

**Domestic Homicide Review**  
**Overview Report**  
**Elizabeth/2015**

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Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

# **1. Introduction**

## **1.1 Background to the Review**

The domestic homicide review was commissioned following the unlawful killing of Elizabeth between 28<sup>th</sup> April and 29<sup>th</sup> April 2015.

1.2 The Chair of the Kent Community Safety Partnership agreed to commission a Domestic Homicide Review in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, because there had been a death of a person over 16 years, which appeared to result from an act of violence from a person with whom she had been in an intimate personal relationship.

1.3 The review commenced with an initial meeting on the 1<sup>st</sup> July 2015, when it was decided that following an initial audit of available information from partner organisations the necessary criteria had been met for a full domestic homicide review to be completed and an Independent Chair was asked to carry out the review.

1.4 A Terms of Reference Meeting was held on the 18<sup>th</sup> August 2015 (appendix A), together with review panel membership, agency involvement with the family and other associated documents.

## **2. Terms of Reference**

2.1 The purpose of a domestic homicide review as set out in the Multi-agency Statutory Guidance for the Conduct of a Domestic Homicide Review is:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic abuse homicide and improve services responses for all domestic abuse victims and their children through improved intra and inter-agency working.

2.2 The specific terms of reference agreed for this review were:

- Were practitioners sensitive to the needs of Elizabeth and Richard, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agencies have policies and procedures for dealing with Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk assessment processes for domestic abuse victims and perpetrators and were those assessments correctly used in the case of Elizabeth and Richard? Did the agencies have policies and procedures in place for dealing with concerns about domestic abuse? Were these tools, procedures and policies accepted as being effective?
- Did the agencies comply with their information sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decision made? Were the appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- Were procedures and practices sensitive to the ethnic, cultural, linguistic, religious and gender identity of Elizabeth and Richard (if relevant). Was the consideration of vulnerability and disability necessary?
- Were senior managers or other agencies and professionals involved at appropriate points?
- Are there ways of working effectively that could be passed onto other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Elizabeth and promote their welfare, or the way it identified, assessed and managed the risks posed by Richard? Are any such lessons case specific or do they apply to systems, processes or policies? Where can practice be

improved? Are there implications for the ways of working, training, management and supervision, working in partnership with other agencies and resources?

- How accessible were the services to Elizabeth and Richard?
- To what degree could the death of Elizabeth have been accurately predicted and prevented?
- The timeframe for the review was agreed as the period January 2007 to April 2015.

The following organisations were requested to complete Independent Management reports (IMRs):

- Police
- Health Agencies: General Practitioner (GP), East Kent University Hospitals NHS Foundation Trust (EKUHFT), Kent Community NHS Health Foundation Trust (KCHFT).

Summary reports containing details of any engagement with family members were requested from the following agencies as their engagement had been determined as minimal:

- Kent County Council (Children's Services)

At a later stage the local school was also requested to provide a report.

- A copy of the Terms of Reference attached at Appendix A.
- During the course of the review it became known that the victim had at times used other surnames for herself and her children and further data checks were requested from those participating agencies identified above.
- It was agreed that the final report would be suitably anonymised before publication.

### **3 Review Process**

3.1 The review work commenced shortly after the Terms of Reference Meeting which was held on the 18<sup>th</sup> August with IMRs being produced by the required agencies along with the requested summary management reports. It was requested that those agencies producing IMRs should carry out a structured individual management review covering their full involvement with the victim and the perpetrator. Therefore, enabling lessons to be learnt and

recommendations to be developed and clearly presented in the final overview report.

