

FL / 2011

The Domestic Homicide Review

Overview Report

Written by Helen Davies

1 INTRODUCTION

1.1 Background to the review

- 1.1.1 This domestic homicide review (DHR) was held as a result of the death of FL, in the context of domestic abuse, which occurred sometime between 27 June and 28 June 2011. This report of the review examines agency responses and support given to FL prior to his death. The review will consider agencies' contact/involvement with FL and his partner, KT, from January 2010 to June 2011.
- 1.1.2 The Chair of the Kent Community Safety Partnership agreed on 2 December 2011 to hold a domestic homicide review in accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004, because there had been a death of a person aged over 16 years, which appeared to result from an act of violence from a person with whom he had been in an intimate personal relationship. There was a delay in convening a review because, initially, FL's death was recorded as an unexpected death. It was not until November 2011 that Kent Police identified it as a possible domestic homicide. There was a further delay in undertaking the review because the first independent Chair resigned, and the subsequent Chair was not able to convene the first meeting of the Domestic Homicide Review Panel until early February 2012. There was a subsequent delay when one of the agencies outside Kent requested to provide a management report submitted it three months after the deadline; there was then a further delay due to difficulties in sharing electronic data securely, which have now been resolved. Hence, this overview report was not completed until October 2012.

1.2 The Terms of Reference

- 1.2.1 The purpose of a domestic homicide review as set out in Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews is to:
- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
 - 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;
 - apply these lessons to service responses including changes to policies and procedures as appropriate; and

- prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.2.2 The specific terms of reference agreed for the review were:

- were practitioners sensitive to the needs of both parties, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- did the agency have policies and procedures for Domestic Abuse Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a Multi Agency Risk Assessment Conference (MARAC)?
- did the agency comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?
- 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?
- 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?
- were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of both parties? Was consideration for vulnerability and disability necessary?
- were senior managers or other agencies and professionals involved at the appropriate points?
- are there ways of working effectively that could be passed on to other organisations or individuals?
- 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?
- how accessible were the services for both parties?
- to what degree could the homicide have been accurately predicted and prevented?

1.2.3 The timeframe of the review was from January 2010 to June 2011 and agencies were requested to provide a detailed chronology for this period. The timescale was from the date that the couple met through to the death of FL. All agencies were also asked to provide a summary of any other information prior to this period if they considered that it might be relevant, such as previous incidents of domestic abuse, alcohol or substance misuse and mental health issues.

1.3 Review Process

1.3.1 Individual management reports (IMRs) were received from the following sources:

- Kent Police
- Kent Probation
- London Probation Trust
- Kent and Medway NHS and Social Care Partnership Trust (KMPT) (mental health)
- East Kent Hospitals University NHS Foundation Trust (EKHUFT)
- KCA (community addiction service)
- Sussex Partnership NHS Foundation Trust on behalf of CRI (community addiction service)

1.3.2 A health overview report was produced by NHS Kent and Medway written by a Designated Nurse Safeguarding Adults in order to review and evaluate the practice of all involved health professionals commissioned by the PCT, including GPs and providers.

1.3.3 IMR authors were provided with a briefing session and Kent Police, Kent Probation, KCA and the NHS overview writer were able to attend.

1.3.4 Additionally, briefing reports were received from four agencies that had contact with the couple during the relevant period and had information that would assist the review. Reports were received from:

- Kent Families and Social Care
- South East Coast Ambulance Service
- Alcohol Rehabilitation unit
- GP

1.3.5 Individual Management Reports (IMRs) and the Health Overview Report were drawn up by officers who had had no previous involvement in the case. All IMR authors based their reports on written and electronic records, while the four agencies that had most involvement with FL also undertook a

number of interviews to inform their IMRs. The Kent Police IMR included details of two incidents investigated by police in area 3 (a large county where FL and KT stayed briefly) and the author interviewed ten officers, including two from area 3. The Kent Probation author interviewed five members of staff, the C1 author interviewed four members of staff and the London Probation author interviewed three.

1.4 Family input to the review

1.4.1 Relatives of both FL and KT were notified of the review by their police family liaison officer. It was agreed that KT's sister and ex husband and FL's nephew should be offered the opportunity to meet with the overview report author. They were all sent letters via their family liaison officer and invited to meet her. They have declined to be involved. Following her acquittal, attempts were made to contact KT to offer her the opportunity to meet with the overview report writer. They have been unsuccessful.

1.5 The Review Panel

1.5.1 The review group membership was as follows:

- Helen Davies (Chair and overview report author)
- Tina Draper, NHS Kent and Medway
- Tim England, Medway Community Safety
- Alison Gilmour, Kent and Medway Domestic Violence Coordinator
- Carol McKeough, Kent Families and Social Care
- Maurice O'Reilly, Kent Probation
- Shafick Peerbux, Kent Community Safety
- Tim Smith, Kent Police
- Tracey Tipping, KCA

1.5.2 Dates of review panels were:

- 3 February 2012
- 29 May 2012
- 23 July 2012

1.5.3 The Chair of the Panel and author of the overview report has had no direct involvement with any of the professionals' work being reviewed. She is an independent Children's Services consultant. She is a qualified social worker who has worked in local authority children's social care for over 30 years, 13 of which were at assistant/deputy director level. She has worked as an independent consultant for a year and is Chair of a Local Safeguarding Children Board in London.

- 1.5.4 The overview report was completely based on information provided in the IMRs and the additional reports.

2 THE FACTS

2.1 Circumstances of FL's death

At the time of his death FL was living with his partner, KT, in a motor home parked in a car park in town A in Kent. During the early hours of 28 June, KT contacted the ambulance service as FL had died. Initially, the police treated this as a non-suspicious death. Both FL and KT were known to be chronic misusers of alcohol. A routine post mortem examination was held and FL was found to have a hairline fracture of the skull which was not easily discernible. Around the time of the post mortem KT's sister informed police that KT had told her that she had thrown FL out of the motor home the evening prior to his death during a disagreement and that he had hit his head on the tarmac parking area.

