

Domestic Homicide Review

**Connie
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 Connie Smith, who lived in Area A, Kent prior to her death in August 2018.

1.2 Connie 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 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 in November 2018.

1.4 On the evening of her death, Connie was at home with her two-year-old child (Child B) and her ex-partner Ryan Davis. As a result of a 999 call made by Ryan, paramedics attended there. He had reported that Connie had hanged herself. Paramedics confirmed that she was in cardiac arrest and despite full advanced life support being administered, Connie was declared dead.

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

1. establish what lessons are to be learned from Connie's 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 abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
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 MAR Panel members. The pseudonyms were discussed when the Independent Chair met Connie's mother (see section 4 below) and she agreed they were suitable. The District of Kent where Connie lived is referred to as Area A.

2. Terms of Reference

- 2.1 The Review Panel met first on 13th December 2018 to consider 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.
- 2.2 A start date of January 2015 was chosen for the review. This takes into consideration the understanding that Connie and Ryan began their relationship in August 2015 and an appropriate balance between encompassing relevant agency involvement with Connie and making recommendations that are appropriate to current policies, procedures and practices.

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 Connie. 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 Connie 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 Connie Smith
Ann Smith	Mother
Martin Smith	Father
Child B	Biological child (infant)

Name	Relationship to Connie Smith
Child A	Biological child
Rose Smith	Sister
Michael Smith	Brother

- 4.2 At the time of Connie's death, Child A was living with their father, Connie's previous partner.
- 4.3 In January 2019, the Independent Chairman wrote to Connie's mother and father, explaining that a MAR was being conducted. He offered to meet each of them following the completion of the police investigation into Connie's death, to discuss the review and to listen to their thoughts and concerns. The same offer was made subsequently to child A's father.
- 4.4 The Independent Chairman met with Connie's mother, Ann Smith, in October 2019. He described the purpose and methodology of the review. He then explained the findings, including the conclusions, lessons identified and the recommendations. Ann was able to provide valuable insight into Connie's life, details of which have been included in this report.
- 4.5 At a later date, the potential of involving Ryan, Connie's ex-partner, in the review was discussed with Ann. It was felt that this would not be appropriate or constructive as he did not take an active part in engagement with social services, would often lay blame on Connie and did not accept any blame himself. This is further confirmed by the Kent, Surrey, Sussex Community Rehabilitation Company (KSSCRC) records that show that through Ryan recognised his abusive behaviour, he minimised his responsibility and continued to blame Connie.
- 4.6 A copy of the Home Office DHR leaflet for family members was sent to Ann Smith by the Independent Chairman who explained that it was originally written for family members of homicide victims. The availability of independent advocacy services was also highlighted.
- 4.7 The final draft of this report was shared with Ann Smith on 6th April 2020. She commented that it was a good report that understood her daughter despite the author having never met her. She raised concerns around the social work service provision where work was put on hold and also feeling there was a bias against her daughter. This was raised with the agency who confirmed they would be following their usual practice of undertaking supervision discussions with those involved in the case and would include Ann's thoughts. Points regarding KSSCRC's involvement were also discussed, and arrangements were made to provide further information to Ann in relation to a number of issues which are

covered in Section 11.4. These were; use of Integrated Domestic Abuse Programmes (IDAP) over anger management programmes, drug testing, home visits and the balancing of a service user's conflicting employment, curfew and appointment times.

5. Contributing Organisations

5.1 Each of the following organisations submitted an IMR:

- Kent Police (including Area A Multi-Agency Risk Assessment Conference)
- Kent, Surrey & Sussex Community Rehabilitation Company
- Centra (Domestic Abuse Service)
- GP Practice A (Connie's GP) *
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Community Health NHS Foundation Trust
- Area A NHS Trust*
- South East Coast Ambulance Service NHS Foundation Trust
- Kent County Council Integrated Children's Services

** To protect the anonymity of Connie, her GP practice and the NHS Hospital Trust covering Area A are not named.*

5.2 In addition to the IMRs, the Independent Chairman conducted an interview with a senior representative of Connie's local social housing provider of the house in which Connie lived. Their involvement became known after the Terms of References were originally set and IMR requests had already been issued. Therefore, in order to progress the review, following the interview the Independent Chairman completed a report, which was considered by the MAR Panel.

5.3 Kent County Council Adult Social Care and Health submitted a report to the review. Its involvement was peripheral and is not subject of further consideration in this report.

6. Review Panel Members

6.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Connie and/or contact with Ryan. The panel also consisted of a senior member of Kent County Council Community Safety Team and an independent domestic abuse advisor.

6.2 The members of the panel were:

Name	Organisation	Job Title
Claire Axon-Peters	Kent & Medway Clinical Commissioning Group	Designated Professional for Safeguarding Adults
Catherine Collins	Kent County Council Adult Social Care and Health	Adult Strategic Safeguarding Manager
Alison Deakin	Kent and Medway NHS and Social Care Partnership Trust	Head of Safeguarding
Yvette Hazelden	Look Ahead Care Support and Housing (Domestic Abuse Independent Advisor)	Community & Strategic Lead
Leigh Joyce	Centra	Locality Business Manager
Dawn Morris	KCC Integrated Children's Services	Quality Assurance Manager
Paul Pearce	Independent Chairman	Independent Chairman
Shafick Peerbux	KCC Community Safety	Head of Community Safety
Ian Wadey	Kent Police	Detective Chief Inspector
Jessica Willans	Kent, Surrey and Sussex Community Rehabilitation Company	Excellence and Effectiveness Senior Manager

6.3 Panel members did not have any contact or involvement with Connie during or prior to the review period. The panel met on three occasions during the MAR. The Terms of Reference were discussed on 13th Dec 2018. The IMRs were discussed on 30th April 2019, allowing for an agreed, achievable deadline for the IMR writers. The first draft of the overview report was then discussed on 22nd July 2019. This time frame took into account the ongoing police investigation which was referred to the Crown Prosecution Service. The Overview report was then finalised via correspondence over the following months. Additional amendments were raised in February 2020 by one agency which required addressing in liaison with the Independent Chair. Following this, the report was shared with the family in April 2020, with follow-up questions and action plan finalisation during May 2020.

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 other than via his role as an Independent Chair on this and previous DHRs. He retired from Sussex Police in 2009 and 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 investigated the circumstances of Connie's death. As a result, the Crown Prosecution Service decided that there should be criminal proceedings against Ryan Davis for breaching his restraining order on the night of Connie's death. He was convicted of breach of restraining order matters. There was found to be no unlawful act of manslaughter and no case of controlling and coercive behaviour.
- 8.2 The Coroner was notified of this review in January 2019. The inquest into Connie's death concluded in March 2020. The cause of death was suicide by hanging.

9. Publication

- 9.1 This Overview Report will be publicly available on the Kent County Council website and the Medway Council website.
- 9.2 Family members will be provided with the website address and also offered hard copies of the report.
- 9.3 Further dissemination will include:
- a. The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Clinical Commissioning Group and the Office of the Kent Police and Crime Commissioner amongst others.
 - b. The Kent and Medway Safeguarding Adults Board.
 - c. The Kent Safeguarding Children Multi-agency Partnership.
 - d. Additional agencies and professionals identified who would benefit from having the learning shared with them.

10. Background Information

- 10.1 The story of Connie's life was told by her mother. The Review Panel is grateful to her for sharing memories of Connie; they set her life in a wider context than her involvement with organisations during the review period. The panel extends sincere condolences to all members of Connie's family and her friends.
- 10.2 Connie was born in Kent and was popular at school, having a lot of friends. She was sporty and particularly good at art, to the extent that after leaving school she attended college and was awarded an art degree.
- 10.3 When she was 20 years old, Connie gave birth to her first baby, Child A. She subsequently separated from Child A's father and lived with another partner, who had a child. This relationship also ended, and Connie moved into a bungalow that belonged to a work colleague – Connie had a part-time job caring for people with disabilities.
- 10.4 Connie had a history of mental illness; she had been diagnosed as suffering from Bipolar Affective Disorder and subsequently with Emotionally Unstable Personality Disorder. In late 2013, she disclosed to mental health professionals that she had been using alcohol and controlled drugs since her teenage years.
- 10.5 Around this time, Child A's father began Family Court proceedings seeking the Court's direction that Child A should live with him. A CAFCASS report recommended that Child A should live with him. Connie was granted access and continued to see her child. The Children and Family Court Advisory and Support Service is a non-departmental public body in England set up to promote the welfare of children and families involved in family court.
- 10.6 She was evicted from the bungalow and lived in various bedsits, before being allocated the house she was living in at the time of her death. In August 2015, she attempted to take her own life and she was twice admitted as voluntary inpatient into a mental health hospital.
- 10.7 Connie's relationship with Ryan Davis began in August 2015; she had known him socially when they were at school. Connie's mother met him and initially thought that he was a nice man. Connie was pregnant with Ryan's child by November that year. She was living with him and gave birth to Child B in August 2016. Shortly after this, she was subjected to an assault by Ryan. He was convicted of this in December 2016; he received a suspended prison sentence and a [Restraining Order](#). He breached the latter and the former was invoked within two weeks of being imposed. In the next 18 months, Ryan was convicted twice more, the first time for again breaching his Restraining Order, the second time for harassing Connie.

- 10.8 In 2017, Connie was diagnosed with a serious form of cancer. This resulted in her having a major operation in November 2017, followed by chemotherapy. At the time of death, her ongoing treatment was due to be reviewed.
- 10.9 Connie's mother said that Connie was vulnerable and sometimes lonely - she wanted to be loved. It was for this reason that she allowed Ryan into her home and her life, despite the incidents of domestic abuse and his Restraining Order. She kept in contact with him when they were separated, and he bought gifts and furniture for her house.
- 10.10 On the day of Connie's death, Ryan was at her home despite this being in breach of his Restraining Order.

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 Connie had with organisations between 1st January 2015 and her death. The facts are based on IMRs and reports submitted by those organisations. The analysis is based on the facts; 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 made in this report: these may need further explanation for other readers. If so, 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 The review panel considered the protected characteristics provided by the Equality Act 2010. The Equality Act covers the same groups that were protected by existing equality legislation; these being age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity.
- 11.2.2 Connie was a white British woman in her 30s. She had mental health issues, having been diagnosed with Bipolar Affective Disorder in her twenties. In the last year of her life, Connie was suffering from cancer. Both conditions may have been serious enough for Connie to be considered disabled as defined by the Equality Act 2010.

- 11.2.3 The review considers whether those agencies that knew about these conditions understood how it increased her vulnerability and made her more susceptible to coercive control. Sex is also a relevant characteristic. The fact that Connie was female, and a mother, shaped her experiences of domestic abuse, and engagement with services.

11.3 Kent Police

- 11.3.1 Kent Police provides policing services across Kent and Medway. It has records of involvement with Connie 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 significant involvement Kent Police had with Connie was in November 2015. One of her neighbours reported that Connie had been 'thrown out' of a ground floor window by Ryan. This was the first Kent Police record of their relationship.
- 11.3.3 Connie was not present when police officers initially attended this incident but when they returned some hours later, she was seen in the house with a knife in each hand. Ryan was arrested for common assault on Connie, who was also arrested after Ryan alleged that she had driven a car at him, causing injury. Each denied the allegations and declined to support a prosecution. A [Domestic Abuse, Stalking and Honour-based Violence \(DASH\)](#) risk assessment was completed for each; these were graded Standard.
- 11.3.4 Connie contacted her mother while she was in custody: it was the first time that she was aware that there was domestic abuse in Connie and Ryan's relationship.
- 11.3.5 In August 2016, about a fortnight after the birth of Child B, Ryan was arrested for assaulting Connie during an evening and into the early hours. She reported that he hit her head numerous times and grabbed her by the neck, attempting to choke her while she was holding Child B. When she sought sanctuary at a neighbour's house, Ryan also assaulted the neighbour and damaged Connie's mobile phone. He was arrested, charged with two counts of assault and one of criminal damage, and bailed to appear at Magistrates Court in mid-October 2016.
- 11.3.6 A DASH risk assessment was completed with Connie following this; it was graded high. She said that she was depressed but not suicidal. A referral was made to KCC Social Work Out of Hours (OOH) Service because of the close proximity of Child B to the violence; Connie had been holding

Child B in her arms at the time of the attack on her. Referrals were also made to Choices (domestic abuse support service), the [Multi-Agency Risk Assessment Conference \(MARAC\)](#) and Kent Fire & Rescue Service. Kent Police fitted a panic alarm in Connie's Home.

- 11.3.7 Following a strategy meeting between Kent Police and an OOH Social Worker, a joint decision was taken that the threshold for a [S.47 Enquiry](#) was met, and that Children's Social Work Services (CSWS) would update the Children and Family Court Advice and Support Service (CAFCASS).
- 11.3.8 Kent Police dealt with this incident of domestic abuse positively by arresting Ryan and making the appropriate referrals to safeguard Connie and Child B. The case was assigned to the Kent Police Combined Safeguarding Team (CST), which managed cases involving domestic abuse victims who were assessed as being at high risk. Since this time, the CST has undergone a restructure and is now called the Vulnerability Investigation Team (VIT).
- 11.3.9 The first MARAC meeting at which Connie was discussed was held on 6th September 2016. The action allocated to Kent Police was to encourage Connie to engage with the Mother and Infant Mental Health Service (MIMHS), an action also given to other agencies likely to have contact with her.
- 11.3.10 On 15th September 2016, Connie reported that Ryan had been in the vicinity of her home in breach of his police-imposed bail conditions. She declined to make a statement, but when Ryan was spoken to by a police officer on the telephone, he agreed to hand himself in. He did this on 29th September and admitted breaching his bail. He was put before a Magistrates Court via video link the next day and the court imposed bail conditions.
- 11.3.11 This was a further example of positive action by Kent Police; an officer pursued the case despite Connie not wishing to. As a result, Ryan was put before a court which imposed strict bail conditions. Breaching court-imposed bail conditions is likely to have more serious consequences than breaching those imposed by the police.
- 11.3.12 On 16th November 2016, Ryan went to Connie's home in breach of his bail conditions. She let him in reluctantly and a verbal altercation ensued, which escalated to violence. Connie stated that Ryan grabbed her around the neck and bit her hand. He then picked up a knife, stabbing and slashing a sofa before breaking a wine bottle. He left before police arrived.