- 3.2 At this stage it became clear that the health records provided were very limited and included very little information relating to the children, Child A (age 5 years) and Child B (age 4 years). All health agencies were asked to review their records once again using additional surnames that had been used by Elizabeth.
- 3.3 The information for the health overview IMR was gathered from records held at the local NHS GP Practice, East Kent University Hospitals NHS Foundation Trust (EKHUFT) and Kent Community Health NHS Foundation Trust (KCHFT). These included consultation reports, referral letters, assessment reports, clinical notes and A & E casualty cards and benchmarked against policy in place at the time.
- 3.4 The Police Reviewing Officer scrutinised relevant incidents relating to the Police involvement with Richard and Elizabeth for the period leading up to Elizabeth's death. In particular, incidents involving domestic abuse, assault and mental health issues have been benchmarked against policy in existence at that time.
- 3.5 The Police review was carried out by members of the Police Serious Case Review Team. In completing their review a number of documents and databases were researched, including: -
- GENESIS Database.
  - STORM Records.
  - Crime Reports and secondary incidents.
  - Police National Computer (PNC).
  - Internal Police Policy Documents.
  - Multi-Agency National Documentation.
  - Murder investigation records.
- 3.6 The Children's Centre records indicate Elizabeth attended the Children's Centre on only two occasions with her older daughter, Child A, in September 2011 and in March 2014. On both occasions, they attended a "stay & play" session. This is "friendly family fun with craft activities and singing for children aged 0 - 4 years".
- 3.7 The type of interaction that Elizabeth had at the Children's Centre was not related to the provision of targeted support and would not have generated an in-depth record. A database search was also carried out using the known

surnames used and this identified no additional information for inclusion within the IMR.

#### **4.0 Family, Friends and Other Input to the Review Process**

- 4.1 With the help and assistance of the Police Family Liaison Officer, communication was made with Elizabeth's Polish Family and friends and also with Richard's parents. The Polish family members formally declined an opportunity to have an input to the review process, despite being offered translation services and support. The parents of Richard originally agreed to participate with the review when approached by the Police Liaison Officer but have failed to respond to letter and telephone communications. Contact was successfully established with a long-standing friend of Elizabeth and a meeting was held that provided useful background context and also further information regarding Elizabeth and Richards's relationship.
- 4.2 With the assistance of the Police Family Liaison Officer a meeting was arranged with the close family friend of Elizabeth's. The friendship had started in Poland when both parties were approximately 17 years of age and after both the victim and the friend had relocated to England the friendship continued through close contact being maintained with regular telephone conversations and visits.
- 4.3 The friend reported that Elizabeth was unhappy in her marriage and that Richard showed very little interest in the children and had little contact with them. It was also reported that Richard had bouts of drinking excessively, becoming unreasonably jealous and being very aggressive and demanding sex. Richard had become obsessed that Elizabeth was having an affair and a few weeks prior to Elizabeth's murder he was drunk and attempted to rape Elizabeth. It was reported that her children had witnessed this and led Elizabeth to recognise that the relationship had to end.
- 4.4 Elizabeth had approached a friend in Poland requesting a loan to help her to move on with her life with the children but she found this difficult, as her whole life was based where she lived. It was felt that Elizabeth would not have sought help from agencies as she considered that it was her responsibility to protect herself and her children. Although Richard was aggressive particularly when he was drunk neither Elizabeth or her friend considered that Richard was capable of killing her and Elizabeth was confident that she could cope with him.

4.5 Contact was also made with a local Polish Association who had a link on their website promoting domestic abuse services but they unfortunately kept no records of use or referrals made.

## **5.0 The Review Panel**

5.1 The review group membership was as follows:

James Parris	Independent Chair and Overview Report Writer (Independent Consultant)
Bonnie Wyatt	NHS England
Alison Gilmour	Kent & Medway Domestic Abuse Coordinator
Rosetta Lancaster	Ashford & Canterbury Clinical Commissioning Group
Wendy Bennett	Ashford & Canterbury Clinical Commissioning Group
Carol McKeough	Kent County Council Adult Services
Tracy Anstis	Kent Police
Tom Stevenson	Kent County Council Children's Services
Liza Thompson	Swale Action to End Domestic Abuse (SATEDA)
Shafick Peerbux	Kent County Council Community Safety

5.2 The review panel met on the following dates:

- Tuesday 18<sup>th</sup> August 2015
- Monday 30<sup>th</sup> November 2015
- Wednesday 13<sup>th</sup> April 2016
- Thursday 26<sup>th</sup> May 2016

5.3 The Chair of the Panel and author of the overview report has had no direct involvement with any of the professional's work being reviewed. The author is an independent consultant who has held senior positions in both the public and private sector and was a Senior Community Safety Manager until retiring in March 2015.