2.2 Police and coroner's inquiries

Kent Police commenced a murder investigation and KT was arrested on suspicion of murder. She was charged with murder on 6 July 2011, and this was subsequently reduced to an offence of manslaughter. KT was on conditional bail while awaiting trial, which took place in June 2012. The trial was stopped following a change in the prosecution evidence, the jury was discharged and the judge entered a verdict of not guilty. As yet, no date has been fixed for the coroner's inquest

2.3 Family structure

Only FL, aged 43 and KT, aged 44, lived in the motor home. They met in January 2010 at a rehabilitation unit where they were receiving treatment following detoxification from alcohol. They began living together at KT's house in town B in Kent in May 2010. The house was sold in July 2010 when KT bought a motor home. Thereafter, the couple had a transient lifestyle, moving between caravan parks in Kent and Medway, and occasionally travelling more widely in England, spending a few weeks in area 3 (a large county) in August/September 2010. FL had two children who are in care. KT has two children who have lived with their father since the end of 2009.

Family background

- 2.3.1 FL described an abusive childhood. In 2002-3 he was living in area 4 (a large county) and was involved in an abusive relationship, which produced two children. He came to the attention of area 4 police on eight occasions for violence towards his partner. In February 2004 he was imprisoned for assault on her and criminal damage. A number of minor crimes followed between 2004 and 2009. In August 2009 FL was convicted in London for possession of an offensive weapon in a public place for which he received a suspended prison sentence and a one year community supervision order, with alcohol treatment requirement. KT reports that FL was homeless in London for many years. He was admitted to an alcohol detoxification unit for 2 weeks in January 2010 following which he moved to the rehabilitation unit.
- 2.3.2 FL's medical records stated that he had alcohol dependence syndrome with a family history of suicide of his sister and the death of his brother due to alcohol dependence.
- 2.3.3 KT describes an abusive childhood and a pattern of heavy drinking from the age of 17. She is educated to degree level and describes herself as suffering from depression throughout her adult life caused by her childhood abuse. She married in 1992 and had two children. She is described as drinking heavily during the marriage, which ended in separation in 2002, followed by divorce in 2004. In 2009 a child protection conference was convened due to concerns that her alcohol consumption was causing neglect of her children. They were made subject of child protection plans and subsequently moved to live with their father when KT was admitted to an alcohol detoxification unit in December 2009.
- 2.3.4 KT had been known to mental health services intermittently since 2005 due to concerns about alcohol misuse and depression, including an overdose.

2.4 Agencies' involvement with the couple

- 2.4.1 FL was under the supervision of London Probation when he met KT at an alcohol rehabilitation unit in January 2010. This supervision order with its Alcohol Treatment Requirement continued until August 2010. London Probation had worked effectively with FL on his alcohol misuse, securing his placements at the detoxification and rehabilitation units. FL was discharged from the rehabilitation unit on 18 March 2010 because he was not prepared to comply with his contract to avoid KT, and KT left on 23 April when she admitted to staff that she had breached the terms of her contract by maintaining contact with FL after his discharge. Following his discharge, London Probation staff only had one meeting with FL before his order

expired in August 2010.

- 2.4.2 Kent Police's first involvement in 2010 was in May when KT's ex husband reported that he was receiving nuisance calls from FL. A harassment warning was issued to FL in June.
- 2.4.3 Early in June 2010 both parties newly registered with the GP practice near KT's home in town B. FL was never seen by the practice and the GP had no knowledge of his history of domestic abuse (the practice did receive information about his history of alcohol dependency when his records were transferred in August). KT was seen by her GP when she registered. She admitted consuming huge quantities of alcohol, but made no mention of domestic abuse. This was the only occasion when her GP saw her.
- 2.4.4 On 19 June 2010 an ambulance and the police were called to KT's house. This is the first recorded instance of domestic abuse between the couple. FL and KT were fighting on the floor and both were intoxicated. They both had minor injuries. KT was taken to hospital 1 and FL was arrested for assault. Later, both denied hitting each other and KT refused to support a prosecution. The police completed a DASH risk assessment, which was categorised as 'medium'. The doctor that examined KT at hospital 1 took a full history and noted KT's intoxicated state. The doctor also noted that KT lived with her partner who had a history of violence but she 'did not have any problem with him'. There is no evidence that the hospital communicated with KT's GP, either directly or by giving KT a transfer letter.
- 2.4.5 On 25 June 2010 the police attended KT's address because FL was reported by a neighbour to be outside the house in possession of a kitchen knife, apparently drunk and arguing with KT. FL was arrested on suspicion of possessing an offensive weapon and was given a fixed penalty notice. KT denied that any domestic abuse had taken place so a DASH assessment was not completed.
- 2.4.6 On 8 July 2010 the police were called to KT's house because a neighbour reported sounds of a domestic dispute. Both had been drinking. FL was arrested because there were fears for KT's safety. She denied that anything more than a verbal dispute had occurred. No charge or prosecution followed and the DASH assessment was categorised as 'medium' risk.
- 2.4.7 On 7 August 2010 Kent police were contacted by KT's sister because FL and KT had visited a caravan site in town C where the sister was staying with KT's children. KT was prohibited from unsupervised contact with her children. FL and KT were ejected from the site and the police notified

Children's Social Services of the incident.