- 11.3.13 A DASH risk assessment was completed with Connie and graded high. She again said she was not suicidal. A child protection referral was made to CSWS, together with referrals to Choices and the MARAC.
- 11.3.14 Ryan was arrested the following day, 17th November. Having been charged with assault and criminal damage, he was remanded in custody to appear before a Magistrates Court. The court remanded him into prison custody, which was repeated at a further two court appearances before his trial on 7th December 2016. He was found guilty and sentenced to 90 days imprisonment suspended for two years, a three-year [Restraining Order](#) and requirements for unpaid work and rehabilitation activity.
- 11.3.15 The actions taken by Kent Police were positive and expeditious, and there were referrals to other organisations as appropriate.
- 11.3.16 Connie's case was discussed the same day, 7th December, at a MARAC meeting. The action for Kent Police was to update her about the meeting and to tell her Independent Domestic Violence Advisor (IDVA) when this had been done.
- 11.3.17 The day after he was sentenced, 8th December, Ryan breached his Restraining Order by entering Connie's home in the early hours. Ann Smith, Connie's mother, was staying with her and Child B, who were sleeping downstairs. Ann heard Child B crying and when she went downstairs, she saw Ryan standing over the child. When she shouted at him, he walked out of the back door, saying nothing.
- 11.3.18 Police were called; they found Ryan and arrested him. He was charged with breaching his Restraining Order and kept in custody for court the following day. A DASH risk assessment was completed with Connie and graded high. She again said that she did not feel suicidal.
- 11.3.19 On 15th December, Ryan appeared before Magistrates and was sentenced to 100 days imprisonment. He was released on licence on 6th January 2017.
- 11.3.20 At a MARAC meeting on 10th January, organisations were encouraged to engage with Connie's social housing association. At that time the housing association Officer was trying to help her move to a new address (see section 11.12 below).
- 11.3.21 On 4th March 2017, City of London Police officers encountered Connie and Ryan arguing in a street in the city. The officers discovered they had spent the previous night in a hotel together. Ryan was therefore in breach

of his Restraining Order and he was arrested. Connie told an officer that she and Ryan were intending to return to Kent when they began arguing about him having '*an affair*'. She said it was a verbal altercation and declined to engage when the officer attempted to carry out a DASH risk assessment. She also declined to make a statement about the incident.

- 11.3.22 Ryan was charged with breaching his Restraining Order and remanded in custody to appear before Kent Magistrates the following morning. City of London Police made a child protection referral to Kent CSWS, which is indicative of the enquiries they made into the wider circumstances of what they could have initially dismissed as a couple arguing in the street.
- 11.3.23 Kent Police contacted Connie and she again declined to engage with the completion of a DASH risk assessment. Using historical information, Kent Police completed the DASH, graded it as high and made a MARAC referral. This was positive action and good practice.
- 11.3.24 On 6th March 2017, Ryan appeared before Magistrates in Kent and was sentenced to 40 days imprisonment suspended for 2 years.
- 11.3.25 A strategy meeting between Kent Police and Child B's CSWS Social Worker in early March resulted in a joint decision that the case should be progressed to an [Initial Child Protection Conference](#). This was held at the end of March and Child B was made subject of [Child in Need \(CIN\) Plan](#).
- 11.3.26 Connie's case was discussed at the Area A MARAC meeting on 6th April 2017. Kent Police updated the meeting with the circumstances of the incident in London.
- 11.3.27 On 28th April, Ann Smith was again staying with Connie overnight when she heard a sound at the back of the house. She stated she saw Ryan walking towards the door and throwing gravel at a window. She rang Kent Police while he was calling Connie's name and continuing throwing gravel. He left before the police arrived and when arrested the following day, he denied having been in Connie's back garden, providing names of alibis. The Crown Prosecution Service made the decision to charge him with breaching his Restraining Order and for him to be remanded in custody for court the following day.
- 11.3.28 On 1st May 2017, Ryan appeared before Kent Magistrates and was released with bail conditions, including to wear an electronic tag. On 4th May, a Kent Police officer spoke to Connie to confirm safety measures and to reinstate the panic alarm at her house. On 1st June 2017, her case was raised again at the Area A MARAC. There were no actions allocated.

- 11.3.29 On 8th June, Ryan alleged that Connie had hacked his Facebook account. He then declined to engage with officers and would not disclose what the hacking involved. The complaint was filed due to lack of evidence.
- 11.3.30 On 31st August 2017, Ryan was found not guilty of breaching his Restraining Order the previous April, when he had allegedly been seen in Connie's back garden. He provided the names of three people who could give him an alibi for that time.
- 11.3.31 On 21st May 2018, Connie reported that two days previously Ryan had sent her 63 text messages within 24 hours. Initially these were amicable but came abusive and, due to her suffering from cancer at this time, very distressing. Ryan avoided arrest until 31st May, when he surrendered at a police station in Kent. He admitted sending the text messages and breaching his Restraining Order by going to Connie's home on several occasions. He was charged with sending malicious communications and breaching his Restraining Order. He was remanded in custody and when he appeared before Magistrates on 1st June 2018, he was sentenced to 60 days imprisonment.
- 11.3.32 While Ryan was awaiting trial, Connie reported that in April 2017, he had punched her in the face, breaking her nose. It is not recorded why she did not report the assault for over a year. Connie provided police with a photograph of her injuries but could not remember when it was taken. She declined to provide a statement and did not wish to support a prosecution. Despite this, police officers interviewed Ryan about the assault, which he denied, saying he did not know how she received a broken nose. There was insufficient evidence to take any further action.
- 11.3.33 It is now known that Connie attended a Minor Injuries Unit with her mother on 20th April 2017, saying that she had suffered a broken nose two days previously in a fall. Kent Police would not have known this at the time.
- 11.3.34 On 6th June, police officers went to Connie's home after a neighbour reported that Connie had caused her alarm and distress during a dispute about a house key. Police advised Connie about her behaviour. Her neighbour reported a similar incident the following day but did not want to support a prosecution, nor did she want officers to speak to Connie.
- 11.3.35 The same day, 7th June, a female friend of Ryan reported to Kent Police that Connie had been sending her threatening messages via a Facebook account created in a false name. She did not want Connie prosecuted and when officers spoke to Connie, she denied the offence but accepted advice about her future conduct towards the woman.

- 11.3.36 Connie's case was raised at the Area A MARAC for the sixth and final time on 7th June 2018, 12 months after the previous occasion. Her second application to move to a new house was discussed and Kent Police took an action to provide Centra (domestic abuse support service) with a letter supporting the move. The meeting discussed whether the [Domestic Violence Disclosure Scheme](#) (DVDS) was appropriate in Connie's case. The meeting decided it was not, because there were no incidents of violence recorded involving Ryan and his previous partners.
- 11.3.37 By the time of this MARAC, Ryan had inflicted violence on Connie more than once, so DVDS would have had limited relevance. There is no record that it was considered at any of the previous five MARACs at which Connie's case was discussed. Partly as a result of Connie's case, Kent Police has identified the need to consider at each MARAC meeting, the appropriateness of implementing DVDS. It is now included in the minute template for each meeting, that it should be considered in all cases. It is also covered in training for MARAC Chairs and Coordinators. The Kent Police MARAC research form includes DVDS, so officers can begin thinking about whether its use is appropriate in each case before the meeting.
- 11.3.38 On 29th June 2018, Ryan was released from prison on licence. On 6th July Connie reported to Kent Police having seen him on 1st July, driving down a road adjacent to the one in which she lived. The officer explained this road was not covered by the Restraining Order. She was given safeguarding advice, but no DASH risk assessment was completed, which was an omission.
- 11.3.39 Following a meeting with Connie on 5th July, her IDVA recorded that the officer who dealt with Connie had an '*awful attitude*', had accused her of '*facilitating the breach*' and told her that lots of aggrieved ex-partners called the police to get ex-partners '*into trouble*'. Connie was clear when speaking to the IDVA that Ryan had been outside her house in his car, not in an adjacent road. This is at odds with Kent Police's record of the incident, but the details of the officer's interaction with Connie were not recorded.
- 11.3.40 On 22nd July 2018, Kent Police received an intelligence report from Crimestoppers stating that Ryan was breaching his '*probation*' by '*...having contact [with Connie] and continuing domestic violence and mental abuse.*' It also stated, '*They are involved in a relationship together again*' and '*Both parents [of Child B] take drugs and physically and mentally abuse each other*'. The report did not say that Connie and Ryan were living

together; in fact, it gave separate addresses for them. Its wording suggested the source may have been more concerned about the risk to Child B, rather than Connie.

- 11.3.41 The source of the intelligence was anonymous, but that is the case with all Crimestoppers reports. At the time it was received, Ryan was on licence until 30th July 2018, and contact with Connie would have been a breach of his Restraining Order. The intelligence report was also disseminated to the Area A MARAC coordinator and Kent, Surrey and Sussex Community Rehabilitation Company (KSSCRC) who were managing Ryan's prison licence, see section 11.4 below.
- 11.3.42 Kent Police assessed the intelligence and decided to take no further action beyond disseminating it as above. Although anonymous, it related to domestic abuse in a family where it was known such abuse had taken place before, the victim was at a high risk and the perpetrator had been imprisoned as a result of committing abuse. Also, it suggested that Child B was potentially at risk, which was known to Kent Police as they had been involved in the formal child protection process.
- 11.3.43 In light of these factors, the decision not to at least contact CSWS and KSSCRC to ensure they were aware and to discuss the intelligence, was a missed opportunity to safeguard Connie and Child B. Ryan was at Connie's house when she died in August 2018. Whether he visited her on other occasions after his release from prison at the end of June 2018, or if he had moved in with her, is not clear.
- 11.3.44 It is also not clear whether the Crimestoppers intelligence report was routed to anyone in Kent Police who had knowledge of Connie's case. Kent Police must have process in place to ensure that intelligence received (from any source) about domestic abuse, particularly if it refers to a high-risk victim, is evaluated and disseminated expeditiously to the relevant department to ensure it is acted upon appropriately.
(Recommendation 1)
- 11.3.45 The last contact Kent Police had with Connie before her death was on 22nd August 2018, when an officer spoke to her by telephone following a further complaint by Ryan's ex-partner that Connie had sent an email to her employer, which had caused upset. An officer rang Connie, who became abusive. The officer decided she needed to be spoken to in person; this was an outstanding action at the time of her death.
- 11.3.46 Overall, Kent Police acted positively to safeguard Connie. Officers responding to calls about domestic abuse in a timely way and took prompt

action to arrest Ryan and bring him before the courts. Where appropriate, they pursued enquiries when Connie did not want them to proceed, which in the circumstances of each incident was good practice.

11.3.47 In general, appropriate referrals were made to other agencies. Connie was identified as a high-risk domestic abuse victim from the first report of serious abuse and DASH risk assessments were consistently graded high, resulting in MARAC referrals.

11.3.48 One example of a DASH risk assessment not being completed has been highlighted, together with the missed opportunity to act following the Crimestoppers intelligence report. The latter is subject of a recommendation.

11.4 Kent, Surrey and Sussex Community Rehabilitation Company (KSSCRC)

11.4.1 In early 2015, private sector Community Rehabilitation Companies (CRC) came into existence as part of the Government's Transforming Rehabilitation programme. CRC's provide probation services for low to medium risk of serious harm offenders. high risk offenders continue to be managed by the National Probation Service (NPS) within the public sector. The contract to provide CRC services in Kent, Medway, Surrey and Sussex was awarded to [Seetec](#).

11.4.2 Transforming Rehabilitation included all custodial sentences involving a period of supervision on release, whereas previously this had only applied to sentences of 12 months or more. Since 2015, sentences of under 12 months have a licence period following early release: during this time conditions can be added, and an offender can be recalled to prison if they breach them. In addition, a subsequent period of Post-Sentence Supervision (PSS) was introduced, which allows an offender to be prosecuted in Court if they breach the PSS terms, although they cannot be recalled to prison. This has resulted in the benefit of supervision post release on short prison sentences, but it has sometimes proven difficult to complete meaningful work in such a short period of time

11.4.3 KSSCRC was created in early 2015, coinciding with the review period of this review. This not only involved merging two former organisations (Kent Probation and Surrey & Sussex Probation), but also a complete restructuring of the senior management team and estate strategy, gradually replacing legacy buildings with new premises. Operational staffing levels

were maintained; Seetec focused redundancies on senior and non-operational roles.

11.4.4 KSSCRC had no contact or involvement with Connie. Their involvement with Ryan was the result of three sentences, each for offences related to the domestic abuse of Connie:

- 07/12/16 – 24-month Suspended Sentence Order (SSO), with requirements for 100 hours Unpaid Work, 40 Rehabilitation Activity Requirement (RAR) days and the Building Better Relationships Programme. The suspended sentence was invoked on 15th December 2016.
- 06/03/17 - 24-month SSO with no additional requirements.
- 01/06/18 - 60 days Custody, including Post Sentence Supervision on release.

11.4.5 The decision as to whether a case is allocated to and managed by either the NPS or KSSCRC is informed by the Risk of Serious Recidivism (RSR) indicator. This was applied correctly by the NPS in each case involving Ryan, and he was allocated to KSSCRC.

11.4.6 Following his release from the prison sentence that began on 15th December 2016, Ryan was supervised on licence from 6th January 2017 until 26th February 2017. The Post Sentence Supervision period began on 26th February 2017 and expired on 7th January 2018.

