perpetrator. Professionals should not, as a matter of course, use these circumstances as the reason for closing a domestic abuse case.

15.2.2 If more than one organisation has been involved in supporting the victim, each organisation should discuss the case with the other(s) to ensure that all information about the victim and alleged perpetrator has been shared. In appropriate cases, a professionals meeting may be the most effective way of doing this.

15.2.3 Overall, professionals must understand the impact that coercion and control have on a victim, who may not be able to make decisions in their own best interests.

15.3 Where possible, face to face contact should be sought by professionals dealing with high risk domestic abuse victims.

15.3.1 Care must always be taken when contacting domestic abuse victims to ensure that the means of contact does not place them at greater risk. No attempt should be made to pressure a victim into doing something they feel frightened or uncomfortable about, or which might place them at greater risk of harm.

15.3.2 Notwithstanding those overriding considerations, a face to face meeting, rather than telephone contact, with a high-risk victim will give a trained professional the best opportunity to exercise professional judgement about the risk to which that person is subject. At the very least, their general appearance (including visible injuries) and body language can only be seen by meeting them. It is also harder for the victim to conceal their true feelings and emotions, which will better inform the professionals of their risk and vulnerability.

15.3.3 If a victim declines the opportunity to meet, it may be an indicator of the degree of coercion and control they are subjected to, or the fear they are living under. Professionals must be mindful of not adding to these but should always consider a meeting as the best way to facilitate accurate professional judgement.

16. Domestic Homicide Review Issue

16.1 Section 18 of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews states:

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be

undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

16.2 The current Home Office publication, Domestic Homicide Review Information - Leaflet For Family Members, is not suitable for use in reviews where the victim took their own life. These cases are not homicides and an alternative title needs to be established. The leaflet needs to be reviewed to ensure that the wording is appropriate. For example, use of the term 'perpetrator' needs to be carefully considered because in most cases where a person commits suicide, there will be no prosecution and wrongly labelling a person a perpetrator could result in action that would not be in the interests of family members or the DHR process.

16.3 The leaflet for friends of the victim must be similarly reviewed.

16.4 The Home Office must produce leaflets for family members and friends that are suitable for reviews using the DHR methodology in cases where a person has taken their own life. **(Recommendation 14)**

17. Recommendations

17.1 The Review Panel makes the following recommendations from this MAR:

	Paragraph	Recommendation	Organisation
1.	11.3.8	Kent Police must ensure that all VIT officers and staff know where MARAC referrals must be sent.	Kent Police
2.	11.3.27	Kent Police must ensure that its Witness Care staff know that when the Crown Prosecution Service appeal a decision made by magistrates to grant bail, the defendant will be remanded in custody pending the outcome of the appeal.	Kent Police
3.	11.3.28	Kent Police's Witness are policy and procedures must state clearly that if Witness Care staff have any doubt about the outcome of a court case, they must contact the court for clarification at the earliest opportunity and advise victims and/or witnesses of the uncertainty until it is resolved.	Kent Police
4.	11.4.21	Centra should consider adopting the Kent Police policy that results in a domestic abuse victim who has been assessed at being at High risk, remaining High risk for at least 12 months, regardless of whether one or more subsequent risk assessments results in a lower grade.	Centra
5.	11.4.28	Centra must instruct their IDVAs to record the rationale for their decision whether to meet a victim face to face.	Centra

6.	11.4.41	Kent County Council must, as part of the performance monitoring of its contract with Centra, consider how the concerns identified in this report are being addressed by Centra to ensure that the service provided to high risk victims of domestic abuse is improved.	Kent County Council
7.	11.7.17	AAC should ensure that Revenue & Benefits Team staff seek all the relevant safeguarding information known within AAC about a client they are interviewing.	Area A Council
8.	11.7.19	AAC should consider and decide whether, in the light of this case, Revenue & Benefits Team staff should attend the face to face domestic abuse training module.	Area A Council
9.	11.9.10	KCC ASCH must ensure that when completion of a KASAF 2 is delayed due to exceptional circumstances, the fact that it is outstanding cannot be overlooked.	KCC ASCH
10.	11.9.29	KCC ASCH must ensure that staff dealing with the safeguarding of high-risk domestic abuse victims understand and act on the fact that apparent reconciliation between a victim and alleged perpetrator may be because of coercion and control, and indicative of the victim being at increased risk.	KCC ASCH
11.	12.19	Kent and Medway Domestic Abuse and Sexual Violence Group must agree a process that ensures all MARAC meetings are accurately minuted and that the allocation and implementation of actions are recorded. The agreed process should be included in the Kent and Medway MARAC Operating Protocol and Guidelines.	KM DASVG