- 2.4.8 On 18 August 2010 police in area 3 (a large county) were called to a caravan park where a 'very loud' argument had taken place between the couple. Both were intoxicated but no offences were disclosed. The DASH risk assessment was initially set at 'medium', but later reduced to 'standard'.
- 2.4.9 On 10 September 2010 area 3 police were called to a different caravan site following an argument between the couple after FL began causing damage to the motor home. FL sustained an injury from broken glass and was taken to hospital 2 for treatment under arrest. KT refused to make a complaint against FL saying he had mental health problems. KT declined to have her details passed onto the domestic violence unit or women's aid. FL was charged and received a conditional discharge at a magistrates' court in area 3. The DASH assessment was 'medium'.
- 2.4.10 On 20 October 2010 KT called an ambulance to a caravan park in town C in Kent due to FL's disturbed behaviour which included cutting his hand with a knife. Kent Police also attended. FL was taken to hospital 3 and was seen by a psychiatric liaison nurse with KT present. He described night terrors related to abuse he had suffered as a child, the terrors were increasing in intensity and frequency, resulting in disturbed sleep and distressed episodes when he 'smashed up' KT's motor home. He reported drinking 67 units of alcohol per day. The nurse contacted the liaison psychiatric service at a London hospital for background risk assessment and was aware of FL's long term alcohol misuse and history of violence, including domestic abuse. The crisis team prescribed medication to aid sleep and advised FL to contact his GP, specialist alcohol services and community mental health services.
- 2.4.11 On 25 December 2010 KT was drinking alone in a pub in town D when she became verbally abusive and damaged a door. Kent Police were called and she was arrested and given a formal caution.
- 2.4.12 On 1 January 2011 Kent Police were called to a caravan site in town A because a resident had seen FL put his hands around KT's neck and also harm a dog. FL, who was intoxicated, was arrested for assault on KT and cruelty to an animal. Initially, KT refused to speak to the police officers, but later attended the police station in town E when she made a statement which detailed previous incidents of domestic abuse, including several incidents of strangulation by FL and being hit over the head with a saucepan. She said he was frequently verbally abusive, often damaged the motor home and kicked the dog frequently. She acknowledged that they were both alcohol dependent and stated that FL suffered from paranoid schizophrenia (there is no record of this diagnosis in medical reports). She told a police officer from

the domestic abuse unit that she and FL checked each other every morning to see what injuries they might have sustained the previous day. The police officer advised her to take positive action because if the couple carried on as they were, then one of them would end up killing the other. FL was arrested and held in custody. The police requested an assessment of FL by the Mental Health Crisis Team, but they were not able to respond due to staffing levels on a bank holiday. The DASH risk assessment completed by the police was 'medium' risk.

- 2.4.13 FL appeared at a magistrates' court on 5 January 2011 and pleaded guilty to causing intentional harassment and alarm against KT from 1/12/10 to 1/1/11. A pre sentence report was requested from Kent Probation.
- 2.4.14 KT attended the minor injuries unit at hospital 3 on 9 January 2011 for treatment for a knee injury. She was seen by a GP from the out of hours service who was concerned about possible alcoholic liver disease, which would need a review by KT's GP, but there is no evidence that this attendance was communicated to her GP.
- 2.4.15 On 26 January 2011 KCA (a community addiction service) completed a triage assessment of FL and advised Kent Probation that he was suitable for an alcohol treatment rehabilitation (ATR) order and recommended that he should attend C1's programme twice a week. On the same day a probation officer based in town A prepared a pre-sentence report. She also completed the Spousal Assault Risk Assessment (SARA). FL was assessed as posing 'medium' risk of harm to his partner. The case was placed at tier 3 indicating the purpose of interventions to be punishment, help and change. The pre-sentence report outline sentence plan proposed that intervention should focus on addressing partner abuse, alcohol misuse, difficulties coping, and education, employment and training.
- 2.4.16 FL was sentenced to a two year community order at town A magistrates' court on 27 January 2011. The order had the 3 requirements proposed in the pre-sentence report. The case was allocated to a probation officer based in town E, where the couple were now staying.
- 2.4.17 On 7 February 2011 KT went to town E police station and reported that FL had caused damage to her motor home the previous day following an altercation. FL was arrested and charged with causing criminal damage and was subsequently fined at a magistrates' court. In her interview with Kent police KT denied any previous incidents of strangulation. The DASH assessment completed by the police was initially categorised as 'medium' risk but later downgraded to 'standard'.

- 2.4.18 FL's probation officer referred KT to a Women's Safety Worker (WSW) on 8 February. The worker never managed to make contact with KT, partly due to KT's transient lifestyle.
- 2.4.19 On 14 February 2011 both FL and KT made threats to the owner of a caravan park near town E. The police record states that it was dealt with as a civil dispute.
- 2.4.20 During February 2011 FL reported to his probation officer on three occasions and missed two appointments. It was confirmed that FL would not attend the integrated domestic abuse programme (IDAP) until his alcohol misuse had stabilised through the treatment order. FL missed his first assessment meeting with KCA but did attend on 23 February 2011, when it was agreed that his alcohol treatment order would commence on 1 March 2011. At his assessment FL was advised to seek medical attention due to concerns about his physical health and possible liver damage.
- 2.4.21 During March 2011 FL attended KCA sessions on seven occasions and missed three, once because KT reported that he was still under the influence of alcohol and had 'smashed up' her motor home. KCA staff discussed him at a case review meeting, as they were concerned about observed alcohol withdrawal symptoms and they decided to refer him for detoxification.
- 2.4.22 FL reported to his probation officer on three occasions in March 2011, and missed once due to a family funeral. As the couple had moved to town C the case was transferred to the nearest offender management unit in town A and allocated to the officer that had completed the pre-sentence report. The manager at this offender management unit had been reluctant to accept the transfer as FL was living with the victim of his domestic abuse. The matter was referred to a senior manager who concluded that Kent Probation was powerless to control where FL lived because he was subject to a community order not a licence, and it was acknowledged that KT wanted him to live with her.
- 2.4.23 On 1 April 2011 KT's sister called the police to her caravan in town C because KT had turned up there in a drunken and abusive state. The police escorted KT from the site and took her home. The DASH assessment was graded as 'standard'. The next day the police attended an incident in town C when both FL and KT were drunk. FL was lying in the street and suffering from a number of visible injuries, allegedly caused in a fight with a man.
- 2.4.24 In April 2011 FL attended six sessions at KCA. In two sessions he was unwell and the staff were concerned about his health so they scheduled an appointment with CRI (another community addiction service) for

detoxification assessment. He missed two sessions with KCA and his appointment with CRI.

