

Domestic Homicide Review

Paul/2012

Overview Report

Author: Helen Carter

**Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership**

Preface

This report of a domestic homicide review (DHR) examines agency responses and support given to Paul (deceased) and Katie, his partner, both residents of Kent prior to the point of Paul's death on 27th September 2012.

The review considered agencies' and service providers' contact/involvement with Paul and Katie from 1st January 2012 until Paul's death.

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

It should be noted, at the outset, that Katie was charged with but acquitted of Paul's murder.

The agencies involved with both Paul and Katie had, by the time of the acquittal, substantially completed their individual management reviews (IMRs) and agreed that even though the circumstances of Paul's death no longer fell within the definition of a domestic homicide there were, nevertheless, useful lessons that could be learned that might help reduce the risk of domestic abuse in future. The decision to complete the review and produce this overview report was taken by the DHR Panel on 24th April 2013. The content and format of the report follows the framework set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews but, as Paul's death no longer falls within the scope of this guidance, the DHR Panel and Independent Review Chair agreed that some discretion could be exercised with regard to the level of detail that is included.

Timescales

The Review was commissioned by the Kent and Medway DHR Core Panel on 1st November 2012.

The DHR panel met to

- discuss draft terms of reference on 23rd January 2013
- review the IMRs on 24th April 2013
- review the first draft of this report on 30th July 2013
- consider a further draft report on 3rd October 2013

The panel agreed the final report on 18th August 2014.

Home Office guidance is that reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. A number of factors have militated against meeting this timescale including the need to increase the pool of Independent Chairs available to call upon and resource constraints within several of the agencies contributing to the review.

Confidentiality

This report has been anonymised and all the personal names contained within it, with the exception of references to members of the review panel, are pseudonyms as set out below.

- Aaron Katie's son from a previous relationship.
- Paul Deceased. Katie's partner from circa March 2012 until the time of or shortly before his death in September 2012.
- Katie Paul's partner from circa March 2012 until the time of or shortly before his death in September 2012.
- Gary Katie's partner during the early part of 2012.

Dissemination

The following recipients have received copies of this report:

- | | | |
|-----------------|---|--|
| Paul Brightwell | – | Kent Families and Social Care, Safeguarding Children |
| Carol McKeough | – | Kent Families and Social Care, Safeguarding Adults |
| Shafick Peerbux | – | Kent Community Safety |
| Gaby Price | – | Kent Drug & Alcohol Action Team |
| Matthew Lewis | – | Thanet Housing |
| Victoria May | – | Thanet Housing |
| Michael Lowe | – | KCA (Substance Misuse Service) |
| Katrina Brown | – | Kent & Medway NHS and Social Care Partnership Trust |
| Andrew Coombe | – | Kent & Medway Clinical Commissioning Group |
| Tina Hughes | – | Kent Probation |
| Andy Pritchard | – | Kent Police |
| Tim Smith | – | Kent Police |
| Alison Gilmour | – | Kent & Medway Domestic Violence Co-ordinator |
| Tim England | – | Medway Safer Communities |
| Sabine Voight | – | Kent Families and Social Care, Safeguarding Children |

Acknowledgments

The contribution of the IMR writers, the people who were interviewed or provided information for IMRs, members of the DHR Panel and assistance of staff working on behalf of Kent Community Safety Partnership is gratefully acknowledged.

1. Introduction

1.1 Background to the review

1.1.1 In September 2012 Katie telephoned South East Coast Ambulance service to report that her partner, Paul, had been stabbed. Paramedics and Police attended the address where Katie lived with Paul. Paul was taken to hospital and subsequently died of his injury.

1.1.2 The Police found knives, blood on the wall and furniture and signs of a disturbance in the flat that Paul shared with Katie. Katie stood trial for Paul's murder in April 2013. She pleaded 'not guilty' and was acquitted. At her trial, she reported that she had been a victim of domestic abuse at Paul's hands.

1.2 Establishing the Domestic Homicide Review (DHR)

1.2.1 Section 6.2 of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews April 2011 (the Guidance) states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership (CSP).

1.2.2 The Kent and Medway DHR Core Panel met on 1st November 2012 to consider whether Paul's death met the criteria for a DHR as defined in the guidance. They agreed it did and the decision was ratified by the Chair of the Kent Community Safety Partnership (under a Kent and Medway CSP agreement to conduct DHRs jointly). As required under the guidance, the Home Office was informed.

1.2.3 Section 6.4 of the guidance states that DHRs should be completed within six months from the date they are commissioned. This has not been possible with this review. The number of concurrent DHRs in Kent & Medway at the time this review was commissioned necessitated the recruitment of additional Independent Chairs. The number of concurrent reviews also has implications for the agencies required to produce IMRs. These are often labour and time intensive and have to be completed from within existing resources. In this case, a number of the agencies/service providers involved did not have anyone with the requisite skills to produce the IMR and others had their capacity severely reduced by staff sickness; in these cases additional support had to be drafted in. It is nevertheless evident from the IMRs that a number of organisations identified lessons to be learned and took action to implement this learning as early as March/April 2013.

1.2.4 The early stages of the review ran concurrently with the criminal investigation about the circumstances of Paul's death and the subsequent trial and acquittal of his partner, Katie. By the time of her acquittal, the IMRs were largely complete and the DHR panel agreed, therefore, that as there were potentially useful lessons that could be learned that might help reduce the risk of domestic abuse in future an overview report should be completed.

1.3 Conducting the review

1.3.1 The review was conducted as set out in the guidance. Agencies were asked to give chronological accounts of their contact with the deceased (Paul) and the alleged perpetrator (Katie) prior to the alleged homicide. These individual management reviews (IMRs) were intended to cover the following:

- A chronology of interaction with the victim and/or his family
- What was done or agreed
- Whether internal procedures were followed
- Analysis, lessons learned, conclusions and recommendations for an agency action plan.

1.3.2 Training for IMR report writers was provided by Kent Police. A template was also provided to assist organisations to gather, analyse and present the required information in a consistent format. The extent to which the key areas were covered, the quality of analysis and the format in which reports were presented varied between agencies. A small number were initially of a wholly inadequate standard in that, for example, they lacked any analysis, omitted key data (including, in one case, only detailing the subject's interaction with one department in the organisation when it was known that, during the relevant period, s/he was in touch with several) and/or did not address the broader terms of reference. In every case these were referred back to the appropriate organisations for further work.

1.3.3 A number of points of clarification or requests for further information were put to most report writers as a result both of the Independent Chair's own analysis and the panel's input.

1.3.4 The responses to the request for IMRs to be reworked or expanded upon, or for more information/clarification to be provided was mixed in terms of both the timeliness and the quality of any reply. Some also provided detail that was at odds with or appeared to contradict information previously supplied in the main IMR even though, originally, there had been no reason to question it. Where relevant and necessary, in the context of the overall purpose of this report, further steps were taken to resolve any such issues.

1.3.5 Where there was no involvement or insignificant involvement, agencies advised accordingly. Those deemed to have some – but not significant – involvement were asked to provide chronologies.

1.3.6 The review focuses, in the main, on events from 1st January 2012 until Paul's death on 27th September that year. Organisations were also asked to record, where it seemed especially relevant, key facts prior to January 2012 and thus their accounts of involvement with Paul are not necessarily coterminous. Some of the accounts have more significance than others.

1.3.7 The chronologies and IMRs form the basis of this overview report.

1.4 DHR Panel

1.4.1 Helen Carter was appointed as the Independent Chair and Author of the DHR overview report. Helen is an independent consultant, based in Kent, with extensive experience in the health, criminal justice and social care sectors. She has been a non-executive director in both health and the Probation Service, a board advisor in the health service and has worked, on a freelance basis, both with the Police and within prisons. She has conducted a number of strategic and multi-agency reviews, is a lay member of two tribunals and sits on a number of professional regulatory bodies.

1.4.2 The Panel first met on 23rd January 2013

1.4.3 The Panel comprised :

Katrina	Brown	Kent and Medway NHS and Social Care Partnership Trust (KMPT)
Helen	Carter	Independent Chair
Andrew	Coombe	Kent & Medway Clinical Commissioning Group (CCG)
Pauline	Dineen	Kent & Medway PCT Cluster/Kent & Medway CCG
Tim	England	Medway Council
Alison	Gilmour	Kent & Medway Domestic Violence Co-ordinator
Tina	Hughes	Kent Probation
Matthew	Lewis	Thanet Council
Michael	Lowe	KCA (substance misuse service)
Victoria	May	Thanet Council
Carol	McKeough	Kent County Council (KCC) (Families and Social Care Adult Services)
Shafick	Peerbux	Kent County Council (Community Safety)

Gaby	Price	Kent County Council Commissioned Services (Kent Drug and Alcohol Action team – (KDAAT))
Tim	Smith	Kent Police
Michelle	Snook	KCA (substance misuse service)
Sabine	Voigt	Kent County Council (Families and Social Care Children’s Services)

1.5 Terms of Reference

1.5.1 Purpose of a Domestic Homicide Review

The Guidance sets out the purpose of all DHRs as being to:

1. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
2. 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;
3. Apply these lessons to service responses including changes to policies and procedures as appropriate; and
4. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

1.5.2 Specific Terms of Reference for this review

1. The scope of the review was set as focussing on Paul (the deceased) and Katie (the alleged offender). Information was not required on any other persons unless there was some relevant link to domestic abuse.
2. The review focused on relevant agencies’ identification of possible and actual domestic abuse and their response to it in accordance with their own and multi-agency procedures in existence at the time. In particular, agencies were asked to focus on:
 - the method used to identify risk and the action plan put in place to reduce that risk.
 - where relevant, current legislation and good practice.

- how the incidents were recorded and what information was shared with other agencies.
 - whether follow up arrangements for users who failed to engage with services/keep appointments were dealt with in accordance with current policies.
 - why Katie (who had been subject to a Multi-Agency Risk Assessment Conference (MARAC) as a victim in a previous relationship) did not apparently have custody of her son by a previous relationship.
 - whether Katie's mental health and alcohol/substance abuse status had been accurately assessed and dealt with appropriately.
 - whether Paul's mental health and alcohol/substance abuse status had been accurately assessed and dealt with appropriately.
 - whether there was any previous history of domestic abuse or violence, whether reported or not:
 - a. between them – with either party as victim or offender
 - b. Involving others with either party as victim or offender
 - whether follow up/data recording etc from their previous domestic abuse histories (involving other partners) and any other violence was adequate.
 - how accessible services were for both parties.
 - at what point the relationship between the victim and alleged offender became known to the various agencies/professionals involved and how. What, if any, use was made of this intelligence; when and with whom was it shared?
3. While it was not the purpose of this review to consider the handling of any child protection concerns which may be related to the case, it was recognised that there may be issues that arise that relate to the safeguarding of children who may be affected by domestic abuse. It was agreed that if this proved to be the case, the issues would be raised, by the relevant agency, with the relevant Safeguarding Children Board. A number of potential such issues were identified and, for completeness and to assist appropriate follow up, reference is made to them in section 2.5.6 below.

1.6 Time period covered by the review

- 1.6.1** Initially, the time period under review was set as being from 1st March 2012 until the date of Paul's death. The start date reflected what was known, at the time, about when Paul and Katie began their relationship. It became apparent, during the course of the review, that it may have started earlier in

the year and the time period was amended to 1st January 2012 – 27th September 2012.

- 1.6.2** Both the subjects of this review have been known to various agencies over many years. The agencies contributing to this review were asked to exercise their professional judgement and include any information relevant to the terms of reference that pre-dated 1st January 2012 particularly if it was felt that it may be relevant such as previous incidents of violence or abuse, substance misuse and mental health issues.

1.7 Contributors to the review

- 1.7.1** The following agencies submitted IMRs:

Barts Health

East Kent Hospitals University Foundation NHS Trust	EKHUFT
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Kent & Medway NHS & Social Care Partnership Trust	KMPT
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Kent Community Healthcare Trust	KCHT
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KCA

Kent Probation

GP Surgery (Kent)	Katie's GP Surgery
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GP Surgery (London Borough of Bromley)	Paul's GP Surgery
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Oxleas NHS Trust

Thanet Housing

- 1.7.2** The following agency submitted a chronology:

Kent County Council Specialist Children's Services	Kent SCS
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Paul's family were written to informing them that a DHR was taking place and inviting them to contribute after the trial. The invitation was repeated after the trial. The letter emphasised that the review did not seek to go over 'old ground' but to identify whether there were lessons to be learned regarding the way in which professionals and organisations work individually and together to safeguard vulnerable people and victims. It offered a number of ways in which views might be put, including a face to face meeting with the review Chair, a phone conversation, postal submissions or via a recording. Both

letters were sent via the Family Liaison Officer. To date, Paul's family have not responded.