5.4 The report is based upon information provided in the IMRs, information disclosed at meetings of the review group, information provided by professionals working in this area of activity and meetings held with a family friend.

## **6.0 The Facts**

### **Police Incident Summary**

- 6.1 Elizabeth was born in Poland. In 2003 she moved to Kent with her then boyfriend, a Polish National, and they subsequently married. After the breakdown of their marriage he returned to Poland. Information suggests that he died in Poland in 2012.
- 6.2 Elizabeth had been living with Richard for about 8 years and they had been married since July 2013. Elizabeth lived with her husband and their two children, Child A aged five and Child B aged four years. Approximately two weeks before her death (Easter Time 2015) Elizabeth returned to Poland with her children to see her parents. It was there that Elizabeth disclosed to friends that her relationship with Richard was in decline and that she was going to leave and divorce him. At the time of her death, Elizabeth was working as a part time barmaid at a public house in a local village. She also worked locally as a cleaner.
- 6.3 On Thursday 30<sup>th</sup> April 2015, Richard reported to the Police that his wife was missing. Richard informed the Police, when he reported Elizabeth missing, that the last time he had seen her was between 00:30 and 01:00 hours in the early hours of Wednesday 29<sup>th</sup> April 2015. He told the Police that he and Elizabeth had not been getting on, that she had been out that evening and that when she got home they had had an argument and she stormed out. He stated that she had done this previously but had stayed at a friend's and then came home. He said that the reason Elizabeth had stormed out of the house was because she had wanted to clear her head. He also detailed that she had left on foot, leaving their family car, which Elizabeth had used that night to drive home.
- 6.4 The call was initially dealt with as a Missing Person Report by Divisional Staff carrying out normal missing person enquiries. On Sunday 3<sup>rd</sup> May 2015, the Missing Person investigation was reclassified as 'High Risk' and Police officers were deployed to conduct a thorough search at the home address and speak to Richard. This re-classification was due to Elizabeth's friends raising concerns about Facebook entries on Saturday 2<sup>nd</sup> May 2015 on Elizabeth's page, which didn't sound like her, but purported to be by her.
- 6.5 Having initially denied any knowledge of Elizabeth's Facebook account/password etc., Richard eventually admitted in interview that he had

accessed Elizabeth's Facebook account and posted the Polish and English entries, pretending he was Elizabeth and stating that she was alive. He said that he had done this to get her relatives and friends off his back and to stop them bombarding him with calls/texts about Elizabeth.

- 6.6 During the 'High Risk' Missing Person search on Sunday 3<sup>rd</sup> May 2015, Police Officers found traces of blood on a doormat and pets bedding. The Police arrested Richard on suspicion of Grievous Bodily Harm. Following the arrest, the home was forensically examined and during the search, further traces of blood were found along with traces of bleach suggesting a cleaning product had been used. A number of swabs were taken from the house that were submitted to the lab for DNA profiling. These were found to match the DNA of Elizabeth.
- 6.7 From the Police IMR it would appear that on Friday 20<sup>th</sup> March 2015 after Richard found a male friend's mobile number on Elizabeth's phone, he texted the male friend asking who they were. He also asked about him at the local public house, which they all frequented.
- 6.8 It would appear from reports from friends that Elizabeth was not happy with Richard due to his drinking and lack of parental responsibility. It was reported that he was very controlling and jealous of her. In addition, there was information from Elizabeth's friends to show that she was planning to leave Richard to start a new relationship. Richard was checking Elizabeth's phone to see who she had been calling. Richard was utilising the tracking App on her i-Phone so he could see where she was at any time. The tracking App was disabled on Elizabeth's phone by her friend on Monday 27<sup>th</sup> April 2015. Until the App on her phone was disabled it seems that Elizabeth was unaware that Richard had been utilising the App to track her movements. This information highlights Richard's controlling behaviour towards Elizabeth.
- 6.9 After locking the pub and finishing work Elizabeth had drinks at a friend's house and then left to go home around 11pm on the 29<sup>th</sup> April 2015. Once Elizabeth got home, she texted a friend to say she was home safely and they swapped a couple of texts, but the last one at midnight was not replied to by Elizabeth. From this point, onwards, Elizabeth was not seen again by any of her friends nor had she any type of contact with them either by social media, texting or telephone conversation. The last person to see Elizabeth alive would have been Richard.