- 2.4.25 FL reported to his probation officer on two occasions in April 2011.
- 2.4.26 In early May 2011 the couple moved to a caravan site at town D. The police were called there on 8 May when FL had a bleeding nose following an altercation and assault by KT. She was arrested and admitted the assault. FL refused to support a prosecution and she subsequently received a caution. The DASH assessment was 'medium' risk. KT was assessed in police custody by a forensic nurse practitioner (a police employed custody nurse) due to self reported mental health problems and her history of self harm. The assessment ruled out mental illness and concluded that alcohol intoxication was the cause. KT reported that she was drinking a litre of vodka per day. She was not deemed to pose any immediate risk to herself or others. The custody nurse did focus on the effect of alcohol misuse on KT and advised her to see her GP about it. There is no evidence that this assessment was shared with KT's GP, nor is there a record that the custody nurse discussed domestic abuse with KT.
- 2.4.27 In May 2011 FL attended five sessions at KCA and missed four. He attended three assessment appointments with CRI and was deemed to be suitable for detoxification. KT also attended two assessment appointments with CRI for her own detoxification. CRI staff were not aware of the abusive relationship between the couple. KT was then seen by a Kent Adult Services care manager regarding funding of residential rehabilitation after the detoxification. He agreed with KT that she needed to engage actively with community treatment services before residential services could be considered. He was not aware of the domestic abuse.
- 2.4.28 In May 2011 FL reported to his probation officer on only one occasion. KT rang the probation officer to tell her that she had assaulted FL, and the probation officer contacted the police for more details.
- 2.4.29 Between 26 May and 23 June 2011 FL did not attend any sessions at KCA or report to his probation officer. Occasionally, KT made contact with them explaining his non attendance – either due to ill health or having to move caravan sites. On 10 June 2011 C1 discussed at a case review their concerns about FL's non attendance and frequent calls from KT that he was unwell. They notified his probation officer. Neither KT nor FL made any contact with CRI regarding detoxification during this period despite CRI staff making efforts to contact them.

- 2.4.30 On 21 June 2011 the couple moved to a caravan park at town F in Kent. On 22 June FL's probation officer discussed his numerous absences with her senior. She was advised to reiterate to him requirements of reporting and to consider breach if he did not engage. She was also advised to contact the police domestic abuse unit to discuss a possible MARAC referral.
- 2.4.31 On 23 June 2011 FL attended KCA and had a three way meeting, which included his probation officer. It was agreed that FL was to present medical certificates if he had any more absences. He was described as very shaky. On the same day FL's probation officer contacted the police domestic abuse unit to raise concerns about his volatile relationship with KT. She states that the call was not returned.
- 2.4.32 On 27 June 2011 the couple left town F and moved to a car park in town A. The owner of the town F site witnessed them having an altercation and stated that FL looked drunk or drugged. The police were not called. Later that day, the incident that caused FL's death occurred.

3 ANALYSIS

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

- 3.1.1 Generally, practitioners were sensitive to the needs of both parties as alcohol dependent adults involved in a volatile co-dependent relationship. Kent police officers were knowledgeable about potential indicators of domestic violence as were Kent probation officers. The police were proactive in their efforts to protect both parties. However, there appeared to be a lack of clarity about MARAC processes among Kent Probation staff. Among Health staff there was little understanding that a history and presenting symptoms of depression and excessive alcohol use might be linked with domestic abuse. However, EKHUFT front line staff were sensitive to domestic abuse when it was disclosed by KT, but she denied it was a problem. Accident and emergency staff and psychiatric liaison staff employed by KMPT had limited knowledge about potential indicators of domestic abuse and limited awareness about how to respond. Both agencies indicated in their independent management reports the need for awareness raising and training in this area. KCA staff indicated that they had varying degrees of knowledge on domestic abuse, and the KCA independent

management report also indicated the need for improved training in this area. The couple's GP and CRI had no knowledge that they were engaged in an abusive relationship.

3.2 Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used in the case of this victim/ perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

3.2.1 In this case, both FL and KT were victim and perpetrator of domestic violence before FL's death. Kent Police has policies and procedures for (DASH) risk assessment and risk management for victims and perpetrators of domestic violence that are described by the IMR author as generally well understood by staff involved in this case. There were six DASH assessments by Kent police officers, which were all 'medium' risk apart from one of 'standard'; this was inconsistent and appears to have been graded without knowledge of previous incidents. As individual occurrences, these gradings appear appropriate. However, it is probable that the information KT gave to a police officer from the domestic abuse unit at the beginning of January 2011 as part of her follow up to the incident of strangulation on 1 January warranted an upgrade to 'high'. This was the only occasion when KT spoke openly about the level of violence in their relationship and described strangulation by FL on many occasions. This escalation of violence, together with excessive alcohol use by both parties, alongside a volatile relationship, would appear to increase the risk of serious harm. Neither party was subject to a MARAC as only cases graded 'high' in the DASH model are referred to MARAC.