In June 2013 Katie's solicitor was asked to contact her to let her know that a multi-agency review was taking place and inviting her to contribute. That request outlined the purpose of the review and that, in particular Katie's views on the support she had received from various health and social services during the period under review might be particularly relevant and helpful. The invitation suggested a number of ways in which Katie might contribute including a face to face meeting, telephone call or by post. To date, she has not responded.

1.7.3 The Panel had regard to the statutory guidance on the involvement with friends, family members and other support networks. As will become evident from the chronology, Paul was a recent arrival to the area and had a somewhat unsettled, chaotic and transient lifestyle. There was nothing in the IMRS, particularly the comprehensive Police and Probation Service (i.e. the two services with whom he had most contact during the relevant period) submissions, to suggest friends or other identifiable networks whom it would be helpful, for the purposes set out in the guidance and the nature and scope of this specific review, to approach.

1.7.4 The views of some of Katie's friends were reflected in the material available to the panel. The Panel considered, given the nature and scope of this review, this to be sufficient.

2. The Facts

2.1 The death, murder trial and inquest.

2.1.1 On the night of Thursday September 27th 2012, Police Officers were called to a flat in Kent at 9.17pm after reports from South East Coast Ambulance Service that a 28 year old man had been stabbed in the stomach.

2.1.2 When the Police arrived, a number of paramedics were attending Paul who was lying in the corridor of the communal entrance of the address. His partner, Katie, was recorded as living at the same address. She had made the original call to the ambulance service. She was present when both they and the Police arrived. On arrival, the Police noted that she appeared 'quite hysterical.'

2.1.3 Paul was taken by ambulance to hospital where he died from his injury at 10.59pm. Post mortem examination showed that death was caused by a stab wound to the stomach.

2.1.4 Katie was arrested initially on suspicion of attempted murder. She was subsequently charged with Paul's murder. She stood trial in the Crown Court in April 2013 and pleaded 'not guilty'. At her trial, she explained that on the night of Paul's death they had been arguing and that he had assaulted her. She explained that he threatened to kill himself and had held a knife to his

stomach which she had grabbed at to pull away but that she had let go and the knife went into Paul's stomach. She explained that it had been an accident. She was acquitted of both murder and manslaughter.

2.1.5 At her trial, Katie reported that she had been a victim of domestic abuse at Paul's hands. She had not previously formally reported this to any of the agencies involved with either of them although the Police and the Probation Service did have some knowledge of it.

2.2 The subjects of the review

2.2.1 The review focuses on Paul and Katie. At the time of Paul's death, they had been in an intimate relationship for approximately 6-9 months and Katie was pregnant by Paul.

2.2.2 Paul was born in July 1983. He had an extensive history of crime, alcohol and drug abuse. He had been arrested several times for assault. He also had a history of domestic abuse/violence; 9 incidents are recorded against him since April 2003. At the time of his death there were four outstanding criminal cases against him. He is known to have used at least 10 variations of his name/aliases.

2.2.3 He had two children from a previous relationship. Neither lived with him and, as far as is known, he had only very limited contact with them.

2.2.4 Katie was born in April 1991. She too has an extensive history of crime including 7 offences against the person (2006- 2009). She is known to have used at least 15 variations of her name/aliases.

2.2.5 Katie had one child (Aaron) from a previous relationship. This relationship ended in 2010.

2.2.6 At the time of Paul's death, Aaron was thought, by Children's Social Services, to be living with his own father. There is also evidence that he spent time with both Katie and Paul. In particular, Paul and Katie are reported as having registered him for school and Paul was known to take him to/collect him from school on a fairly regular basis. Katie told her Probation Officer in August 2012 that Aaron was living with her and that she had resumed the role of being his main carer.

2.2.7 It has already been noted that it was not the purpose of this review to consider in detail the handling of any child protection or safeguarding concerns which may be related to the case as this is more appropriately done by the relevant Safeguarding Children Board(s). Reference is made, however, at relevant points to the involvement of Kent Specialist Children's Services and to issues which the Safeguarding Boards may wish to consider further.

2.2.8 Katie had previously experienced domestic abuse/violence both at the hands of the father of her child and in subsequent relationships. She had, on occasion, called the Police to report abuse and/or violence in the context of

previous relationships. She did not, however, always fully engage with their enquiries, for example:

- Not giving Police all details (9/5/08)
- Declining to make a statement to Police (19/3/10)
- Nor answering standard domestic abuse risk assessment questions put to her by Police (4/4/10)
- Police records note 'victim (Katie) did not want to engage with Police' (8/1/11).

2.2.9 Katie had been the subject of a Multi-Agency Risk Assessment Conference (MARAC) in respect of her relationship with Aaron's father. He was convicted of battery against her and given a 6 month community order by magistrates in December 2010.

2.2.10 There is evidence that suggests that Katie went quickly from one relationship to another and that they sometimes overlapped. In particular there is evidence to suggest this was so in the early days of her relationship with Paul.

2.2.11 Both Paul and Katie had multiple aliases and addresses. The address chronology for Paul and Katie shows him as having 5 addresses during the period from January 2012 until his death and Katie as having 4 addresses in the same period. The address chronology suggests that they sometimes moved back and forth between addresses rather than moving from one to the next in a linear fashion. There is also evidence to suggest that they edited the information, including details of where they were living, provided to various agencies depending on both the purpose of the contact and the perceived powers that agency had.

2.3 Chronology/key events

2.3.1 The combined reports and chronologies about Katie and Paul extend to over 200 pages. The panel decided that this overview report should focus on those elements which

1. give sufficient insight into Paul and Katie's lifestyles both as individuals and as a couple.
2. are most directly related to the terms of reference.
3. highlight any concerns about children's safeguarding which, while not the focus of the report, may need to be considered on a multi-agency basis.

2.3.2 Prior to 2012

- 2.3.2.1** Given the focus of the review, the chronology prior to January 2012 is not repeated in detail here. A number of key incidents and themes are, however, noted below.
- 2.3.2.2** From Aaron's birth (2007) until sometime in 2008/9 Katie and her son appear to have been relatively well supported by the midwife, health visitor and social services. Information appears to have been shared between these three individuals appropriately and Katie was made aware of various sources of support including a young parents' group and women's refuge. She did not always engage well and during 2009/10 missed a number of appointments and visits. The Health Visitor was notified in June 2010 that a MARAC had been held about Katie and in July that year she made a referral for Katie to be allocated a floating support worker but was advised that as Katie had already had two years of such support she was ineligible for further support until October 2010.
- 2.3.2.3** As has been noted, Paul had a record of 9 domestic abuse incidents committed by him since April 2003. They were often linked to misuse of alcohol and/or drugs.
- 2.3.2.4** In 2008 he committed many crimes in the Metropolitan Police area. He was arrested in October that year and dealt with for up to 27 offences.
- 2.3.2.5** There is evidence that some of the recorded incidents of domestic abuse were against former partners. There is also evidence that his relationships were sometimes 'on – off'; for example he assaulted someone who, in September 2009, was referred to as his ex-girlfriend but who was referred to as his girlfriend some 5-6 weeks later.
- 2.3.2.6** As has been noted, Katie's criminal record includes 17 offences against the person between 2006 and 2009. Between 2004 and 2012 it includes 23 offences of theft or against personal property.
- 2.3.2.7** Between 2007 and 2010 she was in a relationship with the father of her son. There are reported incidents of domestic abuse against her, by him, in each of the four years they were together. That abuse continued after their relationship ended.
- 2.3.2.8** Katie disclosed to her Health Visitor in May 2010 that she had poor literacy skills.
- 2.3.2.9** In 2010 Aaron was found, on at least two separate occasions in conditions that were described by social workers as 'very poor' and/or 'dangerous'. These related to the physical environment rather than the risk of violence.
- 2.3.2.10** Katie's GP notes for July 2010 note a depressive episode and that she was drinking heavily. Depression is referred to again in September that year and in March 2011. She was prescribed antidepressants. Her

alcohol consumption is referred to again in March 2011. She was advised by her GP to stop drinking.

2.3.2.11 Between 2010 and the beginning of 2012 Katie was the victim of domestic abuse at the hands of at least one other partner.

2.3.3 January 2012

2.3.3.1 On 19th January Katie was the victim of an assault allegedly in revenge for her having bullied someone at college. She was taken by air ambulance to hospital in London and admitted as an emergency with 2 stab wounds in her back. The hospital records do not at any stage record her address or the circumstances that led to the stabbing. They note that she has a four year old child but nothing is recorded about his whereabouts or whether appropriate safeguarding checks were made.

2.3.3.2 On 19th January, Paul was released from prison.

2.3.3.3 On 26th January Paul was arrested in London for a Section 4 Public Order (Threatening or abusive behaviour) Offence. He had been seen taking some items from a shop. When challenged about this he responded aggressively.

2.3.3.4 On 27th January Katie was discharged from hospital to an address in Kent. There is no evidence that enquiries were made about whether it was safe for her to return there. The date of birth recorded when she was discharged differs from the one on her ward admission form and from that held in other records.

2.3.3.5 On 29th January the Metropolitan Police received a call from an anonymous source reporting that Paul was threatening to kill himself. They took him to a Mental Health Unit in London. He tested positive for opioids and cocaine. He was admitted as a voluntary patient to an acute mental health ward for further assessment. He remained at the hospital, as a voluntary patient, until 15th February when he was discharged into Police custody.

2.3.3.6 During his stay Paul was confrontational, argumentative and intimidating. He threatened staff and other patients and made several threats to kill them and members of the public.

2.3.3.7 On 31st January Katie was visited by two District Nurses at a residential address in Kent to have her stab wounds redressed. She told them how she sustained the wounds. There is nothing to indicate that they were aware that she had a four year old child.

2.3.4 February 2012

2.3.4.1 On 1st February Probation records show that they became aware, from discussions with someone under their supervision, that Katie was living with Gary, who was known to be also sharing his flat with a sex offender,

and that Katie could not therefore have contact with her son. On 6th February, Gary attended the Probation Service as part of his sentence and confirmed that he was in a relationship with Katie. He was told that Katie was not allowed to take Aaron to his flat. There is no record of this information having been passed on to Children's Social Services.

- 2.3.4.2** On 2nd February Katie's wounds were redressed by the District Nursing team, again at a residential address in Kent.
- 2.3.4.3** On 2nd February, whilst a voluntary patient at the Mental Health Unit, Paul was allowed to leave, unaccompanied, ostensibly to visit the local job centre. On his return he tested positive for cannabis.
- 2.3.4.4** On 3rd February, the District Nursing team attempted a home visit to drop off dressings with Katie. She was not there and a contact card was left. The District Nursing team had no further contact with her as the plan was that follow up would be undertaken by her GP surgery.
- 2.3.4.5** On 3rd February, as part of his treatment at the Mental Health Unit, Paul was seen by a Community Drug Project in Greater London. He was advised to contact them post discharge. It was noted that this would be the key intervention to manage the risk of his violence. It was also noted, however, that he remained ambivalent about such input. He expressed the intention to engage but is reported as having shown no motivation to change his drug habits.
- 2.3.4.6** Also on 3rd February, the Metropolitan Police asked the hospital to contact them before Paul was discharged as they wished to follow up a number of alleged offences with him.
- 2.3.4.7** On 10th February Katie was alleged to have committed a criminal damage offence, in Kent, against a former partner, from whom she had recently separated. She was arrested but not charged; no one had seen her commit the offence and the victim did not want to support a prosecution.
- 2.3.4.8** On 13th February Paul was allowed to leave the hospital to go to the shops. He was given permission to be absent for 20 minutes but was gone for four and a half hours. On his return his behaviour and appearance led staff to believe that he had used illicit drugs but a urine drug screen was clear. Another patient subsequently reported that Paul threatened to kill him if he did not provide a urine sample for Paul's use.
- 2.3.4.9** A Specialty Registrar in Forensic Psychiatry assessed Paul at the hospital on 13th February. He diagnosed polysubstance misuse and anti-social personality disorder. Paul's violence was not thought to be linked with major mental illness. The risk of future violence was assessed as 'moderate'. It is not evident that, as might be expected, Paul's substance misuse was formally assessed. The Registrar also discussed Paul's offending behaviour with him and explored whether he would be willing to accept any psychological work to address it. Paul said he did not need

such help. An assessment during his inpatient admission did not consider him suitable for psychological work.