11.4.7 Before Ryan's first meeting with his KSSCRC Responsible Officer on 11th January 2017, an enquiry made by NPS confirmed that Child B was subject of a Child In Need Plan. His Responsible Officer had access to this information, which was recorded on the joint NPS/KSSCRC computer system (Delius). At the first two meetings with Ryan, his Responsible Officer reinforced the conditions of his Restraining Order and the need for him to comply with them.

11.4.8 A risk assessment was completed by Ryan's Responsible Officer on 18th January. He was assessed as posing a medium risk of serious harm to Connie and Child B. This risk of domestic abuse was such that it indicated Ryan required a structured group work programme such as [Building Better Relationships](#). However, the licence and PSS period was too short to complete this work, so the Sentence Plan was for two periods of [IDAP 121](#) with four objectives linked to issues raised in the risk assessment. IDAP 121 is a work programme for men who have abused their wives, partners or ex-partners. The Risk Management Plan omitted the need to undertake call-out checks with Kent Police. These should have been carried out as

domestic abuse cases may have more incidents than those which result in convictions. The failure to carry out these checks meant the plan lacked robustness and fell short of the expected standards.

- 11.4.9 For the remainder of his licence period Ryan attended meetings with his Responsible Officer as required. He had been given evening appointments so that he was able to attend after work; this was good practice.
- 11.4.10 Ryan's prison licence expired on 26th February 2017, when his PSS began. Shortly after, on 6th March, he received a suspended prison sentence for breaching his Restraining Order. This did not result in an extended period of PSS beyond that resulting from his earlier sentence. Although KSSCRC were aware of his latest conviction and sentence, he did not disclose it at his next meeting, which was with a Duty Officer on 14th March.
- 11.4.11 Before their next meeting with Ryan, the Responsible Officer contacted Child B's CSWS to discuss their case and share information; this was in accordance with KSSCRC's safeguarding policy.
- 11.4.12 Ryan was challenged at the next meeting with his Responsible Officer on 21st March and said he had not disclosed the latest breach of the Restraining Order and his conviction because he had met with a Duty Officer (rather than his Responsible Officer) and then forgot about it. The IDAP 121 work with his Responsible Officer began on 28th March and continued for a month.
- 11.4.13 On 2nd May 2017, Ryan disclosed another arrest and court appearance for allegedly breaching his Restraining Order – he was subsequently found not guilty of this. KSSCRC records show that from the start of his licence period and through the IDAP 121 work, although Ryan recognised his abusive behaviour, he minimised his responsibility and continued to blame Connie.
- 11.4.14 Throughout May to July 2017, Ryan's appointments with KSSCRC were of brief duration because of his curfew. This shows how two parts of the criminal justice system have potential to work against each other. Ryan was working, and his finish time, together with the start of his curfew, meant there was little scope to alter the meeting times.
- 11.4.15 Following Ryan's sentence on 1st June 2018, KSSCRC appointed a Responsible Officer promptly (it was not his previous Responsible Officer) and a proposal for additional licence conditions following his release were sent to the prison on 26th June. In addition, a further check was made with CSWS as required by KSSCRC policy.

- 11.4.16 Ryan was released from prison on 29th June and reported to his Responsible Officer on 3rd July for an induction meeting, at which his licence conditions and Restraining Order were discussed to ensure that he understood the *'boundaries and expectations'*. He discussed both his past relationship with Connie, and his offending, in depth with his Responsible Officer.
- 11.4.17 At a meeting with his Responsible Officer on 10th July 2018, Ryan said he did not want a relationship with Connie and stated that Child B would be safer with him. His Responsible Officer recorded that, *'He was agitated and felt he was the victim'*.
- 11.4.18 A risk assessment was carried out on 17th July. Once again, the period of licence and Post Sentence Supervision was too short to enable a structured group work plan, so it relied on 1 to 1 work. Drug and alcohol misuse were discussed with Ryan – he said he had not used alcohol *'to any large extent'* or drugs at all. There was a missed opportunity to carry out a test for Class A drugs – it was a condition of his licence to provide a sample for a test if required.
- 11.4.19 On 30th July 2018, Ryan's licence expired, and his Post Sentence Supervision period began. The following day he told his Responsible Officer that he had no contact with Connie and had not heard anything from her family. The Responsible Officer was aware of Crimestoppers intelligence that he was *'back in contact with Connie'* (Kent Police also had this information, see section 11.3 above). The Responsible Officer did not challenge him, nor did she contact Kent Police to see if they had any further information or corroboration. This was a missed opportunity.
- 11.4.20 On 21st August 2018, the Responsible Officer challenged Ryan when he said he was not seeing Child B, because she had seen him driving past her office with Child B in the car. He changed his account, saying he had *'only recently'* been having contact with Child B. When asked, he denied seeing Connie. This was the last contact KSSCRC had with Ryan before Connie's death.
- 11.4.21 Later that day, having told Ryan what she intended to do, the Responsible Officer sent an email to Child B's Social Worker. She told her about seeing Ryan with Child B and him denying contact. The Social Worker said she had no evidence that Ryan was seeing Connie; he had said that his contact with Child B was through grandmothers.
- 11.4.22 As with Ryan's previous prison release, there is no record of KSSCRC checking with Kent Police to see if there were further incidents of domestic

abuse. This was especially relevant because it was known that Ryan would keep things from his Responsible Officer. In addition, KSSCRC's safeguarding policy requires that home visits be undertaken in several types of case, including those of domestic abuse. These visits were not undertaken after Ryan was released from prison in 2017 or 2018.

- 11.4.23 The risk management of Ryan's case was passive and overly reliant on his accounts. These shortcomings, combined with lack of drug testing, means the management of his case by KSSCRC did not comply with its policies and fell short of its standards.
- 11.4.24 The organisation has identified this, and in order to address the wider issues it is symptomatic of it introduced new Quality Development Officer (QDO) posts in January 2019. This has resulted in the introduction of workshops facilitated by QDOs, focused on areas such as callout checks and home visits that had not been carried out as they should. The creation of the QDO posts follows a recommendation in a previous Kent and Medway DHR. This is evidence that KSSCRC is a learning organisation, which has focused on improving the safeguarding of domestic abuse victims.
- 11.4.25 In late 2018, the Government announced that by 2022, all private contracts for probation services in the United Kingdom would be withdrawn. It is not yet clear what the arrangements will be to supervise offenders currently managed by CRCs.

11.5 Centra

- 11.5.1 Centra is 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.
- 11.5.2 In May 2017, Centra received a referral for Connie from Child B's CSWS Social Worker. Attempts were made to engage her in line with Centra's policies at the time, but she declined to become involved with the IDVA service. The IDVA assigned to Connie was fully qualified and had been in the role for six years. She had worked with Connie previously as part of the domestic abuse support agency Choices. This was prior to the relationship with Ryan. Her experience was that Connie would sometimes engage sporadically, at other times not at all.

- 11.5.3 On 22nd May 2018, Centra received a referral for Connie from Kent Police. This was a 'no consent' referral; Connie had not consented to it being made. The same IDVA as previously mentioned, phoned her and left a voicemail message. Connie responded by phoning the IDVA three days later, stating that she was staying with her mother in Area B. She described historical drug and alcohol misuse and said she had relapsed into using cocaine while in living Area A. She was not doing this while staying with her mother. She was due to attend an appointment about her cancer diagnosis and was intending to remain with her mother. The IDVA arranged a future call to her.
- 11.5.4 On the agreed date, 29th May, the IDVA called Connie and completed a DASH risk assessment with her, which was graded high. Connie disclosed historical violent abuse by Ryan, dating from April 2017. She was encouraged to report this to Kent Police, which she did (see section 11.3 above). She talked about her mental health, which she felt was stable. She was considering a move to a refuge in Area B or a managed house move in Area A, which was an indication she was living in fear. The IDVA offered to undertake a refuge search and raise the managed move at the forthcoming MARAC. She also gave Connie safety advice.
- 11.5.5 The IDVA emailed Connie's social housing provider, the same day. In the reply received the following day, the housing association stated it had limited housing stock but would try to assist.
- 11.5.6 At the MARAC held on 7th June 2018, Kent Police gave an update about Ryan being in custody following a breach of his Restraining Order. Connie had missed appointments with the mental health team.
- 11.5.7 The IDVA called Connie on 11th June and left a message, which she responded to the following day. She said she had met with the housing association who needed supporting documentation for a managed move. The IDVA agreed to help Connie with this.
- 11.5.8 On 14th June, the IDVA called Connie and discussed housing options. A refuge search had been unsuccessful; there were no spaces in Connie's chosen areas. Similarly, the housing association were not optimistic about a managed move. Safety planning was discussed in the light of Ryan's impending release on 29th June. The IDVA gave Connie advice about a housing application in Area B, which she would need to make personally. She was undecided about where she wanted to live. It was agreed that they would speak the following week, but the IDVA emphasised she was available by phone if Connie needed her support in the meantime.

- 11.5.9 On 20th June, the IDVA had a meeting with her manager, during which Connie's case was discussed. The priority was alternative housing and it was agreed that IDVA support should continue.
- 11.5.10 On 28th June, the IDVA spoke to Connie and they discussed safety planning around Ryan's release from prison the following day. This was thorough and covered where she would be staying the next day, not letting Ryan back into a relationship or gain control. The IDVA also gave practical advice to Connie, such as keeping her mobile phone charged and not going out alone.
- 11.5.11 The IDVA next spoke to Connie on 5th July 2018. Connie said she had stayed with friends and her sister. She had returned home on 1st July, two days after Ryan's release from prison, and had seen him outside her house in his car. She had called Kent Police as this breached the Restraining Order. She described the '*awful attitude*' of the officer who had responded. She said her mother had complained to the police control room about this. The IDVA again discussed safety measures with Connie, advising her not to return home. This was the last contact the IDVA had with Connie.
- 11.5.12 There is no record that the risk to Connie was reassessed during their last conversation, either using a DASH risk assessment or informally. Following the conversation there was a missed opportunity in not contacting Kent Police, given what Connie said constituted a breach of Ryan's Restraining Order and the interaction with the officer who attended, which had upset her.
- 11.5.13 Connie's case was reviewed at a case management meeting the following day, 6th July, but there was no discussion about what actions the IDVA should have been taking following Connie's report of Ryan breaching his Restraining Order. The IDVA however, did write a second letter to the housing association supporting Connie's ongoing wish to move to the village in Area A.
- 11.5.14 The IDVA was then on leave for a fortnight and handed her cases to a colleague (another IDVA). She also gave Connie an alternative number to call if she needed IDVA support but did not ask her colleague to contact Connie. There was no contact with Connie during this period and when the IDVA returned from leave on 31st July, she attempted to call her several times without success. The IDVA heard the international dialling tone; Connie was abroad on holiday in Spain at this time, but the IDVA only found this out after Connie's death. The IDVA left text messages but Connie did not respond. The IDVA also contacted Connie's housing

association to find out if Connie had moved, but she was still registered at the same address.

- 11.5.15 A case management meeting was held on 20th August between the IDVA and her manager. It was agreed that attempts to contact Connie should continue, with the aim of completing a DASH risk assessment.
- 11.5.16 In the last week of August, the IDVA called Connie and heard a different automated message, which did not allow a voice message to be left. The IDVA sent Connie a text message. This was the first attempt to contact Connie since the case meeting held on 20th August. The following day the IDVA had a further case management meeting with her supervisor, at which it was decided to close Connie's case due to the lack of success in engaging her. An action was to inform other relevant organisations of the case closure, but Connie died that night, before this was done.
- 11.5.17 In the last two case management meetings there was no record of consultation with other relevant organisations to see if they had any information that might assist Centra in contacting Connie, or to inform the decision about whether to close her case. These were missed opportunities to speak with other organisations that had contact with Connie during August.
- 11.5.18 Connie's first referral to Centra in 2018 was just over three months before her death. Until the beginning of July, the support provided by the IDVA was thorough and supportive of Connie's needs and wishes. Connie seemed happy to talk about the history of her relationship with Ryan, which indicated that she trusted the IDVA. In terms of the safety advice given to her, she chose to accept some but not all. For example, she returned to her home, which she was advised not to.
- 11.5.19 After she told the IDVA about Ryan's breach of his Restraining Order, which took place only two days after his release from prison, there were opportunities missed to contact other organisations to share and seek information. Three case management meetings were held between then and the case closure on the day of Connie's death. To the extent that the opportunity to advise the IDVA to contact other organisations was missed, these meetings were ineffective. Whilst it appears that Connie may have been difficult to engage during that period, more effort should have been made to try to find out why that was.
- 11.5.20 Centra has now chosen to partner with Choices having recognised its experience in domestic abuse services was more related to providing refuge, outreach, and floating support services than for providing IDVA

services and IDVA case management. By partnering with Choices, Centra's intention is to work together to ensure its clients are being supported by the Centra IDVA service whilst also learning from colleagues. Although the IDVAs remain as Centra employees, their cases are supervised and managed by Choices staff.

- 11.5.21 This is a positive decision in the light of the findings from this and a previous DHR; it is indicative of Centra learning lessons. However, it is important that the service given to high-risk domestic abuse victims is properly managed and to ensure that this is now the case, the recommendation made in the previous DHR, May 2018, is repeated and should be implemented expeditiously.
- 11.5.22 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 2)**
- 11.5.23 The recommendation relates to Centra's processes, not individual staff. Connie's mother said that Connie felt that the IDVA was very supportive of her, describing the IDVA as the 'only [professional] who asked her how she felt.' The fact that the IDVA had previously worked with Choices is another reason why Centra's decision to work with Choices is a positive step.