- 6.10 Richard was charged with the murder of Elizabeth on Thursday 7<sup>th</sup> May 2015. Richard subsequently divulged to a family member where Elizabeth's body could be found so that it was possible for Police to narrow down their search. Elizabeth's body was discovered in a field approximately fourteen miles from their home address.
- 6.11 A Post-Mortem was carried out on Wednesday 13<sup>th</sup> May 2015. This concluded that Elizabeth had died from blood loss resulting from four stab wounds.
- 6.12 On the 15<sup>th</sup> January 2016 Richard was found guilty of manslaughter and received a fifteen-year sentence.

## **7.0 Police – Relevant Incidents Preceding the Murder**

- 7.1 Prior to his relationship with Elizabeth, on the 22<sup>nd</sup> June 2006 Richard reported that his previous partner 'was going berserk'. On arrival of the police Richard informed them that his partner had broken objects in the house and that she was claiming that he had thrown the baby at her causing the baby to bite her lip and swelling to the baby's head. The baby was fifteen months old at the time. This matter was considered as a 'Standard Domestic Abuse Incident'. An automatic referral was sent to Social Services regarding the concerns surrounding the child.
- 7.2 On the 9<sup>th</sup> February 2011 Elizabeth called police to help her get her baby daughter to hospital as the child had fallen over and bruised her leg. She told the operator that she didn't have a car and couldn't afford a taxi to take the child. It appears that she meant to call the ambulance service not police. There was no further police action regarding this matter.
- 7.3 On 13<sup>th</sup> February 2011 at 02:03 hours Police were called by Elizabeth reporting an assault by Richard, this occurred at their then home address. She asked the police not to attend that day and said she would go to the Police Station the following day.
- 7.4 The following day, 14<sup>th</sup> February 2011 at 00:19 hours, a further report was made by Richard's father that the couple were at home arguing. Police then attended the home address and were told that Richard had been out with friends and returned home in the early hours of the morning on 13<sup>th</sup> February 2011. He was drunk. He tripped over a child's toy and started shouting at Elizabeth. The two went to bed and it was there that Richard hit Elizabeth

around the head. There were no visible injuries but Elizabeth suffered headaches for some hours after. Elizabeth informed the attending officers what had happened the night before and this resulted in Richard being arrested for causing Actual Bodily Harm.

- 7.5 Elizabeth informed the officers of several other incidents of a similar nature that had not been previously reported to the police. She told the officers that Richard had been drinking to excess and wetting his bed.
- 7.6 The Crime Report indicates that Elizabeth wished to speak to a member of the Domestic Abuse Team, and that she was frightened when her husband was drunk as he was violent towards her and that the two had separated for three to four months when Child A was born in February 2010. The incident was assessed as 'Medium' risk by the attending officer but was later re-assessed as a 'Standard' risk domestic abuse incident and a letter was sent to the victim, providing details of support available which was standard practice at that time. Due to children being present a further review was completed by the child abuse team within Kent Police who assessed the incident as low risk and made a referral to Kent County Council Social Care. There is no record of Elizabeth making any further contact following the receipt of the letter from Kent Police. The Crown Prosecution Service later decided not to progress a charge against Richard for the suspected offence of Common Assault.
- 7.7 Due to children being present a further review was completed by the child abuse team within Kent Police who assessed the incident as low risk and made a referral to Kent County Council Social Care. There is no record of Elizabeth making any further contact following the receipt of the letter from Kent Police. The Crown Prosecution Service later decided not to progress a charge against Richard for the suspected offence of Common Assault.
- 7.8 At the time of this incident Elizabeth was seven months pregnant with her second child, due in April of that year.
- 7.9 A referral was made by Police to the Social Services Department in respect of Child A and the unborn child. There is evidence that the referral was dealt with by Kent County Council Social Care.
- 7.10 The murder investigation has also highlighted that Elizabeth may have been planning to leave Richard taking the children and that she was planning a new relationship. This suggestion has been supported through interviews

with a long term family friend who understood that Elizabeth was making plans to leave and start a new life with her children.