- 2.3.4.10** Early in the morning on 15th February Paul was found smoking in his hospital bedroom. He was reminded that this was not allowed and he became agitated, restless and intimidating. He threatened to kill a member of staff. Paul phoned the Police from a pay phone and demanded they attend the ward for others' safety. The Police attended but no action was taken.
- 2.3.4.11** Later that day, Paul was risk assessed by a consultant and the risk of harming himself was considered to be low. It was noted that he had a history of threatening to kill himself but there were no known deliberate self-harm/suicide attempts. He had committed no such acts on the ward but had been noted as threatening to do so when his demands were unmet. It was assessed that threats to harm others were also used as a means to get his demands met and that they were most appropriately dealt with through the criminal justice system.
- 2.3.4.12** Paul was discharged from hospital on 15th February. The same day, he was arrested by the Metropolitan Police for causing a breach of the peace (he had threatened some hospital staff with a chair). He appeared at the Magistrates' Court on 16th February and was bound over to keep the peace for 12 months.
- 2.3.4.13** On 21st February he phoned his GP's surgery in Greater London to request a letter in support of his housing application. He reported that he had been out of prison for 3 weeks and that he was using heroin, crack or cocaine. He was advised to contact the drug unit for further support. He remained registered with this surgery after moving to Kent and had no further contact with them. The surgery received notification of his subsequent A&E attendances.
- 2.3.4.14** On 22nd February Kent Police became aware, via a third party, that Gary and Katie were apparently in an intimate relationship.
- 2.3.4.15** On 27th February Katie attended A&E; her visit was not drink, drugs or violence related.
- 2.3.4.16** On 29th February, Kent Police became aware first hand, by finding them in bed together during a visit to a residential property that Gary and Katie were in an intimate relationship.
- 2.3.4.17** Twice during February 2012 Katie, who was subject at the time to a 6 month Community Order that started in November 2011, met on a voluntary basis with the women's safety officer. Their discussions focused, in the main, on the abuse Katie had experienced at the hand of Aaron's father.

2.3.5 March 2012

- 2.3.5.1** Gary attended Probation on 6th March. It was recorded that Katie was now on his tenancy and would be moving in with him the next day. There is no record that he was reminded that Katie's son would not be allowed to visit nor that Children's Social Services were informed.
- 2.3.5.2** Katie attended Probation on the same day and was seen by the same Probation Officer. During their discussion, Katie raised concerns about her safety, linked to the stabbing incident in January, and on 7th March her Probation Officer notified the Police about this on the advice of her senior officer.
- 2.3.5.3** Katie's Probation (OASys) record was completed on 8th March. It noted previous violent behaviour and that she had been a victim of domestic abuse and, more recently, the victim of a stabbing. No details on her current partner (Gary) were disclosed or recorded but it was noted she was 'in and out of relationships quickly'.
- 2.3.5.4** The Risk of Serious Harm Summary completed as part of this assessment identified that she posed a risk to the general public in relation to her history of violence and criminality. It was also concluded that she posed a risk to son, Aaron, as it was considered he needed to be in the care of a responsible adult and she was not viewed as such. It was noted that Aaron had been living with his father for the last three months but this last piece of information had, in effect, been 'cut and pasted' from an entry dated September 2011 and had not been checked.
- 2.3.5.5** The assessment also noted Katie's use of alcohol and chaotic lifestyle, both of which potentially increased the level of risk posed. Overall, however, at this time she was assessed as presenting a low risk of harm.
- 2.3.5.6** Kent Police first became aware that Paul was thought to be living in their area on 16th March 2012. They received information from the Metropolitan Police that he had recently been released from prison, was wanted for burglary in the Bromley area and was believed to be living in Kent.
- 2.3.5.7** On 20th March Katie reported to Probation. She told her Probation Officer that she had increased her alcohol consumption but the actual amounts are not recorded. It is unclear whether she was asked, as she should have been, for detail about her alcohol intake as part of the overall risk assessment. For the first time, Gary is named as her partner in her record. All previous records of her relationship with him had been in Gary's own records or the records of Katie's former partner. She reported that the relationship was in difficulty and that Gary would be moving downstairs into a different flat.
- 2.3.5.8** On 21st March Paul was arrested in Kent for shoplifting. Katie was with him at the time of his arrest and officers noted they were in a relationship.

2.3.5.9 The same day, Paul was taken into A&E having been found unconscious in a public place. The discharge note states he had overdosed on heroin. It is not known whether this was accidental or deliberate.

2.3.5.10 On 27th March Katie attended Probation. She said she had split up from Gary. It was also noted that she was drinking more heavily though, again, the amounts were not recorded and it is unknown whether she was asked appropriate questions to risk assess her alcohol consumption.

2.3.5.11 On 30th March Paul was arrested, having been seen shoplifting alcohol. He was charged with theft.

2.3.6 April 2012

2.3.6.1 On 3rd April Katie attended Probation. She said she was in a new relationship. The name she gave is thought to be one of Paul's aliases. The Probation Officer discussed the potential impact of Katie's pattern of relationships on Aaron.

2.3.6.2 On 21st April Katie attended A&E but did not wait. The reason for her visit, and for her failure to wait to be attended to, are unknown.

2.3.6.3 On 24th April Police officers spoke to Gary who was being held in custody. He had a large cut to his face that had apparently been stitched at hospital two days earlier. He was reluctant to say how it happened but he said it was caused by a Stanley knife. He implied that Katie had caused the injury but would not make a formal allegation. He repeated the allegation to the Probation Service some months later.

2.3.6.4 On 30th April Paul and Katie were outside their local Police Station. They were having a heated argument and were shouting at each other. A Police Constable who was in the Police station yard heard the commotion, went outside and dealt with the situation. Paul and Katie were separated and spoken to. Both gave an alias for Paul rather than his real name. The officer attempted to assess whether there was any link to or risk of domestic abuse by asking Katie questions from the 'DASH' (Domestic Abuse Stalking and Harassment Risk Identification) checklist used by Kent Police to assess risk. Katie refused to answer the questions. She also refused to sign the officer's pocket book record. The officer was of the opinion that Katie, whom she had met before, appeared worried. An incident report (Non-crime domestic violence incident) was completed in accordance with policy.

2.3.7 May 2012

2.3.7.1 Katie attended A&E on 8th May with abdominal pain.

2.3.7.2 The same day she attended Probation for her last appointment.

2.3.7.3 On May 15th Paul and Katie approached their local council for housing advice.

- 2.3.7.4** The following day, May 16th, Katie was arrested for burglary. She was held in the cells overnight.
- 2.3.7.5** On May 17th Katie was seen by the Custody Liaison Nurse. She admitted to being drunk at the time of her arrest the previous day and could not remember much that had happened. The nurse noted she had a history of offending behaviour often associated with substance misuse. During their discussion, Katie admitted to 'drinking well in excess of safe limits though not every day'. She also admitted using cocaine and acknowledged that this and alcohol had an impact on her behaviour and what the notes describe as self-harm gestures. The custody notes say that Katie had 'tied a ligature around her neck'. Katie had no recollection of this and said she was not contemplating suicide.
- 2.3.7.6** The nurse noted that, despite encouragement, Katie showed no interest or motivation in trying to address the issues of her drug and alcohol abuse. The nurse advised Katie to make contact with her GP and to self-refer to the local drug and alcohol service.
- 2.3.7.7** The nurse spoke by phone with Katie's GP advising him that he had suggested Katie see him about possible post-traumatic stress disorder linked to an incident in her childhood. The nurse's records also suggest that he made a referral on Katie's behalf to CRI (Crime Reduction Initiative – a voluntary agency providing drug and alcohol treatment services) although there is nothing in their records to suggest that this referral was made.
- 2.3.7.8** Following this, on May 18th Police searched the flat Paul and Katie shared. Paul was present at the time of the search and when asked to identify himself, gave a false name. In a bedroom Police found a set of digital scales and some cling film wrap. Both items can be associated with drug use or dealing but no illegal substances were found. Katie was charged with burglary and bailed with conditions to attend court.
- 2.3.7.9** On 29th May Katie snatched a mobile phone from a woman with whom both she and Paul had previously been associated. As the victim walked away, Paul allegedly approached her from behind and punched her in the back. He is alleged to have said he would get her phone back if she repaid money he said she owed him. Her phone was returned to her following the intervention of her support worker, over the phone. Police visited her at home to take details and, while there, Paul arrived and was arrested for assault. In the absence of CCTV footage and/or independent witness and no discernible injury, no charges were brought. The victim admitted having previously been in a shoplifting gang with Katie and Paul and to having a conviction with them.
- 2.3.7.10** On 30th May the Police received information that Katie was shoplifting every day and that she was using crack cocaine.

2.3.8 June 2012

- 2.3.8.1** On 5th June Paul was arrested in Sussex and charged with obstructing a Police officer as well as drink driving and other traffic related offences.
- 2.3.8.2** On 10th June Katie and another woman were arrested for burglary after being captured on CCTV. Both were charged but Katie's case was withdrawn at court.
- 2.3.8.3** On 11th June Police received intelligence that Paul was in a relationship with Katie. The same day they also received intelligence about a new alias he was believed to be using.
- 2.3.8.4** On 15th June the Police received information that Katie was shoplifting most days and selling the goods on to pay for drink and drug habits.
- 2.3.8.5** On 20th June Katie attended A&E for a known gynaecological problem.
- 2.3.8.6** Also on 20th June Katie's Probation Officer completed the review of Katie's case/compliance with her community order. The 'relationships' part of the review used information from March 2012 and the assessment of her alcohol use were taken from September 2011. In both cases more up to date information was available in her records.
- 2.3.8.7** On 28th June Paul and Katie attended the Early Pregnancy unit for a scan; Katie's pregnancy was confirmed.
- 2.3.8.8** The same day, Paul attended A&E with a broken nose. He self-referred and said he had sustained it 10 days previously.

2.3.9 July 2012

- 2.3.9.1** There is a note in the GP records to show that as at 1st July Katie was 6 weeks pregnant.
- 2.3.9.2** On 13th July Police received intelligence that Paul and Katie had been shoplifting that week and selling the stolen goods on.
- 2.3.9.3** Also on 13th July, the community midwife visited Katie at home. Katie's son Aaron was present as was Paul. Katie told the midwife that she had been stabbed in January. The midwife assessed her social situation. Katie said she had problems reading and that she would need help completing any necessary forms. She said she was well supported by Paul. She was asked whether she was or had been subject to domestic abuse and she did not disclose that she had. She denied smoking, drug and alcohol use and reported no mental health concerns. She disclosed that she had a son from a previous relationship and that she had a shared care arrangement with the child's father. The midwife referred Katie to a Consultant Obstetrician because of her previous medical history and, in particular, the injuries she sustained when stabbed in January 2012.

- 2.3.9.4** On 15th July Katie was stop checked by Police and she said she had split up with Paul. She claimed her medication was 'mucked up' and she was drinking too much.
- 2.3.9.5** On 16th July Aaron's father's Probation records show that Aaron was seeing Katie weekly.
- 2.3.9.6** Late at night on 17th July Paul was arrested following a fight outside his local Police station and charged with assault against 2 people. A third person had been involved but he did not wish to press charges. Everyone involved, including Paul, was apparently drunk when the fight broke out. Paul was released on conditional bail. During the course of the subsequent investigations into this incident the victims reported that they were assaulted after they intervened in a violent dispute between Paul and a female. It is believed that this was Katie as she had been identified at the scene by one of the Police officers.
- 2.3.9.7** As this episode was not verified as a domestic incident no DASH assessment was made.
- 2.3.9.8** Following this assault, Paul attended A&E, while in Police custody, on 17th July.
- 2.3.9.9** On 20th July Katie attended the early pregnancy unit for a scan.
- 2.3.9.10** On 25th July, as part of preparing a pre-sentence report (PSR) for the courts, Probation wrote to Katie inviting her for an Alcohol Treatment Requirement (ATR) Assessment.
- 2.3.9.11** Also on 25th July, Katie's GP received a pregnancy booking from the midwife asking if there were any details known to the surgery which might have an impact on her wellbeing or that of her unborn children. Nothing is shown as having been sent although the practice reports that a discharge summary from her stay in hospital in January after she had been stabbed was sent.
- 2.3.10 August 2012**
- 2.3.10.1** On 1st August Police discovered Paul and Katie were living together at the address at which Paul later sustained his fatal injury.
- 2.3.10.2** On 5th August Katie attended A&E. She left without being seen. There is a note that she was pregnant.
- 2.3.10.3** On 6th August Paul was arrested for stealing alcohol from a shop.
- 2.3.10.4** On 8th August Katie attended A&E. It was noted she was pregnant with twins. No mention is made in the notes that she also had a young son. She attended complaining of a cough and shortness of breath. Blood samples were taken for testing but she did not wait to receive the results. There is nothing to indicate that the midwife was informed about the visit.