3.2.2 London Probation did not undertake a Spousal Assault Risk Assessment (SARA) on FL when his pre sentence report was prepared in August 2009 because the index offence was not of domestic abuse and, at that time, he did not have a partner. However, as FL had a history of perpetrating domestic abuse, a SARA should have been triggered. Had the assessment been undertaken, it might have improved London Probation's approach to managing FL when new information came to light in May 2010 that he was living with KT. Also, the OASys risk assessment was not updated when significant events occurred – eg FL starting a relationship within the rehabilitation unit; when London Probation was informed that FL had moved out of London and was living with a woman in Kent.

- 3.2.3 Kent Probation prepared a standard delivery pre-sentence report on FL in January 2011, as required in all domestic abuse cases. This enabled a full Offender Assessment System (OASys) risk assessment to be undertaken, which triggered the Spousal Assault Risk Assessment (SARA). The assessments concluded that KT was at 'medium' risk of harm from FL. However, the SARA was incomplete, and the risk management plan did not reflect the risks associated with FL continuing to live with KT. Also, the OASys risk assessment was not updated as events unfolded (eg KT's assault on FL in May 2011).
- 3.2.4 KMPT has no policies and procedures for (DASH) risk assessment, although the risk assessment tools in the Care Management Approach address all categories of abuse, including domestic abuse. KMPT acknowledged in its IMR that a more robust approach to domestic abuse is required.
- 3.2.5 There is no evidence that DASH assessment tools were in use or expected to be used in EKHUFT. However, the IMR does state that there are clear procedures for referral to MARAC if staff suspect domestic abuse, but consent of the victim is required. This is a misunderstanding.
- 3.2.6 KCA has robust policies and procedures that are described as well understood by staff and include DASH assessment and MARAC referral process. However, in this case, with the information available at the time, these were not considered to be necessary.

3.3 Did the agency comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?

- 3.3.1 Area 3 police did not share information about the two incidents in their area with Kent police although they were aware that previous domestic abuse related offences had occurred in Kent. There is no evidence within the Health IMRs that agencies complied with the Kent and Medway information sharing protocols.

3.4 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?

- 3.4.1 Before FL's admission to the rehabilitation unit in January 2010, his engagement with London Probation had been positive, and the intervention to address his alcohol misuse was appropriate and effective. However, following his discharge from the unit in mid March, opportunities were lost to update the risks he posed to the community and specifically to KT, as London Probation Trust knew that he had started a new relationship. By May

it was known that he was living with KT and by June it was known that he had relapsed into alcohol misuse. However, the failure to review OASys and the inadequate assessment of FL's domestic abuse offending prevented other risk management strategies being considered by London Probation – ie MAPPA, possibly MARAC, and transfer to Kent Probation. There was an opportunity for London Probation to take enforcement action against FL when he left the rehabilitation unit with no fixed abode. Attempts to breach him were not followed through. While enforcing the order quickly may not have reduced the risk of harm, it is significant that there were three incidents of domestic abuse between the couple in June/July 2010 when FL's order was not being enforced.

- 3.4.2 Between June and December 2010, there were three DASH risk assessments by Kent police and all were categorised as 'medium', which was appropriate. At another incident, police officers did not complete a DASH assessment because KT refused to answer questions. However, they issued a penalty notice for disorder (PND) to FL, which enabled the incident to be registered on police records. Area 3 police made two DASH assessments in September 2010, categorised as 'standard' and charged FL with criminal damage to the motor home for which he received a conditional discharge.
- 3.4.3 During the same period, there were opportunities for assessment by health professionals. The couple's GP did not follow up on background information (of longstanding alcohol dependency by both parties and KT's history of depression) and assess their health needs. At KT's presentation in June 2010 to hospital 1 Accident and Emergency with an injury caused by domestic violence, there was a limited assessment of the nature of the abuse. However, KT was adamant that she did not have 'any problem' living with a partner with a history of violence. In October 2010, FL was taken to hospital 3 Accident and Emergency due to disturbed behaviour. He was appropriately referred to the A&E liaison psychiatric service provided by KMPT. FL recognised that his problems of night terrors and agitation related to childhood abuse and to his long term alcohol abuse and that he required help to address it. The couple spoke of their abusive relationship, but no full assessment was made, which was a missed opportunity.
- 3.4.4 In 2011, there was increased professional involvement with FL, as he became subject to the supervision of Kent Probation, with a requirement for alcohol treatment rehabilitation by KCA. This followed an incident on 1 January 2011 of violence to KT (strangulation) and to their dog for which FL was charged with common assault and harassment. This was a significant event, as KT cooperated with the police investigation and, in her follow up interview with a police officer from the domestic abuse unit (DAU), KT spoke

openly for the first and only time about the level of violence in their relationship, including previous incidents of strangulation by FL. She spoke of their alcohol dependency, mental health problems and social isolation and made worrying remarks about the couple checking each other for injuries each morning and FL stating that 'he would die for her'. However, she was adamant that she was not frightened of FL and wished to continue their relationship. The DASH assessment following the incident on 1 January was graded as 'medium', but it is unclear if this took account of the information given to the DAU officer. It would have been more appropriate to assess the risks as 'high', given the escalation in violence and the background information provided by KT. This would have resulted in a MARAC and possibly a proactive multi agency approach to address escalating domestic violence.