## **8.0 Health Overview – Summary of Involvement**

### **Richard**

- 8.1 The murder investigation indicated that Richard has for some years been receiving medical help for post-traumatic stress disorder following the death of a girlfriend in 2003, (she fell in front of a bus and was killed instantaneously). He was receiving treatment for depression in 2007 and on 26<sup>th</sup> March 2015, one month before the murder of Elizabeth, he saw his GP relating to stress related problems with his wife and home life. He was prescribed medication for this.
- 8.2 In July 2007, Richard discussed with his GP that he was stressed at work, and had ‘split’ from his previous partner one month ago, and that she was preventing him from seeing his two-year-old daughter. He was living with his mother and he reported that he had low self- esteem and was suffering from poor sleeping and eating patterns. This was making his job as a van driver difficult. He claimed not to be suicidal. He was prescribed an antidepressant, Citalopram. (*Citalopram is a selective serotonin reuptake inhibitor (SSRI) antidepressant drug that is widely prescribed for depression and anxiety; it works by increasing levels of serotonin in the brain*). GP records indicate that the prescribed drug was reviewed with Richard by his GP during 2007 and then prescriptions ceased in late 2007. After a subsequent visit to the GP on the 26<sup>th</sup> March 2015 one month’s supply of Citalopram was prescribed again. This was his last GP appointment prior to the incident and notes recorded: ‘stress related problem, self-employed which stressful, having problems at home with wife. Away from home lots of the time and wife feels neglected. Wants to go back on Citalopram, declined RELATE counselling which was offered for now; have made plans to take wife somewhere so they can speak about their problems’. *Relate is a charity providing relationship support throughout the United Kingdom. Services include counselling for couples, families, young people and individuals, sex therapy, mediation and training courses*
- 8.3 During the period of August 2007 to March 2015, Richard visited the KCHFT Minor Injuries Unit, EKHUFT A&E Department and consulted the Out of Hours services a total of sixteen times regarding injuries to his hand and for

back pain. Although the attendances are regularly reported to the GP the attendances were mostly musculoskeletal in nature and Richard was already seeing his GP for these symptoms and therefore these were not a cause for concern.

## **Elizabeth**

- 8.4 Medical records indicated that Elizabeth was born in Krakow, Poland. She first came to live in the UK in October 2003. Until 2013, she was registered under the surname of her previous marriage and reported that she was a widow and her next of kin was Richard.
- 8.5 Under the name of her previous marriage, Elizabeth was given maternity care for both children at EKHUFT and recorded Richard as the father. As part of normal practice, Elizabeth was repeatedly risk assessed for her mental health and social factors. This is intended to reveal any concerns about domestic abuse, which is standard midwifery practice and no concerns were identified.
- 8.6 During this time, Elizabeth received numerous medical examinations by doctors and midwives and there was nothing documented of any form of physical abuse. There were no concerns raised about her mental wellbeing or social factors by staff. She always attended appointments and engaged fully in her maternity care.
- 8.7 During March 2010, following the birth of Child A, Elizabeth had a number of routine visits from KCHFT Health Visiting services. There was no evidence in the Family Health Needs Assessment record to indicate a history of domestic abuse nor had any information been received from other agencies that indicated a history of conflict within the family up until this point.
- 8.8 On the 24<sup>th</sup> February 2011, health visitor records evidence a telephone call from Kent County Council Social Services to discuss a domestic abuse incident. It is recorded that although the family had a history of arguing, this incident was of a more serious nature and Elizabeth had contacted the police. It was suggested that Richard's family considered that Elizabeth was suffering from Post Natal depression following the birth of her child. However, this was not thought to be the case by the visiting Health Worker. Richard was described as having a history of domestic abuse with a previous partner. Elizabeth was described as having informed social

services that she will not accept this kind of behaviour any more. The notes also stated that the case was closed by Social Services meaning that they were no longer involved and there was no evidence of the General Practitioner being made aware of the incident.