- 2.3.10.5** On 8th August Probation emailed Social Services asking for information about Katie's domestic situation to be included in the PSR. Social Services were initially unable to trace her from the details provided to them.
- 2.3.10.6** Katie was due to be assessed for her suitability for an ATR on 9th August. She was 20 minutes late and the appointment was postponed until 23rd August.
- 2.3.10.7** On 9th August a pre-sentence report (PSR) was prepared about Paul by the Probation Service to assist the court in deciding the most appropriate sentence for a number of offences he had committed in June 2012. The report noted that Paul admitted to having used alcohol to excess over a number of years and was aware of its link to his criminal behaviour. He said that he no longer drank every day and that he and Katie had jointly agreed to become more responsible in their alcohol use, given the impending birth of their twins. He did, however, report that he was still drinking socially once a week and this could involve the consumption of 20 pints of beer in one session. He claimed to be no longer using illegal drugs and that he had not done so for two months. Less than two weeks later he tested positive for cocaine on arrest and claimed to have been 'on it all day'.
- 2.3.10.8** The PSR report noted it was 'of some concern that if his current relationship breaks down, that he would return to drink and drugs'. This does not fully reflect the reality of Paul's then current behaviour as he had self-reported it – i.e. it does not reflect the fact that by his own account he was still binge drinking over 45 units in a single session once a week.
- 2.3.10.9** It also noted that he had failed to comply with previous drug or alcohol treatment orders but that he explained he had not felt ready to deal with it previously. He maintained that he was willing to cooperate now and this appeared to be linked to the fact that Katie was pregnant.
- 2.3.10.10** The report noted that Paul said he had had an argument with his girlfriend the day before the offence and had been drinking heavily as a result. It was not known whether the girlfriend he referred to was Katie or not but the general context makes it likely that it was. It noted that there were reports of previous aggression between him and former partners. It reported that there had been no reports of domestic abuse within his current relationship, but that Paul admitted that there had been disputes between them and said that he had had to remove himself from the situation to calm down. The report recommended that a curfew order would not be appropriate due to Paul's history of aggression against former partners.
- 2.3.10.11** The PSR author recorded as a fact that Paul was living with Katie and Aaron but there are conflicting reports held within other agencies. There is no indication that any potential risk to Aaron and/or Katie's unborn children was identified or assessed.

- 2.3.10.12** The report considered Paul posed a medium risk of serious harm to the general public.
- 2.3.10.13** In preparing the report the Probation Officer sought advice by email from KCA as she was unsure whether an alcohol or drug treatment would be most useful/appropriate. As Paul's offence was alcohol related she was told he could be booked in automatically for assessment and it suggested that an ATR would be the route to take. KCA's records show that they were told Paul was drinking 10 pints once a week. Probation records show the reported amount was 20 pints. In requesting advice the Probation officer also noted that Katie was due to have an ATR assessment with KCA and recommended that if both Paul and she were given ATRs, they would be given appointments on different days.
- 2.3.10.14** On 16th August Katie attended her GP surgery due to anxiety and shortness of breath. It was noted that she had attended A&E with this problem and had recurring symptoms. She admitted to underlying anxiety and a referral for psychological talking therapies was made on 28th August.
- 2.3.10.15** On 17th August Children's Social Services and Probation exchanged information about Katie. As part of this, Social Services made Probation aware of Katie's history of domestic abuse within a previous relationship and Probation made Children's Social Services aware that Aaron was now living with Katie and Paul, and of Katie's on-going drug use.
- 2.3.10.16** On the same day, Probation sent a Domestic Violence information request to the Police and a Child in Need and Child Protection Referral form to Children's Social Services. In the latter, mention was made of Paul's alcohol misuse but not of his history of domestic abuse against previous partners. It was noted that Paul and Katie had been in a relationship for about 8 months – this is the first suggestion that it predated March 2012. Katie was described as isolated.
- 2.3.10.17** Paul was arrested for burglary on 18th August. When spoken to by Police he stated that his partner Katie was pregnant and that he was working as a carpenter although he would not say where. He tested positive for cocaine and admitted he 'had been on it all day'. He claimed that he had swallowed heroin worth £250 and was taken to A&E. He refused to be x-rayed and A&E recorded the reason for his visit as 'assault'. Police records show that this was the fourth time, over several years that Paul had falsely claimed he had swallowed heroin and that it appeared to be a tactic to avoid being taken into custody.
- 2.3.10.18** On 20th August Katie attended midwifery day-care for routine scans and screening tests.
- 2.3.10.19** On 21st August, Probation received information from the Police in response to their request made on 18th August, for information about domestic abuse involving Katie and Paul. The only information that was on record was the incident of 30th April.

2.3.10.20 On 22nd August Probation and Social Services discussed the Child in Need/Child Protection referral and Social Services indicated that they would complete an initial assessment starting with an unannounced visit. The Social worker's assessment, prior to any such visit, was that Katie posed a low risk of harm to her son but the social worker was concerned about Katie's ability to cope with more children. It was noted that Katie was living with Paul who was being charged with drink driving, possession of a class A drug and obstructing the Police. It was also noted that there was one incident of domestic abuse on record. Katie's previous unsuitability for an ATR and the reasons behind this were also mentioned. In the course of their discussion, it became apparent that up until this point Social Services had been unaware of the fact that Katie had been stabbed, sustained serious injuries and hospitalised as a result in January 2012. Probation followed this conversation up with more detailed information in an email.

2.3.10.21 On 23rd August Katie attended KCA for her ATR suitability assessment. She reportedly engaged well. A number of risk factors were noted including alcohol consumption, previous exposure to domestic abuse and concerns about her son's wellbeing. It was reported that he did not live with the couple. This is at odds with Katie's previous assertion that he now lived with her and Paul. She stated she had only had 2 drinks since her pregnancy and that she had not drunk alcohol for a week. This differs from the information held by the Police and her GP. She was given information about Foetal Alcohol Syndrome.

2.3.10.22 KCA phoned Probation on 23rd August to advise them that Katie was assessed as being suitable for ATR and currently motivated. KCA summarised the information, noted above, about her current domestic situation and alcohol consumption. This does not seem to have been cross-referenced with the conflicting data available in Katie's Probation records.

2.3.10.23 On 23rd August, KCA advised Kent Probation that they had seen Paul that day and they recommended he be given an ATR. They noted that he had been a poly-drug user since 2011 but that he claimed he had not used cocaine since June 2012 and heroin since 2011. He had in fact, used cocaine more recently than that and been taken to A&E having overdosed on heroin earlier in 2012. His alcohol use was recorded as 15 units a day 2- 6 times a week. The assessment noted that he had two children, neither of them living locally.

2.3.10.24 Between 23rd and 30th August Social Services made numerous unsuccessful attempts to contact Katie by phone and unannounced visits. Calls were also made to the health visitor, midwife and Aaron's father. On 30th August, the social worker saw Aaron at his paternal grandmother's and concluded that he had irregular contact with his mother, appeared well cared for and there was no cause for concern.

- 2.3.10.25** On 24th August Probation received a letter from Children's Social Services stating that Aaron lived with his father and that they did not think they needed to be involved currently but that Probation should re-refer if they had any future concerns about Katie's unborn children. This is at odds with the information Katie had provided to Probation earlier in the month, in which she said that Aaron had lived with his father until approximately 4 weeks ago but had now returned to live with her as the primary carer. This conflicting information does not seem to have been explored or attempts made to verify which account was accurate.
- 2.3.10.26** The same day, August 24th, Probation completed their PSR report on Katie. The report noted that Katie had acknowledged that she had misused alcohol 'constantly' for the last two years and consumed large quantities such as half a bottle of vodka, three litres of cider, wine and beer in a day. It noted that she had reportedly stopped drinking but that, given her history, she would need help to maintain abstinence. Reference was made to past and present mental health issues. Reference was also made to previous drug misuse, noting that Katie had disclosed she used to 'misuse cocaine and ecstasy every weekend.....however she ceased her misuse approximately six months ago.'
- 2.3.10.27** The PSR writer noted that Katie reported that she and Paul had been in a relationship 'for approximately eight months'. This would mean it began circa January 2012.
- 2.3.10.28** The PSR writer noted potential risks to Aaron and to Katie's unborn children and her liaison with Social Services about this.
- 2.3.10.29** In summary, Katie was regarded as posing a medium risk of serious harm to the public. She was assessed as presenting a low risk to known adults, children, staff and herself. It was noted that if she became stressed and returned to alcohol misuse this would increase her potential to cause serious harm to herself and others. She was, given her history of offending and other lifestyle factors, assessed as being a high risk of reconviction. It was suggested that a full risk of harm assessment be undertaken after sentencing given her then current behaviours and circumstances, and her history. The PSR counselled against imposing a curfew on the grounds that this might expose Katie to unnecessary risk.
- 2.3.10.30** On 24th August Paul attended for his induction at Kent Probation but could not complete it as he also had an appointment with KCA.
- 2.3.10.31** Paul was sentenced on 24th August to a 12 month community order which included a 6-month alcohol treatment requirement (ATR) for offences committed in June 2012 (driving with excess alcohol, obstructing a Police officer, driving without a licence and breach of a conditional discharge). He was also disqualified from driving for 3 years.
- 2.3.10.32** On 29th August a Social Worker contacted the Health Visiting team to let them know that Katie was pregnant and had been charged with burglary and that a risk assessment needed to be carried out but that she was

having difficulty reaching Katie at home. The Health Visitor reported that she had not had any contact with Katie's son, Aaron, for some years and that he had not attended any developmental assessments. The Social worker reported that Aaron was living with his father.

2.3.10.33 Later that day, the Health Visitor and Social Worker met by chance and the Social Worker updated the Health Visitor further about Aaron's situation. He reportedly had minimal contact with his mother, and was cared for by his paternal grandmother while his father was at work.

2.3.11 September 2012

2.3.12 Sometime in September Aaron was enrolled at school by Katie and Paul. Children's Social Services records show that Paul had regular contact with him and appeared to be the person who took him to school most often. Aaron started school and transferred from the Health Visiting Team to the School Nursing Service.

2.3.13 Paul failed to attend an appointment at KCA on 3rd September.

2.3.14 Katie visited her GP on 7th September. She was 16 weeks pregnant, reported that she had argued with her partner and was expressing suicidal thoughts. She said she had lots of issues but 'did not want to talk about them today'. The GP was concerned about self-harming. Katie was prescribed anti-depressants and referred to the mental health crisis team. They were initially unable to contact Katie on her mobile phone and called Paul, leaving a message with him saying they would call her again. They managed to speak with her by phone later that day. She denied any thought or plans to self-harm and is reported as having been reluctant to engage in conversation about her wellbeing. She denied any alcohol intake; this was not explored. No immediate risks were identified and she agreed to see the mental health access team on 10th September.

2.3.15 Paul attended Kent Probation Offices as part of his community order on 7th September. Katie came with him and stayed in the waiting room. It was reported that there was a loud and heated exchange between them. No intervention was made and the incident was not investigated at the time. When asked informally about it, they explained it was because they had learned they would be able to discover the sex of their twins the following week. This explanation was readily accepted.

2.3.16 On 8th September Katie attended the midwifery led unit at her local hospital, with abdominal pain. Tests were carried out and she was sent home with medication.

2.3.17 Katie failed to attend to meet the Mental Health Access Team on 10th September. The team made several attempts to contact her by phone before sending her an 'opt in' letter asking her to get in touch within 5 days. The letter also gave the number of a 24-hour helpline.

- 2.3.18** On the same day, 10th September, Katie attended the ante natal clinic at hospital. No safeguarding concerns were noted. A request was sent to her GP asking for information about the stab wounds that she had received in January 2012.
- 2.3.19** Paul had an appointment to attend KCA on 10th September in respect of his ATR. He had been given a travel warrant. He was also told that an evening group was available as concerns had been expressed about his ability to attend a daytime group. He failed to attend. A new appointment was made for 13th September.
- 2.3.20** Paul attended the front counter at his local Police Station on 11th September. He said he wanted to report that Katie had been sexually abused between the ages of 8 and 12 by a family friend. He was told that she would need to come to the Police station herself and talk to officers.
- 2.3.21** Katie was stopped about 90 minutes later for breaking a curfew. The Police officers involved believe that the indecent assault report made by Paul was some sort of smoke screen to prevent her being arrested for breach of bail conditions. There is no record on Police files of her having made such allegations before or since, although mention of it is made in Probation Service records.
- 2.3.22** On 13th September Paul attended an appointment at KCA and appeared to be under the influence of drugs or alcohol. While there, he went to the toilet and took some cocaine. KCA ended the meeting at this point and suggested a 3 way meeting, to include Probation, and suggesting that a DRR (Drug Rehabilitation Requirement) might be more appropriate for him.
- 2.3.23** The same day (13th September) he was arrested following a fight with a man. During the course of his arrest, he assaulted several Police officers. The matter had not been brought to court before Paul died.
- 2.3.24** Also on 13th September Katie attended her GP for a review. The notes record that she was feeling a bit better and awaiting an appointment with CRI. They had, however, written to her on 10th September (and copied to the GP) asking her to get in touch with them as they believed she had failed to attend/respond to 3 appointments. This approach was in line with policy.
- 2.3.25** The same day (13th September) she also attended a midwifery clinic at the local children's centre for a routine appointment.
- 2.3.26** On 14th September Katie attended A&E. She was taken there by ambulance. The ambulance crew had noted that she had a five year old child, who lived with his father. There is no evidence from the record keeping that this information was passed on to the A&E staff. The clinician who attended her in A&E did, however, explore her social situation and noted that there was a child with shared custody and that the child was currently with their father. Katie had a minor head injury and

said she had fallen the previous night and hit her head on a wall. She smelled strongly of alcohol and admitted to drinking the previous evening. It was noted she was pregnant and she was advised not to drink alcohol during her pregnancy. There is no indication that the midwife was informed.