12.	14.5	Kent County Council to consider using their commissioning relationship with the domestic abuse service providers to require that all front facing staff (IDVAs, outreach workers etc) complete face to face suicide prevention training.	Kent County Council
13.	14.6	All agencies involved in this review should add suicide prevention training to their directory of training available to staff and encourage take up.	Agencies subject of this review
14.	16.4	The Home Office must produce leaflets for family members and friends that are suitable for reviews using the DHR methodology in cases where a person has taken their own life.	The Home Office

Kent & Medway Multi-Agency Review

Deceased – Mary Lucas

Terms of Reference

These terms of reference were agreed by the Multi-Agency Panel following their meeting on 24 July 2018.

Background

In May 2018, Mary Lucas, aged 52 years, was found dead by police officers at her home Kent. It is believed that she may have taken her own life.

At the time of Mary's death, her husband William was in prison, having been remanded in custody for assaulting her causing grievous bodily harm, coercive or controlling behaviour and perverting the course of justice. It is believed that Mary may have taken her own life.

Mary was not the victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

> *Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*

Consequently, in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 11 June 2018. It agreed that the criteria for a multi-agency review (MAR) had been met and this review will be conducted using the DHR methodology.

That agreement has been ratified by the Chair of the Kent Community Safety Partnership and the Home Office has been informed.

The Purpose of the MAR

The purpose of the MAR is to:

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

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

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

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

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

f) highlight good practice.

The Focus of the MAR

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

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

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

The subject of this review will be the deceased, Mary Lucas.

MAR Methodology

The MAR will be based on information gathered from IMRs, chronologies and reports submitted by, and interviews with, agencies identified as having had contact with Mary and/or William in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance

misuse. The MAR Panel will decide the most appropriate method for gathering information from each agency.

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

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

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

Each agency required to complete an IMR must include all information held about Mary or William from 1 January 2016 to early May 2018. If any information relating to Mary being a victim, or William being a perpetrator, of domestic abuse before 1 January 2016 comes to light, that should also be included in the IMR.

Information held by a statutory agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Mary and/or William. 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 2015, X was cautioned for an offence of shoplifting).

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

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

Specific Issues to be Addressed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

xv. Did any staff make use of available training?

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

xvii. How accessible were the services to the Mary?

GLOSSARY

Abbreviations and acronyms used in the report are listed alphabetically.

Abbreviation/Acronym	Expansion
A&E	(Hospital) Accident & Emergency Department
AAC	Area A Council
AP	(NPS) Approved Premises
ASCH	(KCC) Adult Social Care & Health
ASB	Anti-Social Behaviour
CCG	(NHS) Clinical Commissioning Group
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DASH	Domestic Abuse, Stalking and Harassment
DASVG	(Kent & Medway) Domestic Abuse and Sexual Violence Group
DWP	Department for Work and Pensions
ERF	Entitlement Review Form
ESA	Employment Support Allowance
GP	General Practitioner
GPP	General Practitioner Practice
IMR	Independent Management Report
IOPC	Independent Office for Police Conduct
KASAF	Kent Adult Safeguarding Alert Form
KCC	Kent County Council

KCHFT	Kent Community Health NHS Foundation Trust
MAR	Multi-Agency Review
MHA	Mental Health Act
MIU	Minor Injuries Unit
MSK	Muscular Skeletal Physiotherapy Service
NHS	National Health Service
NPS	National Probation Service
PO	Probation Officer
SAC	(KCC) Safeguarding Adults Coordinator
SATEDA	Support & Action To End Domestic Abuse
VIT	(Kent Police) Vulnerability Investigation Team

Explanations of terms used in the main body of the Overview Report are listed in the order that they first appear in the report.

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.

Criminal Procedures Rules – Part 14.9

Part 14.9 of the Criminal Procedures Rules, which deals with appeals by the prosecution against bail decisions, can be viewed by clicking on the link below. The sub-section that imposes the requirement on the court that granted bail to remand the defendant in custody pending the outcome of the appeal is highlighted.

Criminal Procedure Rules Part 14.9.pdf