- 8.9 On 26<sup>th</sup> April 2011, the family was visited by the health visitor following the birth of Child B. Richard was described as being very helpful. A note in the Family Health Needs Assessment stated that '*a reported incident of domestic abuse during pregnancy but mum has Children's Centre*'. This comment would suggest that Elizabeth could access support on domestic abuse matters from the Children's Centre.
- 8.10 Elizabeth's last two appointments with the GP were in February and March 2015 complaining on both occasions of a cough.

### **Child A & Child B**

- 8.11 Both children had routine visits from the Health Visiting services. No concerns were noted and growth and developmental stages were all age appropriate.
- 8.12 A KCHFT Community Nursery Nurse visited the family home on the 11<sup>th</sup> July 2012 and also gave telephone advice on the 25<sup>th</sup> July 2012 regarding the children's sleeping and dietary needs. Child B aged one year, was described as off her food but her weight was stable.
- 8.13 On the 27<sup>th</sup> November 2012, Elizabeth was advised by the Community Nursery Nurse to take Child A, aged two, to the GP as she was concerned that she may be anaemic as she looked tired and had dark rings under her eyes. There was no record in the GP's notes that this appointment was made.
- 8.14 Both children were taken to the GP practice for their immunisations. On the 25<sup>th</sup> September 2013, the family was visited by the local Health Visiting services as they had just moved to the area. No concerns were noted and Elizabeth was described as happy living in her village.
- 8.15 There were two occasions where Child A needed healthcare for minor injuries. On the 23<sup>rd</sup> March 2012, she was taken to A&E, EKHUFT, to have a bead removed from her nose. No sign of trauma noted. On 28<sup>th</sup> August 2014, Child A was taken to her local Minor Injuries Unit to have a small

foreign body removed from her right foot. A routine Children's Safeguarding Assessment Form was completed. There was no concern for the child and it was documented that the injury was consistent with the history given.

- 8.16 On the 17<sup>th</sup> March 2013, Child B was taken by Elizabeth to A&E, EKHUFT, following a fall down the stairs sustaining a head injury. This was noted as accidental injury and there was no cause for concern. On the 24<sup>th</sup> March 2015, Child B was taken to a local Minor Injuries Unit by Elizabeth for treatment for a superficial wound on her finger caused by catching her finger in a drawer at home. A Children's Safeguarding assessment form was completed and injuries were noted as consistent with the history given.

## **9.0 Children's Centre – Summary of Involvement**

- 9.1 There were only two recorded presentations at the Children's Centre for generic "stay & play" sessions that are open sessions available to all families in the local community.
- 9.2 Elizabeth attended the Children's Centre on two occasions with her older daughter Child A, according to the information available. Once in September 2011, when Child A was nineteen months old and again in March 2014, when Child A was four years old. On both occasions she attended a generic "stay & play" session which would not generate any attention or record keeping from Children's Centre staff; and there appears to have been nothing in her demeanour which generated any concern given the absence of a case record.

## **10.0 Analysis of Agency Involvement**

- 10.1 The analysis of the Police records and calls relating to their engagement with Richard and Elizabeth and the children or unborn child prior to the murder have been confirmed as appropriate and met policy guidelines in place at that time. However, domestic abuse policy and practice has changed significantly since 2011 with many changes being made to processes and procedures based upon the learning from DHR reviews, Her Majesty's Inspectorate of Constabulary (HMIC) Inspections & Reports and national/local initiatives. Therefore although a letter was sent to the victim which complied with standard practice at the time, it is acknowledged this may not be the most appropriate or effective way in which to communicate with victims of domestic abuse. This practice no longer exists and the service offered to victims has improved through new commissioning

arrangements set up by the Kent Police and Crime Commissioner. All victims are now referred to Victim Support and contact is made via the telephone. Victim Support will offer safety planning and crime prevention advice as well as wellbeing and emotional support. They will also refer the victim to a community service provider.