- 2.3.27** On 14th September Paul failed to report for a Probation appointment.
- 2.3.28** On 18th September, Probation sent Paul a 'compliance letter'; noting that he had missed two appointments and asking him to attend a review on 24th September.
- 2.3.29** On 21st September Police were called to an address in Kent where Katie had been visiting a friend. Paul had turned up wanting to speak to her but she did not want to speak with him. The situation got heated and the Police were called. When they arrived nobody made any allegations. The officers decided to diffuse the situation. One took Paul home and one tried to engage with Katie but she was reluctant to talk.
- 2.3.30** The officer said he spoke to her about general 'stuff' for 5 minutes and then started talking about the points within the DASH risk assessment process. In the course of the assessment, Katie said that she and Paul had 'separated for sure today but has been trying for a couple of months to get rid of him' and, when asked whether he ever threatened or attempted suicide that he did so 'whenever she didn't want to be with him'. Katie was given advice about how to keep herself safe. She said that she was already in contact with the Domestic Violence Unit and she did not want them to teach her to 'suck eggs'. The DASH assessment was completed. The case was recorded as a Non-Crime Domestic Violence Incident in accordance with policy and the risk level to Katie was assessed by the officer as 'standard'. As a result, no follow up was deemed necessary.
- 2.3.31** On 24th September Paul missed his Probation compliance meeting as he appeared before magistrates in court that day. His failure to attend his Probation meeting was in breach of his community order and a warrant was issued for his arrest. The matter was still pending when he died.
- 2.3.32** On 27th September Paul was outside his local Police Station and told a Police officer that someone from the Police wanted to speak to him but he did not know who. It has not been possible to establish whether this was true and, if so, who wanted to see him and why. It appears though, to be unconnected with the arrest warrant issued on 24th September since this was not shown on the computerised records held about him at the time by the police.
- 2.3.33** He was told to go to the front counter and ask for a message to be relayed to staff that he was there. As he was making his way in, he was spotted by the Officer who was investigating the assault that took place on 17th July. She told Paul that she wanted to speak to Katie in connection with this but that she had been unable to make contact. Paul said that he

could speak to Katie and get her to come to the Police station. He asked if he could use her phone and the Officer let him, thinking that it would mean that she would have Katie's up to date phone number and, if necessary, she could subsequently call her direct. Paul appeared under the influence of drink or drugs. He made a phone call, using the Officer's phone, and it is believed the call was to Katie. A short time into the call Paul started shouting and swearing at the recipient. Although not reported as threatening it was very abusive. This was regarded as Paul's standard behaviour. Paul ended the call after about a minute and handed the phone back before walking off.

2.3.34 Later that day (27th September 2012) Paramedics responded to a call from Katie after Paul received a stab wound from a knife at their address. When they arrived he was lying on the corridor of the communal entrance. Katie was also present. The paramedics called the Police. Paul was taken by ambulance to the Queen Elizabeth the Queen Mother Hospital in Margate where he died from his injury at 10.59pm. Katie was arrested on suspicion of attempted murder. As has been noted, she was tried and found 'not guilty' in April 2013.

2.4 Information from other sources.

2.4.1 Following Paul's death a murder investigation was carried out. The murder investigation does not, of course, fall within the Terms of Reference. Some of the enquiries made in the course of the investigation do, though, shed potential light on Paul and Katie's relationship and their conduct towards each other. These details were not known by the Police prior to Paul's death and therefore are included here as contextual information rather than as part of the 'known chronology'.

2.4.2 One friend who said she had known Katie for about 10 years and that they were very good friends gave evidence to the Police that during 2010 Katie had been in a relationship with someone who was very controlling. She had sustained a black eye when fighting with her then partner. This incident had not been reported to the police.

2.4.3 Around February 2012 the same friend was with Katie when they 'bumped into a bloke (Paul) who later became Katie's boyfriend'. She said the pair seemed to get on well and started a relationship. They moved into a flat together. The witness reported that Katie had told her that Paul had previously used crack and heroin but was now off it. The witness suspected that was not the case and said that around August 2012 Katie came home one day and found Paul smoking heroin in the flat.

2.4.4 She said it became clear that Paul did not want Katie away from him and he was quite possessive. She had seen them arguing 'just like any other couple' although since Katie had become pregnant their arguments had got more frequent.

2.4.5 She had only ever seen Paul start the physical fights. Katie would fight back and they would both hit each other. She said Katie feared Paul but would never call the Police as she loved him and didn't want to be without him.

2.4.6 Around June 2012 Katie was visiting her at her flat. The friend said, Paul arrived and kicked the door in and came bursting into the flat. He grabbed Katie around the neck and pushed her up against the wall. He then dragged her by the hair into the hallway and then bathroom. She kept shouting 'help me' and calling her friend's name. Her friend tried to drag him off but he was too strong. The witness said 'he was drunk and just going mental at her'. The incident was not reported at the time to the Police.

2.5 Analysis and Observations

2.5.1 General observations

2.5.1.1 Both Katie and Paul were well known to the Police and criminal justice system. They both had extensive criminal records and both had previous convictions for violence. Both were also heavily involved in drug and alcohol abuse. This, in turn, was linked to their violence and criminal behaviour.

2.5.1.2 Katie had previously been involved in relationships where domestic abuse had been a regular occurrence. Initially it appears in the relationship with the father of her first child she was reluctant to pursue Police action but eventually as the situation got worse she supported a prosecution and he was convicted. He received a 6 month Community Order. This is unlikely to have given Katie much confidence that any future reports of domestic abuse against her would be taken seriously and dealt with in a way which would help ensure her safety.

2.5.1.3 Katie also suffered domestic abuse at the hands of a subsequent partner and was again reluctant to report it or, when she did, to engage with Police. This reluctance to report and unwillingness to engage with support services, including the Police, appears to have been a hallmark in Katie's previous relationships where she was the victim of domestic abuse and it carried over into her relationship with Paul.

2.5.1.4 There may be a number of factors, including the complex nature of - and power imbalances within - relationships in which domestic abuse is a feature which underpin a victim's apparent reluctance to seek help or to accept it when offered. It has already been noted that the sentence her former partner received when she did finally agree to support his prosecution may also have contributed to her reluctance to seek help or file a report when faced with domestic abuse. The Review Panel thinks it likely that anyone who engages in frequent criminal activity and who is arrested and held in custody by Police may be reluctant to engage with or trust them on other matters. This raises potential policy issues for how such services are organised and which organisations they are identified with. It also

underlines the importance of all relevant agencies and service providers being aware of the signs/symptoms of domestic abuse and how they should be dealt with.

2.5.1.5 During the period covered by the review there is no evidence (other than some questioning by the Police) of agencies having signposted Katie to voluntary sources of help for victims of domestic abuse. Whilst her history might have identified her as someone more likely than not to experience abuse, she consistently failed to disclose, when invited, that she was in abusive relationship with Paul. Thus, on the face of it at least, there was no reason for agencies to signpost her to other sources of support in this regard.

2.5.1.6 Although there is evidence to suggest Katie had been violent towards former partners and that she had committed a crime against the property of a former partner, there is no evidence to suggest that she initiated any violence against Paul.

2.5.1.7 Paul had committed domestic abuse against former partners both while he was in a relationship with them and subsequently. The recorded incidents (there are 9 since 2003) were often linked with alcohol and or drug misuse.

2.5.1.8 Paul and Katie's relationship appears to have been 'on/off' for some of the time. At the very least, this is how it was presented to various agencies. There is, for example, evidence that:

- They were in a relationship by March 2012 and throughout April 2012.
- Katie told Probation that she split up with Paul in May 2012 (her PSR report notes that she split up from her boyfriend in May, although it does not name him) whilst, at the same they are recorded by the Housing department as having jointly sought housing advice.
- On 13th July Police received intelligence that the two were engaged in joint criminal activity that week but on 15th Katie said she had split up with him. On 17th July Paul was arrested having assaulted three people who apparently intervened to break up an argument between Paul and Katie.
- In early September they appeared to be co-operating together to concoct a smoke screen to detract attention away from her failure to meet her curfew.
- In September they were reportedly still living together and Paul was taking Aaron to school regularly.
- In mid/late September Katie was allegedly trying to split up with Paul. On 21st she told Police Officers that she had been 'trying to

get rid of him for a couple of months' but had 'separated for sure today.'

- 2.5.1.9** The apparently 'on/off' nature of their relationship potentially made it difficult for agencies to make a realistic assessment of risk of the likelihood of domestic abuse. It is also potentially a 'red flag' that should have alerted officers to the potential of an increased level of risk. This is recognised in one of the DASH questions (have you separated or tried to separate in the past year?) which, if answered in the affirmative is taken as an indicator of increased risk.
- 2.5.1.10** There is a consistent theme – running across several agencies – of Paul and Katie's self-reported levels of alcohol/drug misuse and/or willingness to engage with treatment or rehabilitation programmes going largely unchallenged even when, as was usually the case, their claims were not credible in the context of their long history of substantial misuse.
- 2.5.1.11** Linked to this, there is a theme particularly, but not exclusively, within Probation of failing to record the detail of Paul or Katie's alcohol use. As their accounts to different agencies appear to have varied (and thus figures from other agencies could not necessarily be relied upon) this lack of attention to detail made it even less likely that an accurate risk assessment could be made.
- 2.5.1.12** Alcohol and drug misuse are both known to be factors which can be linked to increased risk of domestic abuse and of other criminal behaviour. Professionals need to recognise the warning signs and to be confident and skilled in challenging and interpreting self-reported consumption rates.
- 2.5.1.13** Both Paul and Katie had multiple aliases and addresses. There is evidence to suggest that they edited the information provided to various agencies depending on both the purpose of the contact and the perceived powers that agency had. They appear to have had several mobile phones between them and to have changed numbers during the period under review. All these factors increase the challenge to professionals in identifying and assessing risk. As such, they underscore both the importance of robust and well understood policies and information sharing protocols and the challenges implementing them effectively and consistently across a wide range of circumstances.
- 2.5.1.14** The use of aliases and multiple addresses also made it difficult for agencies to get in touch with Paul or Katie. The Police, for example, tried unsuccessfully on several occasions to contact Katie by phone to talk with her about the fight between Paul and three others which was, according to the three, the result of them having intervened in an argument between Paul and a woman believed to be Katie. The mental health team wrote to Katie on several occasions with no response. Whether her failure to respond was because of her having multiple addresses or because of her poor literacy skills or an unwillingness to engage is unclear. What is clear is that agencies who try more than one means of communication and who

seek the cooperation of others in keeping their records up to date stand a better chance of success than those who do not.

2.5.2 Police involvement

2.5.2.1 Katie and Paul's first involvement as a couple with the Police for a domestic incident was on 30th April when they were arguing outside their local Police Station. Katie failed to answer the DASH questions and refused to sign the officer's notebook. The officer did however manage to complete some of the information required and correctly recorded the incident on a Secondary Incident log. At this time there was no knowledge in Kent (other than on the Police National Computer (PNC)) of Paul or his past domestic violence and as the incident itself was minor in nature appropriately no action was taken.

2.5.2.2 The Police IMR notes that 'recently updated and republished domestic abuse policy specifically states 'a victim must not be reclassified as a lower risk category due to non-engagement'. Whilst, certainly so far as the initial incident in March 2012 is concerned, there is no suggestion that the level of risk was wrongly assessed, it may be that further guidance and training is needed to enable officers to accurately assess risk where victims routinely refuse to engage/cooperate with enquiries.

2.5.2.3 Once it became apparent that Paul's alleged assault on 3 people in July was linked to an argument with Katie, the investigating officer spent some time trying to contact Katie to interview her in relation to the case. This is good practice. Despite visiting her address several times and trying to call her, she had not managed to complete this enquiry prior to Paul's death. As this had not been verified as a domestic incident no DASH assessment was made.