11.6 GP Practices (GPP)

- 11.6.1 During the review period, Connie was registered at two GPPs. From before 1st January 2015 to May 2017, she was registered at GPP A and from then until her death at GPP B. Her mother told the review that Connie changed GP practices because she had moved and no longer lived in the area covered by GPP A. The GPs she saw are numbered chronologically in this report.
- 11.6.2 Connie's GP records confirm that she had a history of mental health problems, which predate the start of the review period. As well as receiving psychiatric care, she was treated by specialist mental health services for alcohol and drug misuse.
- 11.6.3 In January 2016, Connie presented at GPP A with her mother and saw GP1. She reported being in a new relationship, giving the first name of her partner as Ryan. She said she had taken no alcohol or drugs since discovering in November 2015 that she was pregnant. She said she was attending Crime Reduction Initiatives (CRI, which has since changed its

name to [Change Grow Live](#)) weekly for substance misuse support. She had been discharged from secondary mental health services (KMPT) to the care of a primary care Community Psychiatric Nurse. Knowing that Connie was pregnant, there was an opportunity for GP1 to share the information she had given him with her obstetrics team, which was missed.

- 11.6.4 During a visit to GPP A on 19th May 2016, Connie mentioned to GP1 she was visiting her child (who was then of primary school age) two to three times a week and was finding this stressful. She said she was abstaining from alcohol and drugs but the GPP A had received no correspondence from CRI to corroborate this.
- 11.6.5 In July and August 2016, GPP A received letters from the Mother and Infant Mental Health Service (MIMHS) indicating that Connie had not been keeping appointments. Because of this, MIMHS discharged her back to GPP A in August. GP2 saw her a few days later, but there is no record this non-attendance was raised.
- 11.6.6 On 26th August 2017, GP1 received a call from a CSWS Social Worker who told him that Connie had been assaulted by her partner a few days previously. He shared relevant information with the Social Worker.
- 11.6.7 GP2 saw Connie with her mother on 20th September 2016. Connie was suffering from anxiety following the domestic abuse incident three weeks previously. GP2 advised her to call the '*domestic violence victim support unit*' as it was '*likely counselling would help.*' There is no record that any contact was made with CSWS or the Health Visiting Service. This was a missed opportunity as Child B was only several weeks old. GP2 also recorded '*Review in one month.*'
- 11.6.8 GP3 carried out a review with Connie on 30th November 2016. She requested anti-depressants for ongoing stress following her partner assaulting her again the previous week. Although he was back in prison, it would have been appropriate to pass the information to CSWS and the Health Visiting service, but again this was not done. There is no record of medication being prescribed.
- 11.6.9 At the end of March 2017, GP4 put a note on Connie's medical record outlining her mental health and substance abuse history. It also flagged her as being at risk of domestic violence and requested any information about this be sent to GP4. This was good practice, but there is no evidence that concerns about domestic violence were included in Connie's notes that were transferred when she registered at GPP B.

- 11.6.10 Clinical Commissioning Groups should ensure that when it is known to a GP practice that a patient is a victim of domestic abuse, this is clearly highlighted in their notes if they transfer to another practice.
(Recommendation 3)
- 11.6.11 On 1st June 2017, Connie attended GPP B for a new patient check with GP5. In July 2017, GPP B was sent a detailed report about a consultation with KMPT, at which Child B was present. This content gave a good insight into Connie's history and current state, which would have been available to other GPs in the practice if Connie presented to them.
- 11.6.12 In late August 2017, GPP B received a laboratory test report that was the start of Connie's cancer diagnosis. The condition was confirmed in mid-November 2017 and two weeks later she had a telephone conversation with GP5. She reported suffering from anxiety, panic attacks and poor sleep related to the diagnosis; she was prescribed Diazepam.
- 11.6.13 She was seen four days later, at the start of December 2017, by GP6, having been told she would need an operation the following week. GPP B was informed, in a letter dated 20th December 2017, that the operation had taken place.
- 11.6.14 From then until her death, GPP B received correspondence with updates on Connie's cancer treatment and her mental health condition. She was seen by GP5 on three occasions in 2018, once in June and twice during August in the fortnight before her death. These contacts were for discussions about her physical health, and on one occasion the prescription of medication for anxiety. There is no record that her personal circumstances, including domestic abuse, were discussed. This was a missed opportunity because she was the primary carer for her young child; their safeguarding and care were relevant too.
- 11.6.15 During the review period, Connie's mental health and cancer were both serious enough to result in treatment from secondary mental health services. It is possible that for this reason, her involvement with GPs was irregular and lessened towards the end of her life. It is not clear whether, on becoming aware of her cancer diagnosis, GPP B communicated this to KMPT.
- 11.6.16 Towards the end of the time when she was registered with GPP A, one of the GPs flagged Connie's electronic computer record to the effect she was at risk of domestic violence and asked to be told of any concerns. This was good practice, although other GPs there had known about the risk to Connie and could have taken this initiative earlier.

- 11.6.17 Most GP practices now have electronic systems on which patients' notes are recorded. Although the systems differ, many practices can flag issues on the electronic system, to alert anyone opening a patient's notes. Some GP surgeries use this to highlight safeguarding issues, including domestic abuse, and this is to be encouraged. GPs may be alerted to domestic abuse by a patient or in correspondence from other organisations; flagging the issue when it is first raised enables any GP in the practice to be aware of it when the patient presents subsequently.
- 11.6.18 Kent and Medway CCGs should encourage GP practices that have electronic recording systems for patients' notes with a flagging facility, to use this to flag patients (and where relevant, children and other family members) who are victims of domestic abuse. **(Recommendation 4)**
- 11.6.19 Connie registered at GPP B about two months after she was flagged at GPP A, and within a month she attended a new patient check, which was good practice. The record of the meeting lists various issues in a way that suggests if the GP had known about her being a domestic abuse victim, or she had raised it, it would have been recorded.
- 11.6.20 The first record of GPP B being made aware of Connie having a history of domestic abuse with Ryan was in a letter sent by KMPT in May 2018. This referred to '*her ex-partner*', which may have given the impression it was historical. By that time, her cancer was a significant medical issue, and on the two occasions she was seen at GPP B before her death, it was her physical health that was discussed.
- 11.6.21 There is no record that either GPP1 or GPP2 were invited to attend, or asked to provide input to, any of the MARAC meetings that discussed Connie's case. This is an issue, because MARAC coordinators are unlikely to know who a victim's GP is unless it is recorded in the referral. Therefore, GP input into MARAC meetings is not routinely available. The review panel feels that this is an omission and that a person's GP can often be the source of information relevant to the MARAC.
- 11.6.22 A previous Kent DHR also highlighted issues with GP input into MARACs. This along with general acknowledgement by MARAC coordinators of the challenge at securing GP input has prompted the MARAC supervisor to work closely with CCGs to make improvements. This work is currently ongoing. Kent and Medway Domestic Abuse and Sexual Violence Group should consider how best to ensure that a high-risk domestic abuse victim's GP is invited to attend or contribute to a MARAC meeting at which one of their patients will be discussed. **(Recommendation 5)**

11.7 Kent and Medway NHS and Social Care Partnership Trust (KMPT)

- 11.7.1 KMPT provides secondary mental health services for adults and is commissioned to do this by a consortium of the eight NHS Clinical Commissioning Groups in Kent and Medway. KMPT delivers its services in the community through [Community Mental Health Teams \(CMHT\)](#) and [Crisis Resolution Home Treatment Teams \(CRHTT\)](#). In addition, it has inpatient hospitals, a Psychiatric Liaison Service in acute hospitals and provides a Criminal Justice Liaison Service in police stations.
- 11.7.2 KMPT first had contact with Connie in October 2013, when she said she had been recently diagnosed with Bipolar Affective Disorder by a psychiatrist she had seen privately.
- 11.7.3 In January 2015, Connie was referred to KMPT by her GP following a suicide attempt and self-harm. She attended for assessment with her mother and described events in her life which had led her to have suicidal ideation. She described the ending of her relationship with her eldest child's father, receipt of an eviction notice and issues at work as factors affecting her mental health. She did not report domestic abuse. She tested positive for cocaine and morphine.
- 11.7.4 Having been seen by the CHRTT, Connie was admitted to a KMPT inpatient hospital and remained there for 12 days. On one occasion during that period, she left the ward and did not return at the agreed time. When she did return, she appeared to have consumed alcohol.
- 11.7.5 In the five months following her discharge, she initially engaged with her CMHT Care Coordinator. She reported that she was engaging with the CRI alcohol service. Referrals were made to other organisations that could provide emotional and practical support. She attended appointments sporadically, and in late June 2015 she attended an emergency medical review in a distressed state because of the upcoming court case about which parent Child A was going to live with. She did not attend the follow-up appointment and efforts to contact her were unsuccessful until late July 2015, when she said she had received a letter about an appointment but had forgotten to attend.
- 11.7.6 In mid-August 2015, Connie was assessed at home by a KMPT doctor after an ambulance crew attended and she had declined to attend hospital. As a result of the assessment, she was admitted to a KMPT inpatient hospital as an informal patient. She disclosed that she had taken a mixed overdose of prescribed tablets and alcohol on impulse, with '*the intention to die*'. She did not feel her medication was helping, so she had

not been taking it. She had not sought medical advice before making this decision. She was also using alcohol to excess and self-harming by cutting. She said she was living alone but had a new partner.

- 11.7.7 About a week after her admission, Connie was discharged into the care of the CMHT. Her Care Coordinator was advised of this and made an appointment to see her, which Connie failed to keep because she had been to court for a residency hearing relating to her child. She attended the CMHT the following day saying she needed a psychiatric report as part of the Family Court process.
- 11.7.8 The following day, 27th August, her Care Coordinator called and arranged an appointment for 1st September, which Connie did not attend. On 10th September, her Care Coordinator made an unannounced home visit, which was good practice. There was no response but as the Care Coordinator was leaving, a man came out of the house and said Connie was in bed and unable to meet. The Care Coordinator gave this man a sealed envelope addressed to Connie which contained appointment details for 21st September 2015. Connie did not attend this.
- 11.7.9 Connie's case was discussed at a KMPT multi-disciplinary meeting in early October 2015; a possible discharge due to non-engagement was considered. Concern was raised regarding potential risks, and a plan was put in place to try and engage her, contact her mother, and update her GP regarding non-engagement and current concerns. Not closing the case based on the potential risks to Connie arising from her mental health issues was good practice.
- 11.7.10 As a result of contact via her mother, Connie attended a mental health review in mid-October 2015. She did not attend a follow-up appointment on 9th November. When the Care Coordinator contacted her via her mother, she said that in the future she only wanted to see a doctor. She took the Care Coordinator's contact details.
- 11.7.11 On mid-November 2015, Connie was arrested for allegedly driving over her partner's foot. He was also arrested for assaulting her. As she said she had been diagnosed with Bipolar Affective Disorder, she was seen by the Criminal Justice Liaison Service Nurse at the police station. Connie did not wish to engage, saying she was stable and would contact her Care Coordinator the following week. This was the first KMPT record of Connie being a victim of domestic abuse.
- 11.7.12 In early December 2015, Connie attended a medical review with a KMPT Psychiatrist. Her mental health was stable, and it was agreed that there

would not be a follow-up appointment; Connie could contact the CMHT if she needed to.

- 11.7.13 At the end of December 2015, a KMPT multi-disciplinary meeting was held regarding Connie's future care as a referral had been received by the Mother and Infant Mental Health Service (MIMHS) from her midwife. Discharge to Primary Care Mental Health was reviewed, but it was agreed that she would remain with CMHT to facilitate MIMHS assessment. This was a good decision which put her care as the priority.
- 11.7.14 Connie was seen by a KMPT Medical Trainee (doctor) in early March 2016. He recorded her diagnoses of mental and behavioural disorders due to use of alcohol/dependence syndrome, emotionally unstable personality disorder and bipolar affective disorder. He also noted a history of non-compliance with medical treatment and regimen. The latter was reinforced as Connie said again that she had stopped taking her medication without seeking medical advice. She said she had a new partner who she had plans to live with in the future. There were no concerns about her mental health at that time.
- 11.7.15 Over the next three months, Connie did not attend any appointments with MIMHS. Her midwife advised the service that Connie did not want input from them, and she was discharged.
- 11.7.16 In mid-September 2016, after she had given birth to Child B, Connie's case was discussed at a MIMHS team meeting although her case was closed to it. The reason for the discussion was that at a MARAC meeting held in early September resulted in an action for the KMPT representative to ask MIMHS to try engaging with Connie. At the team meeting it was recorded that she had been making violent threats to her ex-partner, the father of her elder child. Connie's case had come to the MARAC because she had been the victim of a violent assault by Ryan, but at the MIMHS team meeting she was portrayed as a perpetrator.
- 11.7.17 Throughout the rest of 2016, Connie either did not attend or cancelled appointments with her Care Coordinator; one appointment being cancelled by her mother. In early January 2017, following a failed appointment, it was agreed that she would be subject to an unannounced home visit.
- 11.7.18 Four days later, the CMHT received an email from KMPT's Head of Safeguarding stating that Connie had been a MARAC subject, having been victim of domestic abuse committed by her partner. KMPT contacted CSWS, which confirmed Connie did not have an open case.