- 10.2 Information sharing from Kent Police was good and it was confirmed that they made appropriate referrals to the Social Services Department.
- 10.3 The Police Missing Person Policy was adhered to and raised to high risk as the evidence presented itself resulting in the arrest and charging of Richard for the murder of Elizabeth.
- 10.4 The review identified that effective practice was confirmed in that where each domestic incident was reported to police and it was identified that children were involved a suitable referral was made to Social Services.
- 10.5 In terms of Health Agencies involvement during the period January 2007 to April 2015, Elizabeth had a number of contacts with the primary, acute and community health services. Most of these contacts were related to her two pregnancies and the new born babies.
- 10.6 KCHFT Health Visiting services were informed by Social Services of an episode of domestic abuse on the 24<sup>th</sup> February 2011. There was domestic abuse guidance for Health Visitors in place at the time that advised staff to discuss issues around domestic abuse, if it was safe to do so. The Family Healthy Needs Assessment had and still includes questions regarding past and current abuse. When Elizabeth was next seen, she was accompanied by Richard and Richard's parents and therefore the discussion could not take place. There were further opportunities when Richard was not present in August 2011, November 2012 and July 2013 and it was recorded that the relationship was okay but this may have been a reference to the relationship with the baby. It is not clear from the records whether on subsequent visits the Health Visitor was aware of the previous domestic abuse incident in 2011. It is therefore important that clear and accurate notes are recorded by health practitioners not simply for the purposes of reviews, but more importantly for other practitioners working with individuals or families.
- 10.7 Although Health Visitors do hold liaison meetings with GP's no evidence was found in the 2011 notes that Social Services or the Health Visiting services had shared information about the domestic abuse incident with the General

Practitioner. In this instance, the information sharing could be improved and the relevant information passed onto the GP.

- 10.8 Apart from the incident in February 2011, Elizabeth did not self-report or mention any issues related to domestic abuse with the clinicians she had contact with that may have thrown light on her relationship with Richard. Additionally, the health care professionals who conducted home visits did not identify any risk factors that identified her as a vulnerable person.
- 10.9 The injuries that occurred to both children were assessed by the health care professionals as accidental injuries. Safeguarding Protocols were followed and a Children Safeguarding Assessment Form was completed on each occasion by KCHFT.
- 10.10 The minor injuries, described as cuts, which Richard sustained were recorded as accidents and not self-inflicted and it was established that assaults had not occurred.
- 10.11 There were two entries in the GP notes in 2007 and 2015 where Richard was prescribed antidepressants. There was no record of alcohol or substance misuse issues.
- 10.12 The Children attended a local primary school that confirmed it operated robust procedures involving teachers, senior leadership team, family liaison officer, Special Educational Needs Coordinator (SENCo) and school team leaders, providing the opportunity to raise safeguarding concerns regarding pupils or their families. Non-teaching staff were also engaged in these discussions. Prior to the death of Elizabeth the school has no record of any concerns being raised regarding the children. Instances are recorded relating to Richard attending the school after Elizabeth was reported missing and making requests to the staff not to allow Elizabeth to take the children away if she came to the school.
- 10.13 Elizabeth attended the Children's Centre on two occasions with her older daughter, Child A, according to the information available. Once in September 2011, five months after the birth of her second child, Child B, when Child A would have been nineteen months old and again in March 2014, when Child A would have been four years old. On both occasions she attended a generic "stay & play" session which would not generate any special attention or record keeping other than recording names of visitors to Children's Centre.