2.5.2.4 On 21st September Police were called to an incident involving Paul and Katie at the house of one of her friends. The officer who stayed with Katie while Paul was taken home spent some time talking to her to gain her confidence to an extent that she would talk to him with regard to the DASH questions. He assessed the risk as standard despite the fact that 9 of the 18 'High Risk' questions were answered in the affirmative. These included Katie saying that:

- She was frightened
- The abuse was happening more often since she told him she wanted to finish their relationship.
- Paul was controlling and tried to stop her seeing her family and friends.
- (In answer to the question whether she was constantly being followed, stalked or harassed) he kept finding her on the street and then she couldn't get rid of him.

- The abuse was not only becoming more frequent, it was also getting worse and she was frightened she would be held against her will.

- 2.5.2.5** If 14 out of the 18 high-risk indicators in the DASH questionnaire are answered in the affirmative a case is automatically assessed as high risk. Where, as in this case, that threshold is not met there is some discretion as to whether the risk should be assessed as higher than suggested by the scores alone. This discretion is covered in the MARAC Guidance and Protocols (updated 2012) which allude to professional judgement and the need to refer cases which fall short of the scoring matrix, but where professionals have serious concerns for the safety of an individual. Whilst the officer, in making his assessment, took immediate contextual factors into account (e.g. that Katie was with friends, Paul appeared calm) it appears that the incident was not viewed in the wider context of Katie's pattern of being in abusive relationships nor of Paul's relationship history.
- 2.5.2.6** It is possible, but by no means certain, that had this assessment been subject to review or supervision it may have been upgraded. Had, however the assessment been 'medium' this would not have automatically led to any different action being taken at the time.
- 2.5.2.7** The Kent Police Domestic Violence Policy was updated and republished in March 2013. There is now a requirement that all DASH Risk Assessments are subject to supervisory checks whilst the officer is still with the victim. As part of this, a safety plan is agreed and ratified by the supervising officer before the attending officer leaves.
- 2.5.2.8** Katie was reluctant to engage and she did not want to be seen as 'a grass'. Officers were not, however, prepared to take 'no' for an answer and continued with their attempts to engage with her and complete the relevant assessments and investigations. This is good practice.
- 2.5.2.9** In investigating the assault (July 17th) which allegedly arose when three people intervened in a dispute between Paul and Katie, the investigating Officer made repeated, but unsuccessful, attempts to contact Katie. When, by chance, she saw Paul on September 27th she mentioned to him that she needed to speak to Katie about the incident. At one level, Paul might have expected that since Katie had witnessed the assault (whether or not a dispute between the two of them was the catalyst) the Police would want to speak to her. It is, though, one of several instances, across several agencies, where Paul - known by some to have perpetrated violence against Katie and by others to have the potential to do so – is asked to contact her or to pass a message onto her or is present during a meeting about a matter which he might not wish to be pursued with her. In these circumstances it is possible that, at best, the message might not get passed on and that, at worst, it might be a catalyst for further abuse. Whilst, therefore, officers and staff are to be commended for persisting with efforts to contact Katie it is of concern that the possible unintended consequences of their actions were not recognised at the time.

2.5.3 Health

- 2.5.3.1** The position of clinical regulators and professional bodies is generally that if something is not recorded in the notes, it did not happen. The records of the hospital where Katie was treated in January for serious injuries as a result of stab wounds do not at any stage record her address or the circumstances that led to the stabbing. It was not related to domestic abuse; but there is no record that they either enquired about or knew that. They note that she has a four year old child but nothing is recorded about his whereabouts or whether appropriate safeguarding checks were made. When she was discharged, there is no evidence that enquiries were made about whether it was to a safe address. Given the nature of her injuries, such enquiries would have been prudent. These factors combined suggest that the hospital fell short in several key safeguarding areas and, in common with some other health agencies, appear to have treated the symptoms rather than the whole person.
- 2.5.3.2** The District Nursing Team attended Katie in January/February 2012 following her having been stabbed. The issue of domestic abuse was not considered since the circumstances of the stabbing were known to be unrelated to domestic abuse. They do not, however, appear to have enquired about her social situation and appear unaware that she had a young child, albeit not permanently resident with her at the time. Their involvement with this review has raised their awareness of and interest in some of the potential issues that might arise in future. This has been addressed through briefing and training (see 3.2 below).
- 2.5.3.3** It is evident from the KCHT chronology that Katie was barely literate although this may have improved over time since reference is made in the Probation IMR to her having passed an English exam. It is not known at what level. It does not appear that her low level of literacy was known to other agencies. A number of them wrote to Katie about her failure to attend appointments. Her low levels of literacy and frequent changes of address mean that such communication was unlikely to be effective.
- 2.5.3.4** Katie's midwife tried to assess possible risks to Katie and her unborn children, she covered appropriate ground with Katie, including abuse. Paul was present throughout. He was questioned about his smoking habits and he did not disclose his drug use. He is reported as having been supportive towards Katie. The paperwork used to guide the questioning to assess risk has, coincidentally, subsequently been altered to include drug and alcohol use by any member of the household.
- 2.5.3.5** It is understandable that one or all parties (expectant mothers, fathers and health professionals) may want both expectant mothers and their partners to be present at some consultations and there can be real benefits flowing from this. There are, though, some matters that are best dealt with in private. Questions about alcohol and drug use, mental health concerns

and domestic abuse are unlikely to be answered totally frankly with both parties present if there are any tensions between them.

2.5.3.6 Following this visit, the midwife contacted Katie's GP asking if there were any details known to the surgery which might have an impact on her wellbeing or that of her unborn children. This is good practice and evidence of her trying to treat the whole person, triangulate data rather than rely solely on self-reporting and to take account of possible safeguarding issues. The surgery's reply was wholly inadequate. Nothing is shown as having been sent although the practice report that a discharge summary from her stay in hospital in January after she had been stabbed was sent. This was important information to share since Katie had experienced on-going health problems since the attack which punctured both lungs. What was not shared with the midwife, however, was information – available from Katie's GP records – that was also highly relevant to assessing possible risks to Katie and/or her unborn children. This included information about:

- Katie having previously been subject to a MARAC (which, by implication, raises the likelihood that she was at increased risk of domestic abuse in future) and that, in June 2010 her family were involved with social services and regarded as 'high risk'.
- Katie's history of drug and alcohol related problems including the fact that as recently as May 2012, Katie had seen the custody liaison nurse and been advised to seek help in relation to alcohol and drug abuse.
- Katie's history of depressive episodes.
- Katie having been stabbed on more than one occasion.

2.5.3.7 There is little, if any evidence in Katie's GP's IMR of an understanding in relation to her history and presenting symptoms of depression, high alcohol use and their possible relationship to domestic abuse. The symptoms appear to have been treated in isolation even though it is evident from the GP records that the surgery had knowledge of some, at least, of the abuse Katie had suffered. She was advised, more than once, to give up alcohol but there is no evidence that any practical support or guidance was offered or explored.

2.5.3.8 When Katie consulted her GP and reported that she had argued with Paul and was having suicidal thoughts this was seen only as a potential mental health issue. No consideration was given to the possibility of domestic abuse or to possible safeguarding concerns for her son or unborn children. The surgery have indicated that they are not 'an agency' and that it is for patients to choose how much or how little they want to discuss. Whilst the latter point is undoubtedly true, and it is recognised that Katie had a history both of failing to engage and of telling different agencies and providers different bits of the story, it would appear that the practice's safeguarding, vulnerable adults and child protection policies were either wholly

inadequate or lamentably insufficiently well understood/followed. In this case, for example, a referral to Social Services and signposting to other sources of support should have been considered as well as the referral that was made to the mental health crisis team.

- 2.5.3.9** The usefulness of historical MARAC data in helping identify patterns of abuse or an increased level of risk seems to have been totally unrecognised by her GP/the surgery – even when prompted (whether by the midwife’s enquiry or Katie’s reporting that she was suicidal following an argument with her partner) - in this case. The practice has subsequently developed a domestic abuse protocol, amended some of their record keeping processes and staff have undertaken relevant training. More is said on this at section 3.2 below.
- 2.5.3.10** The Mental Health Crisis Team also seem to have considered the ‘presenting issue’ of suicidal thoughts without looking at the bigger picture and do not seem to have identified the possibility – given that Katie reported she had argued with her partner *and* was pregnant, *and* she was expressing suicidal thoughts – of domestic abuse. Had they done so, they almost certainly would not have phoned Paul with a message for Katie. The IMR author states
‘The vulnerability of a pregnant woman who reaches a stage where the GP feels the need to prescribe anti-depressants, coupled with Katie’s reluctance to disclose information should have prompted the staff to consider whether the case was as straight forward as it first appeared.’
- 2.5.3.11** It may, given the circumstances, have been appropriate for the Mental Health Crisis Team to offer a home visit although there must inevitably be some doubt as to whether Katie would have accepted such an offer.
- 2.5.3.12** They should also have made a referral to Children’s Social Services on safeguarding grounds since Katie’s mental state and suicidal thoughts may have posed a risk to her unborn children.
- 2.5.3.13** The risk assessment and plan by the Custody Liaison Nurse following Katie’s overnight stay in custody in May 2012 leant towards Katie having substance misuse issues rather than a mental illness. He clearly saw Katie as a threat to others with her aggressive and violent behaviour and summarised this in his risk assessment. He linked this to her substance abuse of drugs and alcohol. His plan to refer her to an agency providing services to people who misuse drugs as well as trying to encourage Katie to engage with KCA was appropriate. His notes record both that Katie was advised to self-refer (which she did not), that he made a referral (there is no record of this having been received) and also notified Katie’s GP. Policy at the time was that individuals had to self-refer rather than be referred direct. This has changed and direct referrals by the KMPT Police Custody Liaison and Diversion Service to drug intervention programme (DIP) workers are now possible.

- 2.5.3.14** The Mental Health Crisis Team may have been influenced by that assessment which would see Katie as a perpetrator not a victim and having impulsive gestures when under the influence of alcohol. As she was pregnant however, and anything she did or was subject to would have consequences for her unborn children, not just herself, the assessment of risk should have taken this into account and not just focused on her as an individual. This tendency to take things at 'face value' is also evident in their failure to explore or challenge her assertion that she was not drinking.
- 2.5.3.15** The Mental Health Access Team did not see Katie and unlike the Crisis team, did not get the opportunity to speak with her on the phone. Again they were guided by the social issues discussed in the original assessment by the custody liaison nurse and did not really look at the risks surrounding a pregnant individual. The standard risk assessment covers both aggression from others as well as aggression to others and this was not pursued.
- 2.5.3.16** When Katie attended A&E on 14th September 2012 no enquiries were made about how she came to trip/fall and hit her head. Whilst it may, as was perhaps assumed, have been alcohol rather than domestic abuse related, this failure to explore how the injury occurred is another symptom of a tendency across a number of health providers to apparently take things at face value rather than to scratch beneath the surface by 'routinely enquiring'. The Children's Safeguarding Team have previously identified that practitioners across the Trust can find it difficult to identify situations where domestic abuse may have contributed to attendance at hospital. A programme of level 3 Children's Safeguarding training on this issue is currently being undertaken across the Children's Workforce and Accident and Emergency staff. More is said about this at section 3.2 below.
- 2.5.3.17** It would also have been appropriate for A&E staff to notify Children's Social Services to check that Aaron was, as Katie told the ambulance crew, subject to a shared care arrangement.
- 2.5.3.18** Katie's attendance on 14th September 2012 should also have raised concerns about the welfare of her unborn twins. Although she was advised not to drink during pregnancy there is no evidence that this episode was shared with the Community Midwife.
- 2.5.3.19** In January/February 2012 Paul was a voluntary patient at an acute mental health unit for just over 2 weeks. As part of his treatment he was seen by a Community Drug Project. He was advised to contact them post discharge. It was noted that this would be the key intervention to manage the risk of his violence. It is not evident that, as might be expected, during his stay Paul's substance misuse was formally assessed. Although he was not diagnosed as having a major mental illness, it is nevertheless somewhat surprising that once discharged there were no follow up plans to facilitate and/or monitor his reintegration into society.

2.5.3.20 The manager who summarised and did an initial analysis of the health IMRs noted that ‘there was no evidence of current risk assessment tools in use from any provider when disclosures of previous domestic violence were disclosed’. Once again, this would seem to indicate a tendency, already commented upon, to treat the symptoms rather than the individual.

2.5.4 Kent Probation

2.5.4.1 Katie’s period of supervision coincided with a period in which she got involved with a range of boyfriends, often of short duration and often with their own criminal histories. This situation created difficulties in assessing and managing risk.

2.5.4.2 The potential impact of Katie’s pattern of relationships on Aaron was generally recognised and raised with her, by her Probation officer, during supervision. This is good practice and shows an awareness of wider safeguarding issues.