- 11.7.19 An unannounced visit was made to Connie's home in early March 2017. The timing of such visits is risk based, but it should be made within seven days of the decision that it was needed. In this case, it was nearly two months. It was not expedited following the information about her being a victim of domestic abuse, which was an indication of increased risk to her safety.
- 11.7.20 There was no answer when the visit was made, and a message was left on her mother's voicemail. This resulted in Connie attending a care plan review in late March 2017. This was over a year since KMPT last had contact with her, although considerable efforts had been made to contact her during this time. The review was conducted by her Care Coordinator. Her mother, with whom she was living at the time, was present. It was noted that Connie had no GP and would register at a new practice. Not being registered with a GP had prevented Connie from getting her medication. As a result of a discussion with a KMPT doctor, she received an emergency prescription.
- 11.7.21 Connie was seen again in early April 2017 when she was still living with her mother. Although KMPT had a record of her being a victim of domestic abuse earlier in the year and her saying that her relationship had ended (an event that can increase the risk to a domestic abuse victim), there is no record of her safeguarding, or that of Child B, being considered at the meeting. Although her mother was present, this was a missed opportunity.
- 11.7.22 Connie's Care Coordinator attended a CIN meeting in late April 2017. The meeting heard Connie had been involved in a domestic incident in London with an ex-partner, and he had come to her house in the early hours despite his Restraining Order.
- 11.7.23 From May to the end of September 2017, Connie was seen several times by her Care Coordinator; she kept her appointments. After this, she could not be contacted following a missed appointment in late October 2017. She missed a further three appointments before mid-March 2018 when contact was made with her mother who confirmed Connie had been diagnosed with cancer. The diagnosis had been made in September 2017 and she had a major operation in November that year. This may have been the reason why she did not keep KMPT appointments. Had KMPT contacted her GP they would have been aware of this.
- 11.7.24 Connie was seen in late March 2018 with her sister present. She reported what had happened to her in the preceding few months. As a result, she

attended an urgent mental health review a few days later, when her medication was amended.

- 11.7.25 She was seen again in late May 2018, having missed an interim appointment. She talked about her cancer and *'concerns that her ex-partner could return and may harm her [and she reported a] history of domestic violence'*. No referral to, or enquiry with any other agency was made despite her obvious vulnerability and the potential risk of harm to Child B. This was the last time Connie was seen by KMPT.
- 11.7.26 The only contact after this was in early August 2018, in response to a request from Connie for help with completing her Personal Independence Payment application, when she was spoken to by her Care Coordinator. She did not turn up for an appointment in mid-August 2018. An unsuccessful attempt was made to phone her, and the plan was for her Care Coordinator to follow this up.
- 11.7.27 When the KMPT MIMHS team discussed Connie's case in September 2016, she was portrayed as a perpetrator, rather than a victim, of domestic abuse. This may have been because of a previous record of her being in police custody for assaulting her partner (which was only half the story) and, only five days before the team meeting, there was a record of a telephone call from Connie's Children's Social Work Services social worker stating there was *'ongoing domestic violence.... [being] witnessed by Connie's [youngest child]'*.
- 11.7.28 Connie's Care Coordinator was not present at the MIMHS team meeting, but the meeting notes were recorded on Rio, KMPT's IT system. The Care Coordinator was accessing Rio before and after the meeting. The Care Coordinator may not have looked at the record, but if she did, there is no record she asked Connie about domestic abuse or her relationships.
- 11.7.29 The Care Coordinator knew in January 2017 that Connie's case had been discussed at a recent MARAC meeting and contacted CSWS, which was good practice. From then until April 2017, Connie reported she was living with her mother, who was present at meetings. There is no record of Connie being asked about domestic abuse or relationships.
- 11.7.30 The next time domestic abuse was mentioned was in June 2017 when Connie *'denied any issues with A (ex-boyfriend), who is currently making effort for mutual contact arrangement to have relationship with his [child].'* Her mother, who was considered by the Care Coordinator as being very supportive, was again present.

- 11.7.31 Connie had the same Care Coordinator from September 2016 until her last contact with KMPT. The Care Coordinator was aware of her being a victim of domestic abuse from January 2017 at the latest. At that time, Connie was living with her mother, who invariably attended meetings with her.
- 11.7.32 In late May 2018 domestic abuse was discussed with a KMPT doctor, with no record of Connie's Care Coordinator being present. Connie raised and expressed explicitly a concern that her ex-partner could harm her. Given that she was suffering from cancer at this time, she was very vulnerable. KMPT has a Safeguarding Lead, and it is of concern that a senior professional did not pass on the concerns that Connie had about domestic abuse.
- 11.7.33 KMPT must ensure its doctors understand the need to inform its Safeguarding Lead about patients who are at risk of domestic abuse.
(Recommendation 6)

11.8 Kent Community Health NHS Foundation Trust (KCHFT)

- 11.8.1 KCHFT provides a 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.
- 11.8.2 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.
- 11.8.3 KCHFT has a dedicated Safeguarding Service that provides a point of contact for staff who need advice or guidance about any safeguarding concerns, including domestic abuse, they have in respect of service users. Staff can contact the Safeguarding Service by telephone between 9am and 5pm, Monday to Friday. This is an example of good practice.
- 11.8.4 The service provided by KCHFT that is most relevant to its involvement with Connie was Health Visiting. She also presented on one occasion at a Minor Injuries Unit (MIU).
- 11.8.5 Connie was first seen by a Health Visitor (HV1) in June 2016. She was pregnant and gave birth to Child B about six weeks later. Ryan was present at the start of the visit but left soon after. He was polite and welcoming to HV1, who had no concerns about his behaviour.

- 11.8.6 After Ryan left, HV1 asked Connie about domestic abuse, which was good practice. She did not report any current or historical abuse, although there had been a domestic abuse incident at her home the previous November when she and Ryan had been arrested. HV1 would not have known about this unless Connie had disclosed it. Connie's history of poor mental health was recorded but there is no record of substance abuse.
- 11.8.7 In mid-August 2016, HV1 saw Connie at home for a routine new-birth visit. Ryan was not present, and there is no record of her being asked about her relationship on this occasion.
- 11.8.8 In late September 2016, HV1 visited Connie at home to carry out a routine 6-week visit post-natal and maternal mood screening. The latter uses the [Edinburgh Postnatal Depression Scale](#); this was completed. The score was not recorded nor was there a written assessment of her mood. It was recorded that there was a discussion about Connie's anxiety level and HV1 agreed with Connie that her mental health would be reviewed in four weeks.
- 11.8.9 In mid-October 2016, Connie missed the mental health review appointment. It was the only KCHFT appointment she missed; the reason is not recorded.
- 11.8.10 In late November 2016, HV1 visited Connie at home, having been told that Child B was subject of a Child In Need Plan. Child B's Social Worker and Connie's mother were also present. HV1 agreed to support the family in accessing Children's Centre groups and to support Connie in accessing domestic abuse services. No plans were made for any further home visits before the next CIN meeting; it was recorded that Connie would contact the health visiting team as needed.
- 11.8.11 In late March 2017, HV1 attended Child B's Initial Child Protection Case Conference. She prepared a report for the meeting about involvement with Connie and Child B. Following it, she recorded the details of the domestic abuse that had taken place and the actions taken by other organisations. HV1 agreed to continue supporting Connie with Child B's growth and development, and to arrange a home visit within two weeks. There is no record that this meeting took place or that there was any attempt to arrange it. The CIN Process was run by Children's Social Work Services Social Worker and there is no record that she followed up on whether the meeting took place.

- 11.8.12 In early April 2017, Connie's case was discussed at the Area A MARAC. KCHFT's Health Visiting Domestic Abuse Lead was present and the action allocated to KCHFT was for the Health Visitor to maintain contact.
- 11.8.13 In mid-April 2017, Connie presented at a KCHFT MIU outside Area A, close to her mother's home. Her mother attended with her. Connie had a facial injury and a nosebleed; she said she had a fall two days previously. There was only one mandatory safeguarding question, *'Is there uncertainty of the history given?'* The Emergency Nurse Practitioner (ENP) marked the answer as *'No'*, so there was no requirement to ask further safeguarding questions.
- 11.8.14 When asked who she lived with, Connie said she lived alone with no dependents. This was not true, but it might have caused the ENP to dismiss the thought of domestic abuse as a cause of the injury. MIU staff use a different computer system to Health Visitors, so the ENP could not see that Connie had a history of being a domestic abuse victim. Over a year after visiting the MIU, Connie reported this injury to Kent Police as domestic abuse by Ryan (see section 11.2 above). It is not clear whether Connie's mother was present when these questions were being asked.
- 11.8.15 HV1 attended Child B's CIN Meeting on 28th April 2017 and recorded the updates Connie gave about Child B's health, a domestic abuse incident and her application for a housing move.
- 11.8.16 In early May 2017, HV1 saw Connie and Child B for a routine 9–12-month development review. There were no concerns about Child B's health or development. HV1 asked Connie about her personal situation. Connie said she was staying regularly with her mother outside of Area A as she felt safer there. She said she was not having contact with Ryan.
- 11.8.17 KCHFT's Health Visiting Domestic Abuse Lead attended a MARAC meeting in early June 2017, at which Connie's case was mentioned. The details were recorded, there were no actions for KCHFT.
- 11.8.18 About a week later, HV1 attended Child B's CIN meeting; it was to be the last. The conclusion was that there were no new domestic abuse incidents and no current concerns. There were no actions for KCHFT.
- 11.8.19 HV1 and a KCHFT Community Nursery Nurse saw Connie with Child B in late July 2017 for their one-year developmental review. There were no concerns and HV1 ensured that Connie had relevant contact numbers because the next scheduled meeting would be Child B's two-year developmental review.

- 11.8.20 KCHFT's Health Visiting Domestic Abuse Lead attended a MARAC meeting in early June 2018, where Connie's case was discussed. The action for KCHFT was for her Health Visitor to complete a home visit to review Child B's development.
- 11.8.21 In mid-June 2018, a Health Visitor (HV2) made enquires with CSWS and Centra to gather information prior to a targeted home visit at the end of the month. Both the enquiries and the home visit were good practice and outside the routine schedule of contact. HV2 made detailed notes of the visits, at which Connie's mental and physical health, potential house move, and domestic abuse were discussed. This was good, but it was not followed up by contact with Connie's GP or KMPT to gain a professional perspective on her issues.
- 11.8.22 On 8th August 2018, HV2 again saw Connie for Child B's two-year development check. The review was clearly documented and HV2 planned to make a further review. This was good practice because it was not part of the health visiting schedule. Connie declined a further home visit but agreed to a telephone call in six weeks. This visit was the last contact KCHFT had with Connie, who died before the planned call.
- 11.8.23 Some examples of good practice have been highlighted in KCHFT's involvement with Connie. Apart from one occasion where there could have been contact with other agencies to get additional information, KCHFT shared information with, and sought it from, other organisations.

11.9 Area A NHS Trust

- 11.9.1 Area A NHS Trust is the NHS hospital trust that Connie was involved with during the review period. The hospital she attended is referred to as Hospital A. In addition to its hospitals, Area A NHS Trust provides community midwifery services in Area A.
- 11.9.2 In April 2015, Connie was brought to the A&E department at Hospital A by ambulance, after she reported taking a mixed drug overdose. Tests for traces of these drugs were negative but she was admitted for observation. She told staff that she was drinking a litre of vodka a day. She was seen by the KMPT Psychiatric Liaison Service at the hospital and was subsequently transferred to a KMPT inpatient hospital (see section 11.7 above).
- 11.9.3 In December 2015, Connie presented at the A&E department of Hospital A. She was eight weeks pregnant and suffering abdominal pain. It was noted that her eldest child was in the care of their father because of

Connie's ongoing mental health history. Although there were no safeguarding concerns for Connie at this time, Hospital A contacted Social Services to tell them she was pregnant. This was good practice.

- 11.9.4 A fortnight later, in December 2015, a Midwife from Area A NHS Trust completed a Concern and Vulnerability form during an appointment with Connie. There is no record of whether Ryan was present at this meeting, although from the answers Connie gave, it seems likely he was not. This was detailed; it recorded her use of controlled drugs from an early age, three suicide attempts and a history of self-harm. Connie told the Midwife that Ryan was her partner and that *'he was planning to move in with her eventually'*.
- 11.9.5 There is no record that Connie was asked if she was a victim of domestic abuse. The Trust's domestic abuse policy advised staff that the most appropriate time to ask about this was when recording a patient's social history and as part of a wider assessment. Given the other disclosures Connie made, the question should have been asked (this assumes Ryan was not present). The Midwife did make referrals to Mother and Infant Mental Health Services (MIMHS) and to Social Services Children and Families Team. Connie subsequently complained about the latter referral but given her history of mental health issues and this being the reason why she did not have full care of her first child, it was appropriate.
- 11.9.6 Connie engaged well with midwifery services, but she disengaged with MIMHS. She was asked about this when her Concern and Vulnerability form was updated during an appointment with a Community Midwife in July 2016. Connie said she did not think she needed MIMHS support because she was feeling well. This was discussed with MIMHS who confirmed that unsuccessful attempts had been made to contact Connie by letter and telephone. Given that Connie had been seen regularly through her pregnancy and there were no signs of mental health issues, MIMHS decided to discharge her.
- 11.9.7 There is no record that Connie reported being a victim of domestic abuse during her pregnancy or that she was asked if she was. She gave birth to Child B in early August 2016, and it was recorded that Ryan was present. She was discharged from hospital the same day and seen at home by a Community Midwife the following day. Before her visit, the Midwife had read the Concern and Vulnerability forms completed during Connie's pregnancy. There is no record that she asked Connie about her relationship with Ryan.