- 3.4.5 The Kent Probation assessment of FL identified him as a perpetrator of domestic abuse, in which alcohol misuse was a major factor. He had no formal diagnosis of mental illness but had paranoid feelings and heard voices. He was assessed as a 'medium' risk to KT but this assessment does not appear to have addressed the risk if they lived together. The risk management plan included community alcohol treatment and engagement in an integrated domestic abuse programme, and it was appropriately agreed that the latter would not begin until progress had been made with alcohol treatment. The plan included the contingency that the case would be referred to MARAC if FL reoffended. There were several opportunities for Kent Probation to update the risk assessment (when the couple moved to a different area, when FL reoffended in February and was charged with criminal damage to KT's motor home, when KT assaulted FL in May, when FL failed to report to his probation officer on many occasions) but these opportunities were not taken. Finally, on 23 June 2011 the probation officer contacted the police DAU to discuss her concerns about the couple's volatile relationship and the possibility of convening a MARAC, leaving a message, which was not responded to before FL's death.
- 3.4.6 Between February and May 2011, Kent Police had several dealings with the couple, resulting in three more DASH assessments. In February, KT attended a police station to report that FL had damaged her motor home. She now denied any previous incidents of strangulation and was clear that she was not afraid of FL. It was positive that KT voluntarily reported this incident and does suggest her acceptance of continued domestic problems, and the police response was positive in arresting and charging FL. However, the DASH assessment was downgraded to 'standard'; this was because the officer looked at this incident in isolation. In April, KT went to her sister's caravan and was abusive. This was rightly assessed as 'standard', as the risks to her sister were minimal. However, it was indicative of KT's continued

dysfunctional lifestyle. The last incident reported to the police before FL's death was in May when KT was arrested for punching FL following alleged verbal abuse. KT was arrested and subsequently received a caution; FL was very opposed to her being prosecuted. The DASH assessment was 'medium', which was correct for this incident, but it does raise the question of whether a threshold should be set whereby following a number of DASH assessments in a specified period a senior police officer reviews the case. For this couple, six DASH assessments had been made by Kent Police in a period of twelve months, as well as two by area 3 Police.

- 3.4.7 Between January and June 2011, there were three opportunities for assessment by health professionals. On 1 January the police requested an assessment of FL by the Mental Health Crisis Team FL, but they could not respond due to staffing levels on a bank holiday. On 9 January KT attended a minor injuries unit due to swelling to her knee. There is no indication of the nature of the injury. The out of hours GP considered that KT should be reviewed by her own GP for possible liver disease. There is no evidence that a written notification was made to KT's GP in this instance or in any other of the instances when KT and FL were seen by A&E staff, including psychiatric liaison staff. This was an omission given the vulnerability of both parties. In May 2011 KT was seen by a forensic nurse practitioner (a police employed custody nurse) at a police station following the assault on FL. The focus was on alcohol consumption and its effect on KT, and the opportunity was missed to discuss domestic abuse, especially as KT was alone. The liaison nurse assessed that there was no evidence of mental illness and that KT posed no risk to herself or others. She was advised to see her GP about alcohol misuse.
- 3.4.8 KCA was the agency that saw FL most frequently between February and June 2011 (on over twenty occasions). Its staff assessed in January that he was suitable for a community treatment package as he appeared physically well at that time. In February a comprehensive assessment was completed that identified as concerns FL's physical health, his history as a domestic abuse perpetrator, and sexual abuse as a child. A major concern was the rapid escalation of his alcohol use to approximately 60 units per day. Due to this level of consumption and concerns about its impact on his physical health, a referral was made to CRI for assessment for an alcohol detoxification. KCA staff often saw physical evidence of fights, and the IMR report writer comments that more information should have been gathered about these injuries to inform an assessment of whether FL was a victim as well as a perpetrator of domestic abuse.
- 3.4.9 CRI assessed both FL and KT (who referred herself) during May 2011. Both were assessed as suitable for detoxification and processes were put in place

to obtain funding. However, both disengaged with CRI during June so no further action took place. KT had been seen by a Kent Adult Services care manager in May who had concluded that she was not ready for residential rehabilitation as she showed no evidence of engagement with community treatment services. It is recorded that KT agreed with this assessment. Neither the CRI staff nor the care manager knew of the couple's abusive relationship.

3.5 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?

3.5.1 Kent police's actions were focussed on protecting the victim when they were called to incidents of domestic abuse. To this end, they removed the alleged perpetrator of the abuse from the incident, whenever possible, and brought charges when they had evidence to do so. Their efforts were hampered by both parties' reluctance to press charges and by their determination to remain living together. After each incident an officer from the domestic abuse unit contacted KT (and FL after the May 2011 incident) to offer advice and support but neither party was interested. Likewise, area 3 police arrested FL and brought charges but KT refused offers of support for herself. This police force also paid attention to protection of the public by removing the keys to the motor home for a short period in an attempt to prevent them from driving while intoxicated.

3.5.2 There is no evidence that health professionals took account of the risks associated with the couple's abusive relationship in their actions. At the time of KT's admission to A&E in June 2010 there was physical and disclosure evidence of domestic abuse, but no evidence of this being taken into account when the decision was made to discharge KT. At the psychiatric assessment of FL in October 2010, the couple spoke of their abusive relationship but there was no follow through, and no advice, support or signposting were given. Staff could have addressed concerns with the local public protection units and could have discussed concerns with the safeguarding leads within KMPT. A similar response occurred when KT saw the forensic nurse practitioner in May 2011. Although aware that KT was in custody for domestic abuse, there was no attempt to address this. Also, the nurse does not appear to have obtained access to KT's health records as her assessment of KT's mental health makes no reference to her past depression.

3.5.3 The level of service offered by KCA was adequate, but could have been improved by addressing more proactively FL's deteriorating physical health

and by some engagement with KT, given that she was in regular contact by phone to explain some of FL's absences and was seen waiting outside the KCA office with alcoholic drinks for him.