2.5.4.3 In contrast, however, they failed to pass on key information about a potential safeguarding risk to Aaron. In February, Probation became aware that Katie was in a relationship with Gary, who was sharing accommodation with a sex offender. They informed him that Katie’s son, Aaron, would not be allowed in his flat. This shows they were aware of the potential risk. It is surprising, therefore, that they neither alerted Social Services nor Katie. Katie was being supervised by Probation at the time by the same officer who was supervising Gary. In March, Gary told his Probation officer that Katie would be moving in with him the next day. Again, this information was not passed on nor does Gary appear to have been reminded that Aaron must not visit his mother at Gary’s flat. Kent Probation has already acted to reduce the risk of a similar failure to share information in future, and this is noted in section 3.2 below.

2.5.4.4 Although generally Probation reports on Katie for the period reviewed were of good quality, some parts of the assessment were not regularly updated but simply repeated from one occasion to the next. This is poor practice and is being addressed through supervision. In particular, some of the entries that were repeated without re-verification relate to where Aaron was living and to Katie’s alcohol consumption. Both were relevant for safeguarding purposes and the latter was also relevant to assessing Katie’s overall risk of harm and of reoffending. Both, therefore, were vital elements of a full risk assessment. Similarly, there are instances of it being reported that Katie’s alcohol consumption was increasing but the relevant quantities being unrecorded.

2.5.4.5 The PSR prepared for Paul on 9th August 2012 notes that Katie was currently awaiting sentence at Canterbury Crown Court and that alcohol was indicated, as it was for Paul, as a factor in her offending behaviour. This is a good example of placing them both in context rather than considering them in isolation.

- 2.5.4.6** In contrast, however, the PSR author recorded as a fact that Paul was living with Katie and Aaron. There is no indication in the report that any potential for risk to Aaron, Katie and/or their unborn children (as opposed to any risk of violence to the wider public) was assessed beyond recommending that a curfew order would not be appropriate due to Paul's history of aggression against former partners. Indeed, there appears to be considerable emphasis on Paul's apparent willingness to address his substance misuse without fully assessing the likelihood of success.
- 2.5.4.7** Although Paul's PSR does not appear to highlight/show much awareness and understanding of potential safeguarding risks, there is some evidence that Probation were aware of this in that they advised Social Services about his potential risk factors. This was, though, done in the context of their discussions about Katie and it is less likely that they would have discussed this had they not made a referral to Social Services while preparing her PSR. Some action to improve the sharing of safeguarding information between Probation and other agencies has, as is noted at 3.2, already been taken and it may be that further actions are deemed necessary following the review by the Safeguarding Children Board referred to at 2.5.7 below.
- 2.5.4.8** Probation sought advice from KCA about whether an ATR or DRR would be most appropriate for Paul. This is good practice. The request was, however, made by email. Whilst such an approach may represent an efficient use of time, it does not encourage or enable a full exploration of the circumstances leading to the request for advice. Such requests are generally better made by phone.
- 2.5.4.9** There was a delay in completing Paul's full risk of harm summary (OASys), once he had been sentenced largely due to Probation staff sickness. Had it been completed in time it may have triggered liaison between Police and Social Services and, if shared with KCA, enable them to take the full risk assessment into account when working with Paul.
- 2.5.4.10** KCA did not receive risk documentation from Probation in respect of Katie. Further investigation showed this failure to provide such information was not an isolated incident.
- 2.5.4.11** There was good evidence of colleagues sharing information within Probation about factors relevant to Katie and Paul. There is also good evidence of them alerting Social Services to potential concerns about Aaron and to Katie's unborn children.
- 2.5.4.12** Apparent discrepancies in information held by varying agencies, of which they became aware (for example, relating to Paul and Katie's living arrangements, their contact with Aaron and their drug and alcohol consumption), do not appear to have been explored nor referred to as an unresolved conflict in reports. This failure is both surprising and concerning.

2.5.5. KCA

- 2.5.5.1** Several procedures were not followed correctly in respect of Katie. No referral or consultation was made to Social Services in respect of the reported pregnancy. The clinical notes do not record whether safeguarding concerns had been appropriately identified and escalated.
- 2.5.5.2** Katie was 20 minutes late for her original pre ATR assessment. The IMR does not record the reason. An alternative appointment was made, for some two weeks later. In the event, this does not seem to have been detrimental as Katie attended, as required, at the second appointment. There is a concern however, that had her attendance been voluntary (she was attending in connection with a PSR and a failure to comply could have negative consequences) she may not have returned for the second appointment and that, given that she had made some effort to attend – albeit arriving with just over a quarter of the 90 minutes appointment time already gone – the process could and should at least have been started in order to help build and maintain her engagement with the process.
- 2.5.5.3** Katie was on KCA's books from the end of June 2012 but was only seen once within this time for her pre ATR assessment. Although they were waiting for the court to sentence her before beginning any formal work with her, it is not clear whether they gave appropriate/adequate advice and support to her during this time. Whilst the policy at the time was that they could not formally engage with her until the outcome of the ATR assessment was known and an ATR order made by the court, they might have considered referring her to CRI alcohol services or other sources of help and support in the interim. In KCA's related Serious Incident Report into their interactions with Katie and Paul, it is noted that, during the course of that investigation, Katie's caseworker says he told her about the dangers of drinking while pregnant and that she said the midwife had already discussed this with her but this is not recorded in the caseworker's clinical notes for her.
- 2.5.5.4** Asked, by Probation, for advice as to whether an ATR or DRR would be most appropriate for Paul it would appear that an ATR was suggested based more on the fact that Paul's index offence was alcohol related rather than a full assessment of his poly substance abuse. Had a full assessment been carried out, a DRR would undoubtedly have been recommended. This is another example of an agency taking things at face value and not – even when evidence was given/available to them which should have prompted further questions – exploring matters fully before making a recommendation or reaching a decision.
- 2.5.5.5** The drug and alcohol services provided by KCA have subsequently been integrated with the effect that, irrespective of the order that is made (i.e. ATR or DRR) the service users receives the service he or she needs. Had this been in effect when Paul was referred to them he would have been put on a programme designed to help address his drug and his alcohol misuse rather than his alcohol misuse in isolation.

2.5.5.6 Paul's suspected use of cocaine on KCA premises was not formally recorded or addressed in line with procedures. Had it been, it might have opened up a route to help him address his drug related problems rather than focussing solely on his alcohol misuse. The failure to deal with this issue in line with procedures and failure to record it formally also risked giving mixed messages about acceptable behaviour and KCA's tolerance of illegal activity.

2.5.5.7 Probation recommended that if both Paul and Katie were given ATRs, they would be given appointments on different days. This was a sensible precaution which was initially disregarded by KCA when allocating appointments for ATR assessments.

2.5.5.8 There is some evidence of KCA being accessible – for example Paul was issued a travel warrant and advised that an evening session was available.

2.5.6 Housing

2.5.6.1 At an early stage in the review it became apparent that both Paul and Katie had had contact with the local housing department. Accordingly, that department was invited to contribute to the review and, in particular, to

- i. clarify the timing, nature and extent of its contact and involvement with Katie and Paul, whether as individuals or as a couple and to include any previous tenancies/requests for assistance.
- ii. identify whether there had been any complaints/reported incidents (for example about noise, arguments, new housing requests) from neighbours, housing staff and indeed from Katie and/or Paul themselves that might be relevant.

2.5.6.2 It was thought this might

- i. help identify when Paul and Katie's relationship started and thus help frame the timescale for the review
- ii. identify whether there were reported incidents that might or should have raised concerns relevant to this review that were disregarded or insufficiently followed up.

2.5.6.3 The IMR showed that

- i. the Housing Department had only very limited contact with either Katie or Paul
- ii. Katie and Paul appeared to be in an established relationship by May 2012
- iii. In August 2012 there was one reported incident of noise/disturbance at one of the residential addresses known to

be used by Katie and Paul. This was appropriately followed up and the department liaised appropriately with the police.

2.5.6.4 Accordingly, there are no specific learning or action points for housing.

2.5.7 Safeguarding

2.5.7.1 While it is not the purpose of this review to consider the handling of any child protection concerns which may be related to the case, it was recognised at the outset, that there may be issues that arise that relate to the safeguarding of children who may be affected by domestic abuse.

2.5.7.2 It was agreed that if this is the case these issues will be raised, by the relevant agency, with the relevant Safeguarding Children Board.

2.5.7.3 A number of issues were identified by the panel and given the agreement at 1.5.2.4 they are not reported on/analysed in detail. A number of themes emerged however, and they are summarised here.

2.5.7.4 There was conflicting information about arrangements for Aaron's care, where he was living and how much contact Paul and Katie had. This conflict was not fully resolved before Children's Social Services closed the case referred to them by Probation. This failure to resolve this issue before closing the case is, particularly given the assessment of the risk of harm Paul posed to others, of concern. So, too, is the apparent failure to fully risk assess the potential risk to Katie's unborn children. It's likely that both these issues will need to be reviewed more fully by the relevant Safeguarding Children Board.

2.5.7.5 That Safeguarding Board may also want to review the information, contained in KCHT's IMR, about interaction between Health and Social Services in respect of Katie and Aaron prior to the period covered by this review. In particular, if policies and practices have not changed since then, they may wish to consider whether,

- arrangements for follow up of service users who are known to be vulnerable and who disengage,
- eligibility for further floating support once an individual's initial entitlement has been exhausted and
- provide adequate safeguards against identifiable risks.

2.5.7.6 Some agencies and service providers, particularly in health, appear to have an inadequate understanding of safeguarding issues particularly in complex and/or chaotic family situations. For example

- Going back over several years, Katie had a history of not attending developmental checks for her son, not answering the door/failing to be in as arranged, missing health appointments. Despite several attempts, the health visitor had no face to face contact with Aaron between July 2009 and August 2012. Given

what was known, at the time, about Katie's circumstances it may be appropriate to review whether current policies, procedures and information sharing protocols are sufficient, and sufficiently well understood, to minimise the risk in future.

- Barts failed to enquire about the circumstances surrounding Katie's stabbing, who was caring for her son while she was in hospital and whether the address to which she was discharged was safe.
- Probation failed to alert Social Services to the fact that Katie was in a relationship with and, subsequently, lived with someone who shared accommodation with a known sex offender.
- A&E failed to notify the midwife of Katie's attendances that were not directly related to her pregnancy but which may have suggested possible safeguarding risks
- Katie's GP failed to respond appropriately to the midwife's request for information which would help her assess risks to Katie's wellbeing and to that of her unborn children.

2.5.7.7 There was some good practice identified within various agencies, including the tenacity of some individuals in attempting to follow things up/enlist help from other agencies in so doing.

2.5.7.8 Looking at their agency's involvement going back several years, however, the KCHT IMR author concluded that

'The impact on Aaron was recognised but Katie's needs and chaotic lifestyle seemed to overshadow those of her son and he was undoubtedly exposed to significant abuse'.

She went on to say

'It would seem there was differing interpretation on thresholds between the Social Worker and Health Visitor regarding the risk and impact of abuse on Katie and her son'.

2.5.7.9 This conclusion – that the assessment of Katie was somewhat one dimensional, often dealing with the 'presenting problem' rather than looking for possible patterns or thinking more widely about the family unit could equally well apply to some other health providers involved in Katie's care and treatment.

2.5.7.10 This is also true of Paul who tended to be regarded as an individual rather than as a father to two children with whom he had only very limited contact, and as the expectant father of two with whom, it appeared, he hoped to have regular contact and involvement. Nor was much attention played to his role in Aaron's life although it is reported that Aaron lived with Paul and Katie for a while and that Paul regularly took him to school.

3 Good practice, action already taken and lessons learned

3.1 Good practice

3.1.1 Whilst this review inevitably focuses on areas for improvement, there were some examples of good practice. In particular:

- Probation
 - recognising and discussing with Katie the potential impact on Aaron of her relationships,
 - advising KCA that Paul and Katie should not be given appointments with them on the same day
 - and that a curfew order might expose Katie to unnecessary risk.
- Probation and Specialist Children's Services exchanging information about Katie, Aaron and her unborn children although reference has already been made to the fact that, when information from one source appeared to conflict with information from the other, this apparent conflict was not adequately addressed.
- KCA making their service accessible by offering sessions at different times of day.
- The Police showing sensitivity in their attempts to engage with Katie with a view to completing the relevant assessments and investigations.
- Probation seeking information from the Police about any history of domestic abuse between Paul and Katie.
- The midwife seeking information from a range of sources to assess Katie's social situation and any risks to her/her unborn children.
- Several individuals and agencies within health, Specialist Children's Services and the Police making repeated efforts - and using different means - to contact Katie.

3.2 Action already taken and lessons learned

3.2.1 A number of agencies have already taken action and/or amended relevant policies and practice. In some cases, this has been prompted by this review, in others the timing has been coincidental. The key points to note are outlined below.