- 11.9.8 A further home visit was made by a Midwife a week later. Two weeks after the birth, at a third appointment, Connie's Concern and Vulnerability Form was updated. There were no concerns and she was discharged from the midwifery service.
- 11.9.9 In April 2017, the Children's Safeguarding Nurse from Area A NHS Trust attended a MARAC meeting at which Connie was a subject. This was the first record of the Trust being aware of Connie being a victim of domestic abuse. No actions were allocated to the Trust.
- 11.9.10 In September 2017, Connie presented with Child B at the A&E department of Hospital A, reporting that Child B was feeling unwell. A letter sent to Connie's GP recorded that she left the hospital with Child B before they were treated. A Child Safeguarding Form was completed during this visit because of the Social Services' involvement following domestic abuse against Connie. Her Social Worker and Health Visitor were informed by the hospital about this visit the following day.
- 11.9.11 From the end of September 2017 to June 2018, all the Trust's records relating to Connie relate to her cancer diagnosis. She had a major operation in November 2017 and post-operative treatment over the following few months. An oncology practitioner noted in March 2017 that Connie was very distressed, and she disclosed she was a recovering alcoholic. She was advised to contact her mental health social worker for support. It was also noted she was a full-time mother to two children, one an infant, and the other who was preadolescent. There is no record that referrals were made to the Trust's Named Nurse for Safeguarding Children or to Social Services.
- 11.9.12 Given what Connie told the oncologist at this appointment, while the practical advice given to her was professional, there was no record that her overall wellbeing and care was considered. This was a missed opportunity. The computer system onto which oncologists record meeting notes is not accessible to staff outside the oncology department, so it would have required proactive action to trigger any further care for Connie.
- 11.9.13 In early June 2018, the Trust's Named Nurse for Safeguarding Children attended a MARAC meeting at which Connie was a subject. No actions were allocated to the Trust, which had no further contact with Connie before her death.
- 11.9.14 Area A Hospital Trust were not aware that Connie was a domestic abuse victim until the MARAC meeting held in April 2017. There were missed

opportunities to ask her about her relationship with her partner during the completion and updating of her Concern and Vulnerability Form, both during her pregnancy and after Child B's birth. The nature of the questions she was asked and the disclosures she made were such that a question about domestic abuse would not have been out of place. Given that she suffered mental health problems and substance abuse, which together with domestic abuse form the '[Toxic Trio](#)', the question should have been asked on each occasion.

- 11.9.15 Area A NHS Trust should ensure that initial and refresher training for staff includes emphasis on asking patients about domestic abuse, including coercive control, when completing the Concern and Vulnerability Form.
(Recommendation 7)

11.10 South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

- 11.10.1 SECAmb provides NHS ambulance services across Kent and Medway. As a regional service, it covers other counties and unitary authority areas in South-East England. SECAmb responds to 999 calls from the public, urgent calls from healthcare professionals and provides the NHS 111 non-emergency telephone service.
- 11.10.2 SECAmb received one call relating to Connie during the review period while she was alive. In August 2015, an ambulance crew attended a report that she had taken a deliberate drug overdose with suicidal ideation. Her mother was present, and Connie was given appropriate treatment before being taken to Hospital A. The recorded trigger for the overdose was not domestic abuse related.
- 11.10.3 SECAmb were called to Connie's home by a 999 call from Ryan on the evening of her death. Four paramedics, including a supervisor, attended. Connie was in cardiac arrest when they arrived and despite full advanced life support being administered, Connie died shortly before midnight.

11.11 Kent County Council Children's Social Work Services (CSWS)

- 11.11.1 CSWS is part of the Children, Young People and Education Directorate of Kent County Council. Its customer facing services are generally delivered by local teams and Connie received services from the Area A team.
- 11.11.2 At the end of December 2015, CSWS received a Child In Need (CIN) referral relating to Connie from the Area A NHS Trust Midwifery Service. Connie was pregnant and the referral was made because of her history of

poor mental health, as well as substance and alcohol abuse. The referral also mentioned Connie's suicide attempts, the last being in August 2015.

- 11.11.3 As a result of the referral, on 5th January 2016, a CSWS Social Worker (SW1) was allocated to begin a pre-birth Child and Family Assessment. The work to be carried out, including the checks to be made and timescales, was set by her supervisor. Having been assigned, SW1 contacted Connie that day and arranged to visit her on 8th January 2016. Connie called SW1 back later the same day and appeared unhappy that an assessment was required. During a home visit on 14th January, Connie again expressed unhappiness at CSWS involvement, as did her mother and Ryan, who were both present.
- 11.11.4 Despite the objections, a thorough assessment was carried out with numerous checks made. It was completed on 5th February 2016, when SW1 concluded that there were no concerns and no further CSWS involvement was required. Connie was seen alone on 11th February and told the result of the assessment. She expressed no concerns at the meeting for Ryan.
- 11.11.5 On 20th August 2016, CSWS received a high-risk domestic abuse notification from Kent Police following a domestic abuse incident that happened while Connie was holding Child B (then two weeks old). A strategy meeting decided that the threshold for a S.47 Enquiry was met.
- 11.11.6 On 22nd August 2016, a CSWS Social Worker (SW2) was appointed to begin the enquiries; she visited Connie at her mother's home that day and Child B was also present. Connie was wavering about whether to support a prosecution against Ryan. She said he was good man; the incident had happened after he had been drinking.
- 11.11.7 When SW2 visited Ryan at his mother's house two days later, Ryan expressed the view that the concerns were being blown out of proportion, the incident having resulted from an argument that had escalated due to Connie being jealous. SW2 asked if there had been a previous incident of him being abusive towards Connie. He said there had not.
- 11.11.8 On 2nd September 2016, SW2 visited Connie at her home with her mother and Child B present. SW2 asked questions exploring her mental health and her relationship with Ryan. She said she had no relationship with Ryan, stating he needed help and her priority was Child B. She said she felt stronger in terms of her mental health.

- 11.11.9 On 6th September 2016, following a MARAC meeting, SW2's supervisor (a CSWS Team Manager, TM1) recorded concerns about Connie's ability to safeguard Child B, her poor engagement with specialist services, ongoing mental health issues and the vulnerability of Child B. She recorded that consideration should be given to progressing the case towards an Initial Child Protection Conference (ICPC). Although this showed an appreciation of escalating concerns, a multi-agency strategy meeting was not held to consider whether to progress to an ICPC.
- 11.11.10 Two days later, TM1 recorded further concerns about the lack of openness and honesty by Connie and Ryan. Connie was not engaging with Choices, the domestic abuse support agency, and she was not showing insight into the impact of the family situation on Child B. This followed Child B's attendance at hospital with Connie and Ryan, who had said they were not seeing each other. The explanation Connie gave was not felt to be plausible. There does not seem to have been any consideration that her decision and attitude could have been the result of her being subject to coercive control.
- 11.11.11 SW2 visited Connie on 6th October 2016, when her mother was also present. Connie did not wish to engage in work reflecting on domestic abuse, she wanted to 'just get on with her life'. SW2 was unable to get to the bottom of Connie's reluctance to engage in the work. Again, there was no consideration by TM1 that Connie might be subject to coercive control.
- 11.11.12 On 18th October 2016, a Social Work Assistant (SWA1) visited Connie to discuss the domestic abuse sessions being offered. She was told that Ryan would also be offered these as a perpetrator and that the sessions would be confidential to each person. Connie pointed out that the sessions were not her choice; she felt she was being bullied to take part in them but would make herself available. The sessions were put in place with the purpose of supporting participants and increasing their safety. It was CSWS practice to advise participants of the impact of engaging with the sessions or not. This would provide transparency about how their situation may improve or not and explain the responsibility of CSWS to respond to either situation. Whilst Connie may have perceived this as bullying, it would have been an appropriate course of action.
- 11.11.13 A decision from a Child and Family Assessment was that a Child In Need (CIN) Plan would be prepared for Child B. SW2 was doing this work under the guidance of TM1.
- 11.11.14 On 2nd November 2016, when SWA1 visited Connie for the first session of the domestic abuse work, she remained reluctant to engage. On 7th

November, SWA1 visited Ryan for his first domestic abuse work session. He was not in and not contactable by phone. His mother was present and said she thought that Ryan really needed help with his anger, having had problems with it for many years. Ryan did not make contact and SWA1 consulted with SW2, who decided to put the work on hold.

- 11.11.15 On 22nd November 2016, Connie's Health Visitor phoned SW2 to tell her Connie had been the victim of another domestic abuse incident committed by Ryan. SW2 visited Connie the same day, which was good practice and an indication of how seriously she was taking Connie's case.
- 11.11.16 On 13th December 2016, TM1 carried out a home visit to Connie, who had complained that she was not happy about how she was being treated and felt unsupported. Her mother and SW2 were also present. Connie felt she was being blamed for something she had little control over. She explained a previous reluctance to engage with CSWS because she feared Child B would be taken away from her.
- 11.11.17 TM1 was clear that events involving Ryan attending hospital with Connie when Child B was ill and entering the family home during the night were concerning (both were breaches of his Restraining Order). She told Connie it was difficult to support her when she was refusing to engage, giving the example of the domestic abuse work.
- 11.11.18 On 11th January 2017, SW2 visited Connie with Child B present. Connie seemed more relaxed and said her mental health was better. The following day a Probation Officer told SW2 that Ryan had been released from prison and was living with his mother.
- 11.11.19 The first CIN meeting was held on 23rd January 2017. Ryan was not present, but both his mother and Connie's were. Connie said she was not accessing domestic abuse support because she wanted to concentrate on her care of Child B. Connie said she had medication for her anxiety and depression, and this was working well.
- 11.11.20 On 9th February 2017, TM1 had to remind SW2 that a CIN visit to Connie was overdue. It is not clear why SW2 had missed this. A home visit was made by SW3 on 20th February. There is no record why there was a change of social worker nor was the visit written up, which was not in line with CSWS procedures.
- 11.11.21 On 6th March 2017, SW3 received a domestic abuse notification from City of London Police about an incident that had occurred in its area (see section 11.2. above). The following day, Connie's case was allocated to a

Senior Social Worker (SSW1) who then conducted a home visit on the 8th March. This was primarily to discuss the London incident and consider what impact it might have on the safeguarding of Child B.

11.11.22 On 9th March 2017, TM1 decided to convene a multi-agency strategy meeting, which was held on 29th March. Ryan was not present, having stated he could not get time off work. The outcome of the meeting was that Child B would be made subject of CIN Plan. Connie insisted that she and Ryan had not resumed their relationship.

11.11.23 On 5th April 2017, a Housing Officer from the housing association, Connie's social housing provider, called SW2 to say that the offer to rehouse Connie had been withdrawn because there was information from the police that Connie was engaging with Ryan (the London incident). This meant she no longer met the criteria for rehousing. The housing association had not been invited to send a representative to the ICPC, which was a missed opportunity as they would have heard representations from other professionals and Connie, which might have influenced this decision. KCC Integrated Children's Services should consider inviting housing providers to Initial Child Protection Conferences.
(Recommendation 8)

11.11.24 On 28th April 2017, at a CIN meeting with SSW1, Connie reported that Ryan had breached his Restraining Order in the early hours of that morning by going into the back garden of her house. SSW1 called a Probation Officer to corroborate this. The Probation Officer said she was aware of the incident and had spoken to Ryan, who denied it. On 9th May 2017, Ryan phoned SSW1 denying that he had been to Connie's house.

11.11.25 At a CIN meeting with SSW1 on 15 May 2017, Connie said she had an appointment with a psychiatrist and was on a waiting list for the [Freedom Programme](#). There appears to have been a lack of professional curiosity in this instance as there is no record that SSW1 sought Connie's consent in order to make any further enquiries to corroborate the information Connie had disclosed.

11.11.26 SSW1 held two CIN meeting with Connie in June 2017; at neither were any concerns raised. At the next CIN meeting in late July, Connie's first born child, Child A was also present. SSW1 told Connie that if other agencies agreed, the CIN plan would be closed as no recent concerns had been raised.

11.11.27 The next CIN meeting was in early September 2017. Connie was upbeat and said a recent change to her mental health medication had contributed

to her positive mood. SSW1 again recorded that the CIN plan was likely to close but pointed out that there would be serious concerns should Connie and Ryan resume their relationship.

- 11.11.28 On 4th October 2017, TM1 decided the CIN Plan would be closed. No CIN meeting was held to consider this and there is no record that any other organisations were consulted about the closure. This was a missed opportunity to better inform an important decision about safeguarding Child B. There was no consideration of the involvement of Early Help and Preventative Services, although at that time EHPS was not part of an integrated child service as it is now.
- 11.11.29 On 22nd May 2018 a high-risk domestic abuse notification was received by the [Central Referral Unit](#) (CRU) from Kent Police. No strategy discussion was held within the CRU and there was no immediate referral to the CSWS Area A Team. This was not in line with CRU practice and resulted in a delay in action being taken to safeguard Connie. On 29th May 2018, a referral was made to SSW1, who immediately attempted to call her, without success.
- 11.11.30 SSW1 visited Connie at home on 8th June 2018. She explained her cancer diagnosis (the first time CSWS were aware of this) and described a deterioration in the support Ryan was providing to Child B. At the time of this visit, Ryan was in prison. SSW1 visited Connie again on 18th June 2018 and the following day contacted a KCHFT Health Visitor to alert the service to current concerns and request a development assessment for Child B. This was good practice.
- 11.11.31 On 2nd July 2018, Ryan called SSW1 to say that he had been released from prison and asked what effect it would have on his contact with Child B. Significantly, he stated that contact between him and Connie had been regular since the last involvement with CSWS and confirmed that they had spent some time living together. He said they had both lied to CSWS about their ongoing relationship. This information was not shared with any other agencies. This was a missed opportunity, particularly given the emphasis that had been placed on the serious concerns that would arise if their relationship resumed.
- 11.11.32 The following day, SSW1 spoke to Connie and told her what Ryan had said about their relationship. Connie denied the claims and became upset, handing the phone to her mother, who also denied them. The information was not shared with other organisations.