- 3.5.4 London Probation worked effectively with FL to address his alcohol misuse until March 2010. Thereafter, inadequate risk assessment and ineffective enforcement action meant that the risks that he posed to KT were not addressed.
- 3.5.5 Kent Probation put in place a risk management plan to address FL's alcohol misuse before addressing the other elements of the plan (integrated domestic abuse programme, training and employment, and housing). There was a requirement for FL to report to his probation officer weekly for the first sixteen weeks. The plan was to be multi-agency involving the police domestic abuse unit, KCA, community mental health team and a women's support worker for KT. For the first month FL was considered to have engaged well. Thereafter, and following transfer to a different area, his reporting to his probation officer was sporadic. KT had frequent contact with the probation officer explaining FL's absences and expressing her concern about his health and her wish to support him. Although the plan was intended to be multi-agency, Kent Probation did not take the initiative to convene a meeting of key agencies (notably KCA and the police DAU) to share information and develop a coordinated approach. Nor did Kent Probation take enforcement action when FL failed to comply with reporting requirements. This was because his absences were explained by poor health and excessive drinking. However, no medical evidence was provided by FL. The women's support worker failed to make contact with KT, partly because of KT's itinerant lifestyle.

3.6 Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of both parties? Was consideration for vulnerability and disability necessary?

- 3.6.1 There is no direct reference to ethnic, cultural, religious or gender identity in the NHS IMRs, and there is limited reference in the other IMRs. The couple were white British. The KCA report highlights that FL's maleness might have affected the workers' ability to view him as a potential victim when they noticed injuries. All IMRs refer to the couple's vulnerability due to their excessive alcohol consumption, their itinerant lifestyle and their social isolation. Neither was disabled, although FL's physical health was deteriorating.
- 3.6.2 Although the male partner died, gender was not considered a significant issue. Throughout the 13 months when agencies in Kent were involved with

the couple, KT was identified as the 'victim' even though she would probably not have described herself in this way.

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

- 3.7.1 All Kent police DASH assessments were reviewed by the public protection unit. There is no evidence that managerial oversight was sought by NHS staff in any of their interactions with the couple nor did they consult with safeguarding leads. Senior Kent Probation staff were involved on two occasions; firstly, at the point of transfer to a new area in March 2011 when the new area's manager was concerned about the risks to KT by continuing to live with FL in her motor home. It was concluded that the supervision order did not give Kent Probation the power to determine where FL should live, so the supervision of FL should focus on managing the risk. The second occasion was when the probation officer notified her supervisor on 22 June 2011 of FL's numerous failures to report to her. She was advised to reiterate reporting requirements, request medical evidence for any future failure to report and consider breach if there was further non-engagement. She was also advised to consult with the police DAU about a possible MARAC referral. The KCA manager was well aware of FL and his sporadic attendance and deteriorating health, as he was regularly discussed in team meetings.
- 3.7.2 Kent Police made appropriate referrals for psychiatric assessments of both FL and KT when they were in custody, and EKHUFT staff referred FL to the A&E psychiatric liaison service. The latter appropriately contacted a London hospital for background information on FL. There was evidence of good practice by Kent police in making swift and appropriate contact with Children's Social Services after incidents. Even though KT's children were not living with the couple, it was recognised that there were potential child protection issues.
- 3.7.3 There was a lack of information exchange between the rehabilitation unit and London Probation, and London Probation should have been more proactive and clearer on how it intended to maintain contact with FL while he was in the unit. London Probation should have been more proactive in identifying where FL was living once it was known that he was living with KT and in making contact with Kent Probation and Kent police domestic abuse unit. Within London Probation there was some management oversight of the case, but it did not focus on risk management and relevant decision making. In particular, stronger management oversight would have been beneficial at the time when enforcement of the order was indicated.

3.7.4 Liaison between Kent Probation and KCA was not as proactive as it might have been. Despite notification of FL's sporadic attendance at his alcohol treatment programme, which was a requirement of his supervision order, there was no evidence of direct contact between the probation officer and KCA until 23 June when a three way meeting took place involving FL. A more coordinated approach between the police domestic abuse unit, probation and KCA was indicated in this case. Even if the case was not deemed to meet the criteria for a MARAC, a meeting could have been convened as part of FL's supervision order.

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

3.8.1 None were highlighted in the IMRs apart from London Probation's success in engaging FL in addressing his longstanding alcohol misuse, culminating in detoxification and placement at a residential rehabilitation unit. Sadly, this progress was short lived. However, the good practice by Kent Police in considering child protection issues in domestic abuse incidents, even when the children of KT and FL lived elsewhere, is to be commended.

3.9 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 risk 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?

3.9.1 These issues are addressed in section 4.

3.10 How accessible were the services for both parties?

3.10.1 Due to their transient lifestyle, there was little consistency in the way the couple engaged with health services. Accessing the ambulance service and A&E and psychiatric assessment did not appear to be an issue. However, once there was access to the services, the necessary and appropriate assessments and treatments could have been improved. There was no feedback to their GP despite the couple's acknowledged vulnerability, and there was signposting by health professionals to community services without taking account of the couple's intoxicated state at the time.

3.10.2 The alcohol treatment services of both KCA and CRI were accessible to the couple, but their attendance was erratic due to their lifestyle.

3.10.3 Domestic abuse support services were offered to the couple but KT was adamant that she did not wish to take them up, and FL was correctly assessed as being unable to benefit from a domestic abuse programme until his alcohol misuse had been addressed. Kent Probation allocated a women's support worker to KT. She did not manage to make contact with KT, but it is unlikely that KT would have engaged with this service. Neither party considered themselves a victim of domestic abuse.

3.11 To what degree could the homicide have been accurately predicted and prevented?

3.11.1 FL and KT were in a dysfunctional volatile relationship in which both were known to be violent. Their excessive alcohol consumption contributed to the verbal and physical abuse, and FL was known to have paranoid feelings and to hear voices, although he did not have a formal diagnosis of mental illness. KT had a history of depression and both had suffered abuse in their childhoods. FL had a history of violence including domestic abuse, while KT's violence appears to have been limited to this relationship. They had additional stress factors of social isolation and leading a transient lifestyle in a motor home. In the light of all these factors, escalating violence could have been predicted, with either party being a victim.