- Kent Police's Domestic Abuse policy has been updated to include additional safeguards to ensure that appropriate professional

discretion is applied when using the DASH scoring matrix to assess risk.

- The paperwork used by midwives as part of their risk assessment has been altered to include drug and alcohol use by any member of the household.
- Offender Managers in Probation have been reminded via the intranet and the service's Practice Bulletin to make every effort to cross reference and verify information when received from various sources and, in particular, when Probation colleagues are supervising offenders known to each other. This is also covered in 1:1 supervision. Supervision also provides an opportunity to 'spot check' records to ensure that entries are not routinely 'cut and pasted' from one entry to the next.
- Kent Probation has updated, strengthened and reissued its guidance to staff on Safeguarding Notifications to Children's Social Services. As part of this a number of forms and templates have been amended or introduced, together with process maps to help ensure that relevant information is appropriately shared in a timely way.
- Kent Adult Social Services have commissioned further training about domestic abuse, to include training on the use of DASH, for over 700 staff.
- A domestic abuse 'learning session' was held at Katie's GP surgery in July 2013. This was facilitated by trainers from a local domestic abuse project and attended by the surgery's GPs and nursing team. Some reception and administrative staff also took part.
- Several members of the team at Katie's GP surgery, including the senior partner, practice manager and deputy practice manager have also attend MARAC training and fed this back to the rest of the team.
- When the surgery is notified of a MARAC they now add a code to the notes of the victim and the notes of any relevant children.
- Eighteen members of the Community Nursing Teams in Thanet attended a presentation in August 2013, to share initial learning from this review and to receive support in identifying and dealing with incidences of domestic abuse.
- In addition, one of the KCHT safeguarding advisors conducted a feedback session to the band 6/7 & 8 community nurses and managers to raise awareness of district abuse with the aim of cascading this across locality teams.

- KCHT has increased the number of domestic abuse leads in post and they will be delivering training throughout 2014 with the aim of ensuring that all relevant staff have been trained by the end of 2014.
- EKHUFT has been providing level 3 Children's Safeguarding training across the Children's Workforce, Midwives, Accident and Emergency and Minor Injuries Unit staff. The training focuses specifically on domestic abuse and the effects on the child. It is part of a rolling programme of staff training and will continue to be provided as part of the suite of safeguarding programmes that includes adult and child safeguarding.
- Work is in hand on behalf of the Kent & Medway Domestic Abuse Strategy Group to streamline processes and standard templates for DHRs, Serious Case Reviews and Safeguarding Adult Reviews.
- It is also relevant to note that the substance misuse service has been re-commissioned and the current provider, Turning Point, offers an integrated drug and alcohol service including the provision of ATRs and DRRs. If someone fails to attend an appointment, they endeavour to contact them by both letter and phone. Any failure to attend is also notified to the referrer.

4. Conclusions

4.1 Individual agencies/specialisms

4.1.1 Overall Police involvement was appropriate and followed relevant policies. There was evidence of some good practice in being both sensitive and tenacious in risk assessment. Since, but not as a result of, their interactions with Paul and Katie Kent Police's Domestic Abuse Policy has been updated to include additional safeguards to ensure that appropriate professional discretion is applied when using the DASH scoring matrix to assess risk. In common with several other agencies, they continue to face challenges in accurately assessing risk where victims routinely refuse to engage/cooperate with enquiries. Again, in common with a number of other agencies, they need to remind staff that it is not always advisable or appropriate to ask the partner of someone who is known or believed to be a victim of domestic abuse to contact them on the agency's behalf.

4.1.2 Although there was some good practice in health (for example, the midwife contacting the GP for information that would assist her in assessing any risk to Katie and/or her unborn children during her pregnancy) the general picture within health in this case is of organisations and individuals:

- Having an inadequate understanding of domestic abuse.
- Taking things at face value.

- Seeing an individual as a collection of symptoms rather than as a whole person within their familial and social context.
- Failing to communicate with other parts of the healthcare system/other agencies involved with Paul and Katie.
- Failing to follow up adequately.
- Of a number of health/health related providers keeping inadequate records. Some of this has begun to be addressed by actions already taken; but more remains to be done.

4.1.3 There was a mix of good and poor practice within Probation. There was some good sharing of information internally between colleagues and, at points, with Social Services. There was also some good information analysis. Equally, there were examples of:

- Missing opportunities to alert other agencies to safeguarding concerns.
- Taking things at face value.
- Failing to analyse risk properly.
- Failing to share risk assessments in a timely way with other agencies.

4.1.4 KCA did not always follow procedures correctly and, in common with other agencies, there is evidence of missed opportunities to:

- Alert other agencies to potential safeguarding concerns.
- Treat the whole person rather than the most immediate or obvious symptoms.

There was, though, some evidence of their service being accessible – for example Paul was issued a travel warrant and advised that an evening session was available.

4.1.5 The degree to which safeguarding risks were adequately understood and appropriately investigated and acted upon was mixed. There was some good practice by and cooperation between individuals. There were, however, worrying failures to identify and communicate potential risks.

4.1.6 As has been noted, the quality, relevance and timeliness of IMRs and responses to subsequent enquires was very variable. Whilst the very real resource constraints experienced by some organisations is acknowledged, it is also evident that some organisations, particularly within health, do not fully understand the statutory nature of the Domestic Homicide Review process, its relevance to them and its importance both locally and nationally.

4.2 Overall conclusions

- 4.2.1** One of the key questions a DHR has to consider is whether the homicide could have been predicted and/or prevented. In this case, Katie was acquitted of both murder and manslaughter and the question is therefore redundant. It is nevertheless noted that although Katie had previous convictions for assault and had assaulted a previous partner, the only recorded incidents of domestic abuse during her relationship with Paul show her as the victim, not the perpetrator. There was no evidence that in her relationship with Paul that she had ever initiated violence against him and, to that extent, had the jury found her guilty of his murder or manslaughter it seems unlikely that the review would have concluded that this could have been predicted or prevented.
- 4.2.2** What is clear is that Paul and Katie had a turbulent and apparently deteriorating relationship. This was exacerbated by their use of alcohol and illicit drugs both of which often gave rise to violent and unpredictable behaviour. Although both had been referred for treatment there is little, if any evidence to suggest that either were sufficiently motivated to address their substance abuse/engage fully in the process. Both minimised the severity of their alcohol abuse and this went largely unchallenged even where it's potential for increasing their violent and unpredictable behaviour was recognised.
- 4.2.3** Equally it is clear that at least five children would potentially be impacted by any change in Paul or Katie's exposure to risk of violence or domestic abuse. There is mixed evidence about the extent to which service providers considered these wider safeguarding issues and/or the potential for either Paul or Katie to be the victim, rather than the perpetrator, of domestic abuse.
- 4.2.4** Given the volatility of Paul and Katie's relationship, their history of abusive relationships, chaotic lifestyles, mistrust of authorities and continuing failure to engage it seems likely that the violence between them would have continued to escalate. Paul had been assessed by a psychiatric consultant as having a history of threatening self-harm/expressing suicidal thoughts as a way of trying to get his demands met and the comments Katie made during the DASH assessment on 21st September suggest this pattern was repeating itself.
- 4.2.4.1** There are a number of factors to suggest that Katie, rather than Paul, was more likely to be at risk of domestic abuse within their relationship and that that risk was increasing. These include:
- Her previous history of having been abused.
 - The fact that she had previously been subject to a MARAC and, as such, identified as a high risk victim.
 - Her pregnancy. Pregnancy is known to be a factor in escalating the risk of domestic abuse.

- Her own misuse of alcohol and drugs.
- Paul's history of domestic abuse against partners and former partners.
- Paul's misuse of alcohol and drugs.
- Paul's controlling behaviours and threats of self-harm as noted during his stay at the Green Parks Mental Health Unit.

But no one saw these together as a whole. As has been outlined at section 3.2, some steps have already been taken to address this failure. More work remains to be done, however, and the action plan that follows is designed to address this.

5. Recommendations

5.1 As has been noted, a number of organisations have already taken action which goes some way to addressing the failings and lost opportunities identified in this report. Some are also continuing to progress the action plans agreed as part of their own IMR. The recommendations that follow below are additional steps the panel consider necessary and they are reflected in the action plan.

5.2 Recommendation 1

All agencies should review their domestic abuse policies, procedures, risk assessment tools and training with a particular emphasis on:

- Ensuring, as far as possible and appropriate, a common approach and language is used; this will aid communication and inter-agency information sharing. Coupled with an increased use of multi-agency training it will also facilitate sharing of best practice.
- Ensuring that apparently isolated or infrequent incidents are viewed in their wider context.
- Building front line staff skills and confidence in using a range of appropriate questions when conducting risk assessments, particularly with people who appear reluctant to engage.
- As part of this review they should also remind staff that it is not always advisable or appropriate to ask the partner of someone who is known or believed to be a victim of domestic abuse to contact them on the agency's behalf and should ensure this is reflected in their procedures and training.

5.3 Recommendation 2

Within health, there appeared to be a particularly worrying lack of awareness or understanding about domestic abuse. Whilst the individual trusts and Katie's GP surgery have taken some steps to address this there is a need to ensure this is firmly bedded in and that other providers, particularly individual GP practices, take on board the learning from this review.

It is therefore recommended that:

- The adequacy and efficacy of the Kent Surgery's Domestic Abuse Policy and training should be independently assessed and, if appropriate, remedial action taken.
- The adequacy and efficacy of the EKHUFT's Domestic Abuse Policy and training of A&E staff should be independently assessed and, if appropriate, remedial action taken.
- CCGs should encourage GP surgeries to review their domestic abuse policies and training and, where necessary, to take positive action to improve their understanding and practice. In this context, the learning from this review suggests that it will be particularly important to ensure that staff, whether clinicians or not,
 - are aware of their role/responsibilities with regard to identifying domestic abuse
 - are aware of the key signs to be aware of with regard to domestic abuse
 - and that clinicians feel able to initiate conversations and routinely enquire about potential abuse.
- It is further recommended that a rolling audit of domestic abuse policies, practice and training across GP surgeries in Kent and Medway be undertaken with a view to identifying where further work is needed. It appears that there is no body that is statutorily responsible for this and, consequently, no funding is available. It also appears that were such an audit to be carried out and were deficiencies to be found, there is no body with the power to do any more than encourage GP surgeries to improve their understanding and practice in relation to identifying, preventing and supporting victims of domestic abuse. Such encouragement is important, and in many cases may be all that is needed. Nevertheless, the apparent lack of robust monitoring and control measures in relation to domestic abuse policy and practice within the existing governance and contract monitoring arrangements for GPs in England and Wales is a significant concern. It is recommended the Home Office review with their colleagues in the Department of Health.

5.4 Recommendation 3

Agencies and service providers should routinely ask services users for information about how best to contact them. This information should be checked at every appointment and for service users known to be at particular risk of failing to attend (because, for example, of their transient lifestyle, substance misuse or mental health problems) more than one means of communication should usually be used.

5.5 Recommendation 4

The delivery of Alcohol Identification and Brief Advice Training should be expanded to Health and Social Care Providers (e.g. Children and Families, Probation Service, Midwifery, etc.).

5.6 Recommendation 5

A comprehensive risk assessment should be made available by Probation staff to substance misuse providers as soon as the initial referral is made.

5.7 Recommendation 6

The membership and processes of the Central Referral Unit (CRU) should be reviewed to ensure that mental health and substance misuse issues are properly managed and providers consulted appropriately.

5.8 Recommendation 7

Referral pathways between Court Diversion/Custody Liaison Service and DIP should be formalised and agreed. In particular, it will be important to ensure that appropriate information protocols are in place to support the correct diagnosis and treatment of individual service users.

5.9 Recommendation 8

Whilst drug and alcohol services welcome self-referral on the basis that the patient needs to be motivated to change, some patients need help taking the first step. It is therefore recommended that, with the patient's consent, health professionals should wherever possible directly refer to drug and alcohol services in preference to or alongside asking the patient to self-refer, and follow up these referrals to monitor patient compliance.

5.10 Recommendation 9

Reference has been made to the variable quality of the IMRs. Several did not follow the template or adequately address the terms of reference. This was particularly a problem within health. It is recommended, therefore, that the revised training and standard letters/support materials be implemented and its impact evaluated so that report authors, and managers signing of the IMRs better understand and meet their statutory responsibilities with regard to domestic homicide reviews.

5.11 Recommendation 10

The Children's Safeguarding Board should formally review the various children's safeguarding concerns raised in this report and agree an appropriate action plan.

5.12 Recommendation 11

Kent Children's Specialist Services should review the timing of and the quality of information used to make the decision to close the cases referred to them by Probation in respect of Aaron and of Katie's unborn twins and, if necessary, amend policies and/or guidance and/or staff training.