- 11.11.33 On 11th July 2018, Ryan visited the CSWS office and spoke to SSW1, confirming that he and Connie had been dishonest throughout the last CSWS involvement regarding their ongoing relationship. SSW1 advised Ryan that if his relationship with Connie resumed, CSWS would again consider Child Protection proceedings. By Ryan's own admission the relationship was not viable. This was a further opportunity to alert other organisations, but it was not done.
- 11.11.34 Two days after a CIN visit by SW4 on 16th July 2018, TM1 wrote a note closing Child B's case to CSWS. There is no record that other organisations were consulted, but the note contains a significant contradiction. It highlighted that the purpose of the assessment was not to establish whether Connie and Ryan's relationship had continued but to focus on the impact on Child B. It went on to state that if there was information that they were resuming their relationship, and there was any risk of domestic abuse, it would result in child protection procedures being considered. There is a clear juxtaposition in this entry; it initially says the assessment was not to establish whether Connie and Ryan were in a continuing relationship but ends by stating that if they were, it would result in child protection procedures being considered.
- 11.11.35 The rationale for the closure was confused and confusing but the Review Panel accepts that one event may not be indicative of wider practices in CSWS. The current practices within children's services include a clear approach to case closures in line with the case audit and performance management protocols. The recently revised supervision policy has clear guidance for managers to discuss closure rationale, and for a senior manager to make an entry on the case notes to justify the closure rationale, clearly recording this on the child's file. Relevant supporting information relating to the current policies, case progression system and quality assurance arrangements can be found in Appendix B, after the glossary. For that reason, no recommendation arises from the case closure.
- 11.11.36 On 21st August 2018, a KSSCRC Responsible Officer emailed SSW1 to say she had seen Child B in Ryan's van. She also explained what Ryan had told her about the mutual arrangement he had come to with Connie for access to Child B. SSW1 said that CSWS would again become involved if it appeared that Child B was being exposed to domestic abuse. SSW1 sent letters to Connie and Ryan the next day highlighting the concerns raised by a report of them resuming their relationship. This suggests further confusion about the trigger for reinstating child protection

procedures – the renewal of the relationship or domestic abuse at which Child B was present.

- 11.11.37 Connie and Ryan each responded to SSW1's letter, denying that they were back in a relationship. Connie's call on 24th August 2018 was her last contact with CSWS.
- 11.11.38 This review recognises that the primary role of CSWS is to protect children. When domestic abuse is taking place in a relationship where those involved have children, CSWS must consider first the impact on any child subject to or witnessing the abuse. However, in the same way that other organisations should tell CSWS when they are dealing with domestic abuse situations that might involve children, so CSWS should share information it receives that may indicate the risk to an adult domestic abuse victim has or will increase.
- 11.11.39 In the last two months of Connie's life, CSWS received and continued to receive information that Connie and Ryan had resumed their relationship. Although Connie denied this, Ryan repeated it, and there is no record of consideration being given to the possibility that she was denying it because she was subject to coercive control.
- 11.11.40 Rather than share this information with other organisations or seek to establish whether there was any corroboration for it, CSWS closed Child B's case during this period. This was despite recording that Connie and Ryan resuming their relationship might have resulted in Child Protection procedures being considered.
- 11.11.41 Whilst decisions and actions in one case do not always extrapolate into general practice, it is concerning that opportunities were missed to establish whether the risk to Connie was increasing, which in turn would impact on Child B, who CSWS had a primary duty to protect.
- 11.11.42 Overall, there was a lack of appreciation of the possibility that Connie's disclosures and decision making could have been due to her suffering coercive control. This is not altogether surprising because CSWS regularly experience parents being less than honest, fearing that the truth may make it more likely that their child will be removed from their care. Connie had experienced this in the past, so might have been expected to give accounts that in her eyes reduced the risk of it happening again.
- 11.11.43 Consideration should have been given to the impact Connie's cancer diagnosis may have had on her decision making.

- 11.11.44 This case is a reminder that CSWS and other organisations that focus on child protection and welfare, should consider sharing and discussing information they receive about adult domestic abuse victims and perpetrators with other organisations that support victims and act against perpetrators. Connie's tragic death, which can only have had an adverse effect on her children, is evidence of this.
- 11.11.45 Since this review began, CSWS has been restructured in Kent to integrate all services such as Early Help and the 18+ Care Leavers Service. This new structure is called Integrated Children's Services (ICS).
- 11.11.46 KCC ICS must ensure that safeguarding training for its staff includes the safeguarding responsibilities of the service beyond its primary role of child protection, including the need to share safeguarding concerns with other relevant organisations. **(Recommendation 9)**

11.12 Local Housing Association

- 11.12.1 Connie's housing association owns and manages more than 5000 properties in Kent.
- 11.12.2 Connie moved into a house from her housing association in late 2015. The property was new; she was the first tenant. She lived there until her death and she never applied for anyone else to be added to the tenancy.
- 11.12.3 In late 2016, the housing association became aware that Connie was a victim of domestic abuse when they were contacted by an IDVA working for Choices. Choices were the domestic abuse support organisation commissioned by KCC to provide services in Area A at the time. The IDVA went on to work for Centra, whose involvement with Connie is considered in section 11.5. The purpose of the IDVA contact was to ask the housing association to begin a managed transfer of Connie to a new address.
- 11.12.4 An application for a managed transfer is usually made by the tenant. As the IDVA made the application on Connie's behalf, it was escalated to the housing association's senior management for authorisation, in line with the company's policy. The managed transfer process was authorised. It could only offer Connie a transfer to another property in Area A. To move to another local authority area, she would have had to apply to the housing department in that area.
- 11.12.5 Connie would normally have had one formal offer of alternative accommodation, but because she was a domestic abuse victim, she

received two informal offers, both of which she declined. It is not known why she declined the offers, but she was living in a new house in a pleasant area and properties of its standard are in limited supply.

- 11.12.6 At a MARAC meeting in January 2017, the housing association representative asked if other organisations who were in contact with Connie could encourage her to engage with the company about the managed transfer process. This was an action that organisations took from the meeting.
- 11.12.7 At a MARAC meeting in April 2017, the housing association representative reported that Connie's managed transfer application was being withdrawn. The housing association Officer dealing with Connie's application wrote to her, telling her of this decision. At the time of this review, the Housing Officer no longer worked for the company and the letter he wrote to Connie could not be found.
- 11.12.8 A reply to the Housing Officer's letter, written by Connie's mother in mid-April 2017, was available and suggests the decision to withdraw her application may have been taken because the Housing Officer had heard about the incident in London involving Connie and Ryan (see section 11.3 above). This might have given him the impression they were back in a relationship and therefore the reason for the managed transfer no longer applied. A letter from Connie's mother in response stated the situation was not as it seemed, and she requested the transfer process should continue. Connie reiterated this in a letter she wrote to the Housing Officer in the first week of May 2017. However, the application was not reinstated.
- 11.12.9 It was not in line with the housing association's policy in force at the time for a Housing Officer to withdraw a managed transfer application. It should have been escalated up company's management structure for a decision to be made at senior level, in the same way as the authorisation to begin the process. This did not happen, and the application was withdrawn.
- 11.12.10 About a month before Connie died, another housing association Officer (she had four during her tenancy) began a second managed transfer process, which was ongoing at the time of her death. This Housing Officer knew about Connie's mental health issues, which were not mentioned in the first application, and knew she was suffering from cancer. Connie had expressed a wish to move to a village within the Area A boundary, but although the housing association have a small number of properties there, none were available.

- 11.12.11 The housing association, in common with other housing associations, has a signposting role in domestic abuse cases. Their staff notify and refer to organisations that can manage the risk, support the victim and deal with the perpetrator. In addition, the company offers domestic abuse victims practical support, such as personal alarms, door and window locks, and in some cases security cameras.
- 11.12.12 During the review period, the housing association were invited to and attended three MARAC meetings where Connie's case was discussed. The association has a domestic abuse policy for how staff respond when a tenant reports or is believed to be a victim of domestic abuse. It has staff trained to carry out S-DASH risk assessments and where the risk is high, either from the score or professional judgement, the housing association will make a MARAC referral. In Connie's case, she had an IDVA assigned to her before the housing association became aware (from the IDVA) that she was a domestic abuse victim. Kent Police were also involved.
- 11.12.13 As a result of Connie's death, the housing association has carried out an internal review of its approach to domestic abuse cases. It recognises that its policy for withdrawing a managed transfer application was not followed in this case and has put checks in place to ensure it is adhered to in future.
- 11.12.14 Connie's first managed transfer process was open for four months and this is typical of the length of time a transfer takes, particularly if a tenant declines property offered to them. However, considering Connie's case, the housing association has recognised that this is too long in cases of serious domestic abuse and is considering how it can expedite such applications.
- 11.12.15 The housing association understands the need to take care when discussing issues such as managed transfer with domestic abuse victims, so as not to alert the perpetrator or increase risk to the victim. Its staff said that Ryan was intimidating, and they recognised that too much interference could antagonise him, further endangering Connie. However, having reviewed this case, the company feels there could have safely been more face-to-face contact with Connie.
- 11.12.16 The association has recognised that its staff need to be alert to the possibility of coercive control influencing the decisions domestic abuse victims make. Connie and Ryan appearing to have resumed their relationship should not in itself have been viewed as a reason to withdraw the first managed transfer application, because it may have been due to

Ryan exercising coercive control. Had the Housing Officer followed the correct procedure when considering the withdrawal of Connie's application, more enquiries may have been made and greater weight given to requests by her and her mother to continue with the process.

- 11.12.17 The housing association staff have received domestic abuse training but, as a result of Connie's case, the company is commissioning Domestic Abuse Housing Alliance, which supports domestic abuse victims with housing issues, to deliver additional training. This is good practice and is something that other housing associations should consider if they have not already done it. Kent and Medway Domestic Abuse and Sexual Violence Group should ask Connie's housing association to report on the additional training provided to its staff and consider circulating details to other housing associations in Kent and Medway. **(Recommendation 10)**

12. How Organisations Worked Together

- 12.1 If organisations involved with domestic abuse victims and perpetrators work well together, the risk of harm to the victim 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.
- 12.2 Section 11 highlights areas of good practice when professionals shared relevant information with, or sought if from, others in relevant organisations. It has also identified occasions when professionals could have done so but did not.
- 12.3 It is positive to note that information sharing and seeking by practitioners, particularly those working for agencies that feature regularly in DHRs, was in general better than in many previous reviews. This is hopefully a sign that the value of this is now widely recognised and that professionals feel empowered to contact other organisations both to impart and enquire about potentially relevant information. However, there are still examples where information was not shared or sought, so there is no room for complacency.
- 12.4 It is understandable that when an organisation, or a part of it, is under pressure, perhaps because of staff shortages or high demand, its focus will be on delivering its core service. It is at these times when information sharing and seeking may become less of a priority. The risk is that the whole picture of the threat to a person and their vulnerability, including that resulting from domestic abuse, does not emerge. Most importantly, this increases the risk to that

person, but it may increase the workload of agencies in the longer term. Prompt and effective information sharing should get the person the support they need, delivered by the appropriate organisations. This increases the chances of reducing the threat they face and their vulnerability, which may in turn decrease their need to seek help.

- 12.5 The Multi-Agency Risk Assessment Conference (MARAC) is the forum in which domestic abuse cases involving high-risk victims are discussed. Connie was referred six times during her relationship with Ryan. Actions were clearly minuted and there was good attendance and information sharing by relevant agencies.

13. Conclusions

- 13.1 Connie was a victim of domestic abuse who, in the last year of her life was suffering from mental health problems and cancer. The Family Court had ordered that Child A live with their father and she was probably fearful that the same would happen with Child B. Any one of these factors would have been stressful; together they made her extremely vulnerable. She needed not only safeguarding, but care. Reviews of this type tend to focus on safeguarding, but the value of inter-agency working is broader because it should also identify vulnerabilities that can be addressed by caring in addition to safeguarding. This is highlighted in cases such as Connie's, where death does not result from homicide but from a person becoming overwhelmed by the pressures on them.
- 13.2 Connie's mother was supportive of her, including providing an alternative place for her to live for a time. Although there are numerous examples of organisations providing a good service to Connie, there seems to have been a lack of appreciation of all the factors that contributed to her vulnerability. Each organisation understood the issue requiring its service, but there is no evidence that the immense weight of the problems she faced was appreciated.
- 13.3 Connie's engagement with organisations was not consistent. At times she would engage for months before stopping. During the last months of her life, organisations found it difficult to contact her. Although some organisations made considerable efforts to contact her and maintain engagement, there is little evidence that the possible reasons for her decision to disengage were explored. For example, there is no record that consideration was given to this being due to her cancer becoming her overriding concern, or her fear that the court could rule that Child B live with their father. The latter must have been a real worry for her because of her experience with Child A. Her mother has confirmed that this was a significant factor that influenced the decisions that Connie made. It was exacerbated by the operation she had to treat her cancer,

which meant she could not have conceived again. It is a sad irony that her mother saw a letter following Connie's death, which indicated that her cancer had been eradicated.

- 13.4 Most importantly, given that Connie was a high-risk domestic abuse victim, her reduced engagement could have been because she was subject to increasing coercive control. She began her relationship with Ryan after separating from her previous partner; the first known incidence of violence in the relationship with Ryan was in November 2015, about the time she became pregnant with Child B. The risk was assessed as 'standard' based on the knowledge the police had at the time. It is unlikely that they were aware of the relationship history (the relationship moved quickly in 2015, mirroring stages that are now more familiar from [Dr Jane Monckton-Smith's Homicide Timeline](#)) or the pregnancy. In hindsight these indicate a greater risk. Domestic abuse and associated risks are often hidden. There were no further reports of domestic abuse until two weeks after Child B's birth when Ryan subjected her to a violent assault. She reported this, but she did not always want to pursue police action against him.
- 13.5 Professionals trying to engage with Connie in the last few months of her life knew she was a high-risk domestic abuse victim; in the case of Centra, that was why they were attempting to contact her. A reluctance by her to engage with organisations should have first raised concerns that she was subject to coercive control. This concern should apply in all cases involving domestic abuse victims who decline to engage, and when it becomes harder to contact a victim, particularly if this has not previously been difficult.
- 13.6 Kent Police pursued prosecutions against Ryan (resulting in prison sentences) when Connie was not supportive of this action. This is seen as positive in relation to the progress being made with respect to prosecutions which may have previously relied upon the complainant's evidence. Though it must consider the impact on, or possible increased risks to, the complainant. Examples of failures to understand that Connie might be behaving in a way that was not wise due to coercive control, led the housing association to withdraw from a managed move process and Centra to close her case.
- 13.7 Connie had lost residency of Child A to their father; this caused her understandable distress. There is no evidence that the fear of this happening again with Child B was considered as a possible reason why she sometimes seemed reluctant to engage with organisations. Research shows that mental health needs and reliance on drugs or alcohol because of an abusive relationship can impact on parenting capability, leading the parent to become a

'gatekeeper' of information¹. This may relate to a fear of losing their children, an abusive relationship or a desire to protect their 'territory'. It is important that social workers recognise the importance of having the right conversations with parents who are resistant to engaging².