3.11.2 The couple were in a co-dependent relationship, and denied, for the most part, the level of abuse in their relationship and were determined to remain together. Therefore, prevention of escalating violence was very difficult. While a more coordinated inter-agency approach would have been desirable, it is unlikely to have prevented escalating violence unless the couple were ready to address their alcohol dependency or unless they were forcibly separated from each other. Both London and Kent Probation had grounds to breach FL but had they done so, it is unlikely that he would have received a custodial sentence.

4 LESSONS LEARNED FROM THE REVIEW

- 4.1 There was variable knowledge across agencies about the domestic homicide review process and its statutory nature.
- 4.2 There were differing levels of knowledge across agencies about potential indicators of domestic abuse and awareness of the actions to be taken if there were concerns. There was limited consultation with safeguarding/domestic violence leads in NHS Trusts or with the police public protection unit.
- 4.3 There was a lack of consistency in the use of DASH victim centred risk assessment; NHS staff did not use it at all; the police used it appropriately but did not always consider historical information and its cumulative impact. Probation staff used a different offender centred risk assessment tool for cases of domestic abuse, but did not complete it fully or update as circumstances changed.
- 4.4 There was a lack of clarity in most agencies about the referral process for MARAC. The threshold for MARAC was also an issue. Only cases assessed as high risk in the DASH model are referred to MARAC, whereas cases such as this where there are several risk factors would benefit from a MARAC. This is likely to have resource implications for all agencies.
- 4.5 Probation practice lacked rigour in use of Spousal Assault Risk Assessment, in updating risk assessments, and in enforcing orders when there was lack of compliance.
- 4.6 A coordinated approach, initially across the three agencies most closely involved (Kent Police, Kent Probation, and KCA), would have improved information sharing and possibly improved intervention with the couple. Such an approach is particularly indicated when alcohol or drug misuse is a feature of domestic abuse.
- 4.7 It is difficult to intervene effectively with a couple engaged in an abusive relationship whose lifestyle is transient; eg Kent Police were not notified of domestic abuse perpetrated in area 3 so their assessment was not based on all the available information, while A&E assessments were not communicated to the couple's GP.
- 4.8 When both partners in an abusive relationship are misusing alcohol and minimise the severity of the abuse because they wish to remain together, an approach that includes home visits and engagement of both partners together could improve the quality of assessment and intervention. In this case Kent probation and KCA were quite reasonably working with FL as he was subject to the supervision and alcohol treatment rehabilitation order,

while the key issue was the couple's mutual abuse of alcohol and its effect on their volatile and mutually abusive relationship. Accredited toolkits (eg by STELLA project) for working with cases which feature both domestic abuse and alcohol misuse were not used in this case.

5 CONCLUSIONS

- 5.1 This review has identified a number of ways in which practice within and between agencies could be improved. In particular, it has highlighted the need for better information sharing and more integrated working between agencies involved with a couple whose relationship is abusive and violent.
- 5.2 It has also identified the need for awareness raising and training of front line staff in indicators of domestic abuse, DASH assessment skills, and the MARAC process.
- 5.3 A number of services were available to assist the couple to address their abusive relationship and their alcohol dependency. However, neither party was motivated to access these services or engage with them in a meaningful way. In these circumstances, it is difficult to conclude that escalating domestic abuse and FL's death could have been prevented. It is clear, however, that there are ways in which services to couples similar to FL and KT can be improved. All agencies made recommendations in their management reviews, not all of which are listed below. These overview recommendations are designed to ensure that the key lessons from this review are addressed. The recommendations have been collated into an action plan agreed by senior managers of the relevant agencies.

6 RECOMMENDATIONS

- 6.1 NHS Kent and Medway/Clinical Commissioning Groups to ensure that all health providers and GPs understand and respond to statutory guidelines, best practice and local policy and procedures for domestic abuse.
- 6.2 NHS Kent and Medway/ Clinical Commissioning Groups, to ensure that all health organisations, including providers and GPs, understand and meet their statutory responsibilities towards domestic homicide reviews.
- 6.3 NHS Kent and Medway/Clinical Commissioning Groups to request NHS providers to identify leads in domestic abuse within each organisation and develop a domestic abuse strategy to include responsibilities and accountabilities from Board level to individual staff.

- 6.4 NHS Kent and Medway/Clinical Commissioning Groups to request NHS providers to develop and initiate a domestic abuse training strategy, and to request GP practices to undertake basic domestic abuse awareness training.
- 6.5 Kent and Medway Community Safety Partnership to ask all member agencies to ensure that their frontline staff understand the MARAC referral process, including issues of consent.
- 6.6 When six DASH assessments have been graded 'medium' or 'standard' in a rolling 12 months period, Kent police should review the case and consider referral to the Public Protection Unit as High Risk case.
- 6.7 When conducting risk assessments, in addition to the DASH process, Kent police should take into account past information and intelligence data.
- 6.8 Kent and London Probation to ensure that in cases of domestic abuse Spousal Assault Risk Assessments (SARAs) are completed to a consistently high standard, that risk assessments are kept under review, and orders are enforced rigorously.
- 6.9 Kent Probation to ensure that other relevant agencies are fully involved in risk assessment and risk management of domestic abuse cases.
- 6.10 Kent Probation and substance misuse services to ensure that there is closer liaison and more rigorous application of compliance with alcohol treatment orders.
- 6.11 Kent and Medway DAATs to ensure that agencies that support and treat individuals with substance misuse issues are aware of domestic abuse toolkits, eg STELLA project toolkit, and use them appropriately.

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October 2012