- 13.8 Recommendations have been made in Section 11 when issues relating to individual organisations have been identified, and which could be addressed to improve the safeguarding and support given to domestic abuse victims in the future. The wider issue is the need to consider a victim's whole life circumstances when considering their vulnerability and the support they need.

14. Lessons Identified

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

14.1.1 This is necessary to ensure that responses are appropriate to individuals and not simply the result of adherence to policy. It may be frustrating for professionals when domestic abuse victims keep in contact with perpetrators. Connie's mother highlighted how vulnerable Connie was and how she wanted to be loved.

14.1.2 Information sharing and seeking are important to gaining a clear understanding of the issues the victim is experiencing and possible motives for decisions they take that may not seem to be in their best interests, at least from the professionals' points of view. A number of factors can influence decisions such as maintaining a relationship with an abusive partner or declining offers of support. Moving away from a one size fits all approach to an evidence-based approach for developing a needs-led set of interventions may allow offers of support that are better tailored and therefore accepted.

14.2 If a domestic abuse victim becomes more difficult to engage, professionals must consider whether this might be because she or he is subject to coercive control.

14.2.1 People are entitled to decline to engage or stop engaging with organisations; they do not have to justify their reasons for doing so.

¹ [Children Experiencing Domestic Violence: A Research Review, Nick Stanley \(2011\)](#)

² [Engaging resistant, challenging and complex families. Research in Practice, Strategic Briefing \(2012\).](#)

14.2.2 Some organisations have policies for managing people who decline to engage or stop engaging. Others may consider withdrawing their efforts to engage on a case by case basis. With either approach, the organisation needs to be able to demonstrate consistency. For people who are identified as victims of domestic abuse, the approach must not be mechanistic; it should consider *why* the person is not engaging.

14.2.3 When considering withdrawing services from a person who is a domestic abuse victim, a primary consideration must be that if she or he does not or will no longer engage, this may be due to them being subject to coercive control. Disengaging may make the person more vulnerable to harm. Every effort should be made to establish their current circumstances from other organisations who are dealing with the person before deciding to withdraw the service.

14.3 The vulnerability of a domestic abuse victim to coercive control may be increased by other factors in their life and professionals must take all the issues known about the person into account when making decisions about safeguarding and supporting victims.

14.3.1 As is clear from Connie's case, other life factors such as mental and physical health, and child residency, are likely to increase a victim's vulnerability and may influence their assessment of risk.

14.3.2 Professionals cannot prevent a domestic abuse victim with mental capacity from making decisions that they may not agree with, but they should consider all life factors when deciding how best to provide safeguarding and support.

15. Recommendations

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

	Paragraph	Recommendation	Organisation
1.	11.3.44	Kent Police must have processes in place to ensure that intelligence received (from any source) about domestic abuse, particularly if it refers to a high-risk victim, is evaluated and disseminated expeditiously to the relevant department to ensure it is acted upon appropriately.	Kent Police
2.	11.5.22	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
3.	11.6.10	Clinical Commissioning Groups should ensure that when it is known to a GP practice that a patient is a victim of domestic abuse, this is clearly highlighted in their notes if they transfer to another practice.	CCGs in Kent and Medway
4.	11.6.18	Kent and Medway CCGs should encourage GP practices that have electronic recording systems for patients' notes with a flagging facility, to use this to flag patients (and where relevant, children and other family members) who are victims of domestic abuse.	CCGs in Kent and Medway
5.	11.6.22	Kent and Medway Domestic Abuse and Sexual Violence Group should consider how best to ensure that a high-risk domestic abuse victim's GP is invited to attend or contribute to a MARAC meeting at which one their patients will be	Kent and Medway DASVG

	Paragraph	Recommendation	Organisation
		discussed.	
6.	11.7.33	KMPT must ensure its doctors understand the need to inform its Safeguarding Lead about patients who are at risk of domestic abuse.	KMPT
7.	11.9.15	Area A NHS Trust should ensure that initial and refresher training for staff includes emphasis on asking patients about domestic abuse, including coercive control, when completing the Concern and Vulnerability Form.	Area A NHS Trust
8.	11.11.23	KCC Integrated Children's Services should consider inviting housing providers to Initial Child Protection Conferences.	KCC Integrated Children's Services
9.	11.11.46	KCC ICS must ensure that safeguarding training for its staff includes the safeguarding responsibilities of the service beyond its primary role of child protection, including the need to share safeguarding concerns with other relevant organisations	KCC Integrated Children's Services
10.	11.12.17	Kent and Medway Domestic Abuse and Sexual Violence Group should: ask the housing association to report on the additional training provided to its staff; and consider circulating details to other housing associations in Kent and Medway.	Kent and Medway DASVG

Kent & Medway Multi-Agency Review

Deceased – Connie Smith

Terms of Reference

These terms of reference were agreed by the Multi-Agency Panel following their meeting in December 2018.

Background

In August 2018, South East Coast Ambulance Service were called to a house in Area A, Kent by Ryan Davis, who had found his partner, Connie Smith, hanged in the bedroom of the home she shared with their infant Child B. Connie Smith was in her early 30s at the time of her death.

At the time of Connie's death, there was a Restraining Order preventing Ryan from contacting Connie or attending her home. Information suggests that he may have been staying at the house on a permanent basis since his release from prison in June 2018.

Whilst Connie was not the victim of a homicide (the killing of one person by another), 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 20 November 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 this Multi-Agency Review is to:

Appendix A

- a) establish what lessons are to be learned from Connie's 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 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 Connie Smith.

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, Connie Smith.

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 Connie and/or Ryan 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 had any direct involvement with Connie or Ryan, 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 Connie or Ryan from 1 January 2015 to August 2018. If any information relating to Connie being a victim, or Ryan being a perpetrator, of domestic abuse before 1 January 2015 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 Connie's death, 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 Connie and/or Ryan. If the information is not relevant to the circumstances or nature of Connie's death, 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:

Appendix A

- i. Were practitioners sensitive to the needs of Connie, 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 Honour-based Violence (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Connie? 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?

Appendix A

- 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? Ways of working effectively that could be passed on to other organisations or individuals?
- xiii. 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?
- xiv. Did any staff make use of available training?
- xv. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
- xvi. How accessible were the services to Connie?

GLOSSARY

Abbreviations and acronyms used in the report are listed alphabetically.

Abbreviation/Acronym	Expansion
A&E	(Hospital) Accident & Emergency Department
ASCH	(KCC) Adult Social Care & Health
CAFCASS	Children and Family Court Advisory and Support Service
CRC	Community Rehabilitation Company
CSP	Community Safety Partnership
CST	(Kent Police) Combined Safeguarding Team
CSWS	Children's Social Work Services
DHR	Domestic Homicide Review
DASH	Domestic Abuse, Stalking and Honour-based Violence
DASVG	(Kent & Medway) Domestic Abuse and Sexual Violence Group
DVDS	Domestic Violence Disclosure Scheme
GP	General Practitioner
GPP	General Practitioner Practice
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Report
IOPC	Independent Office for Police Conduct
KASAF	Kent Adult Safeguarding Alert Form
KCC	Kent County Council

Abbreviation/Acronym	Expansion
KCHFT	Kent Community Health NHS Foundation Trust
KMPT	Kent and Medway NHS and Social Care Partnership Trust
KSSCRC	Kent, Surrey and Sussex Community Rehabilitation Company
MAR	Multi-Agency Review
MARAC	Multi-Agency Risk Assessment Conference
MHA	Mental Health Act
MIU	Minor Injuries Unit
NHS	National Health Service
NPS	National Probation Service
PSS	Post Sentence Supervision
ROSH	Risk of Serious Harm
RSR	Risk of Serious Recidivism
SECAmb	South East Coast Ambulance Service NHS Foundation Trust
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 & Honour-based Violence (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking 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.

Multi-Agency Risk Assessment Conference (MARAC)

A 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).

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.

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 covering the 13 MARACs.

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.

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.

Section 47 Children Act 1989 Investigations

A Section 47 enquiry requires the local authority Children's Social Services Department to carry out an investigation when they have '*reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm*'.

The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child. The child's parents/carers will be interviewed, as well as the child (unless the child is too young). The assessment will also include information from relevant agencies such as the child's school, doctor and other professionals.

Child Protection Conference

A child protection case conference is a meeting which is held when Children's Social Care and the police are still concerned about a child's health, safety or happiness after an enquiry has taken place.

Government guidance called Working Together to Safeguard Children (2015) says that, in such cases, a child protection conference must be held.

There are two types of conference. The first one to take place after an enquiry is called an initial conference. There will be other conferences after the initial conference, and these are called reviews.

Child in Need Plan

Child in Need Planning Meetings will follow an assessment which has concluded that a package of family support is required to meet the child's needs under Section 17 of the Children Act 1989.

The Planning Meeting provides an opportunity for a child and his or her parents/carers, together with key agencies, to identify and agree the package of services required and to develop the Child in Need Plan.

All Child in Need Planning Meetings should be attended by the child (depending on age and understanding), parents/carers and those agencies whose potential/actual contribution is recommended as an outcome of an assessment.

Domestic Violence Disclosure Scheme

The Domestic Violence Disclosure Scheme (DVDS) – often referred to as “Clare’s Law” after the tragic case of Clare Wood, who was murdered by her former partner in Greater Manchester in 2009 – was rolled out across all 43 police forces in England and Wales in March 2014 following the successful completion of a 14 month pilot. The Scheme was introduced to set out procedures that could be used by the police in relation to disclosure of information about previous violent and abusive offending by a potentially violent individual to their partner where this may help protect them from further violent and abusive offending. A review of the scheme was conducted in 2015.

The Domestic Violence Disclosure Scheme did not introduce any new legislation. The scheme is based on the police's common law power to disclose information where it is necessary to prevent crime. The scheme provides structure and processes for the exercise

of the powers. It does not, in itself, provide the power to disclose or to prevent disclosures being made in situations which fall outside this scheme.

The Home Office has published [guidance](#) on the implementation of DVDS.

Building Better Relationships (BBR)

BBR is a nationally accredited programme designed to reduce re-offending by adult male offenders convicted of intimate partner violence. The programme, based on group work, takes account of recent developments in thinking and research in relation to aggression within relationships.

Central Referral Unit (CRU)

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

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

Bipolar affective disorder and emotional unstable personality disorder (EUPD)

EUPD is characterised by pervasive instability of interpersonal relationships, self-image, mood, and impulsive behaviour. Sufferers experience rapid fluctuations from confidence through to despair, fear of abandonment and rejection. They have particularly strong tendencies towards suicidal thinking and self-harm, with transient psychotic symptoms, brief delusions, and hallucinations. ³ People with EUPD are particularly at risk of death by suicide,⁴ or (presumably) death by misadventure.

³ See [Borderline personality disorder information at Patient | Patient](#) Accessed 28th April 2021

⁴ [Leichsenring F, Leibing E, Kruse J, et al; "Borderline personality disorder" *Lancet* 1377\(9759\) \(January 2011\) 74-84](#)

Additional Information – Children’s Services

Children’s Services – Additional information for 11.11.35

Excerpt from Integrated Children’s services supervision policy (updated and agreed in 2019)

Reviewing the impact on families of completing previous actions. Supervision must review the children’s plan, previous supervision actions and analyse the impact of the family’s participation with services. Comparing between where the family was, what was aspired to be achieved and the impact of the family engaging with services, allows supervision to challenge drift and assess the effectiveness of service delivery. There must be a willingness to accept the practice may have been limited and to try something different against analysis of the family’s capacity to change. There must be analysis of the impact of not providing the practice, or the family not making changes. This supports documenting defensible decision making with respect to ending ICS’ involvement or understanding the level of support a family requires (whether to step up or step down). It supports the supervisee in developing the narrative to share with families and multiagency to explain next steps.

Case progression system - a weekly meeting between managers and their staff to assess the family journey and ensure that all actions taken are appropriate- see excerpt below:

The Case Progression Framework includes some key elements to ensure this model is used to drive good practice from practitioners:

- Case Progression Boards – Each of the 6 stages has a board. Each sensible family group is represented on a magnetic tile which is placed onto the appropriate board;*
- Case Progression Meetings – Where the boards are used to identify when families are progressing onto a new part of their plan or getting stuck at a certain stage of the change process. These cases are then discussed as a group using the Signs of Safety framework which should result in a consideration of the effectiveness of the plan and the need for changes to enable the family to continue to progress;*
- Recording of Discussions – When a case is discussed, the content should be recorded on the child’s file and the group supervision template in Liberi used to record the content of the discussion.*

Quality assurance arrangements should involve:

Appendix B

- *As a minimum it is expected that each Case Progression meeting is audited every two months against the agreed quality assurance tool;*
- *There is an expectation that Service Managers and Practice Development Officers and Team Managers audit each team's Case Progression meeting alternately twice per year;*
- *Formal audits should include cross referencing with case files to quality assure decision making and recording;*
- *A regular dip sample audit (timescales and process to be agreed) considers a sample of closed/Stepped Down cases 3 - 6 months after closure to test that changes for the child have been achieved and sustained. Cases that are re-referred or re-opened over this period should be reviewed (process to be agreed) to support learning in relation to the case progression process.*