## **11.0 To what degree could the homicide have been accurately predicted and were opportunities missed?**

### **Police**

- 11.1 Police sent a referral to Kent County Council Social Services regarding an incident on the 22<sup>nd</sup> June 2006 relating to Richard's first partner.
- 11.2 A second incident was reported on the 13<sup>th</sup> February 2011, with the result that Richard was arrested for actual bodily harm. Elizabeth informed the police officers of other incidents of a similar nature and Elizabeth asked to speak to a member of the Domestic Abuse Team. The incident was assessed as a standard risk domestic abuse incident and a letter was sent to Elizabeth offering her the opportunity to make contact with the domestic abuse unit (as highlighted above in 10.1, this practice has now changed and the process is now more victim focussed). An appropriate referral was then made to Kent County Council Social Services. There is no record of Elizabeth following up this offer.
- 11.3 Elizabeth was pregnant with her second child at the time of the February 2011 incident and the attending police officers categorised the incident as a "medium" risk domestic abuse incident which was later re-assessed by the supervising officer as a "standard" risk domestic abuse incident with the child protection issue also being re-categorised as "low" risk. The assessment followed policy that was in place at the time of the incident. However, had the original assessment of 'medium' had been maintained the actions taken at the time would not have been different.
- 11.4 Apart from the procedural changes arising from the establishment of the Partnership Central Referral Unit (CRU) highlighted in the subsequent paragraph 11.8, the HMIC inspected the Kent Police Force in 2014 in relation to Domestic Abuse. HMIC acknowledged that the Force had robust processes in place to ensure that any learning from the DHR process, as well as Serious Case Reviews was highlighted and addressed with any learning being reflected in improvements to frontline policy and procedure. The 2014 report also made fourteen recommendations that were subsequently monitored and implemented leading to significant changes to frontline procedures and policies across the Kent Force. The 2014 HMIC report was linked to a national review of domestic abuse services HMIC "Everyone's Business." A number of recommendations in this report relate to service delivery at Force level and these have also been fully

implemented. Other major changes to policy and procedure have been delivered by the Force as part of planned operations including the introduction of a domestic abuse victims' satisfaction survey. Another example is Operation Encompass which is a process where all safeguarding agencies share information about domestic abuse incidents to help protect any children who are involved.

- 11.5 In relation to the decision by the Crown Prosecution Service (CPS) not to pursue any charges against Richard for Actual Bodily Harm; an analysis of the crime report indicated that the CPS would not support a charge of common assault as the allegation was denied, there were no witnesses and no previous bad character was recorded.

### **Children's Services**

- 11.6 The incidents recorded in 2006 and 2011 were both referred to Kent Social Services. Following the 2011 incident a social worker met with Elizabeth. The records indicate that Richard was not present and Elizabeth stated that there had been previous arguments but nothing like the incident in question. Elizabeth said she would not allow this to happen again and if necessary she would leave. The assessment concluded that no further action would be taken by Children's Services and following further agency checks, with the General Practitioner and the Midwife, the case was recommended for closure. The closure records indicate that Elizabeth was provided with advice and information and advised of the view of Children Services if a similar referral was received.
- 11.7 Since 2012 a multi-agency Central Referral Unit has been established that deals with all Kent County Council Social Care referrals. It consists of a range of statutory agencies, including Kent Police, who are or might be involved with vulnerable children, and with adults in relation of matters of public protection. The Central Referral Unit facilitates more consistent threshold application between agencies, reduces duplication, promotes more effective information sharing and thereby promotes more timely and targeted intervention for children and families. The services are co-located making multi-agency planning and intervention easier, with access to relevant data and systems. The following partners are engaged: Children Services, Police, Adult Services, Kent Surrey & Sussex Community Rehabilitation Company, National Probation Service and Health Agencies.

## **Health Agencies**

- 11.8 Health organisations work to the current Kent and Medway Domestic abuse protocols to support the identification and prevention of domestic abuse. These protocols are reviewed and refined following incidents of this type to ensure that learning is included within the protocols. Elizabeth did not disclose any relationship issues of concern with Richard. However, for all organisations the culture of questioning around domestic circumstances could be developed further to discover levels of risk or safety. It is possible that if the incident of 2011 was reported / recorded in the GP's notes, a more holistic response may be taken to the stress factors which Richard later disclosed.
- 11.9 The local Clinical Commissioning Group now has in place a Safeguarding Lead professional, who is a named General Practitioner and their role includes raising the profile of domestic abuse and promoting information sharing across the primary care group.

## **Other Opportunities**

- 11.10 The lack of engagement with family members, friends and colleagues during this review has lessened the opportunities to determine if Elizabeth was searching for domestic abuse support services and for the opportunity for disclosing her situation to agencies. The interview with Elizabeth's friend indicated that Elizabeth would not have sought help and was focussed upon making arrangements herself for her own safety and the safety of her children. However, she did have some limited contact with the Police, Health Agencies and a Children's Centre who could have signposted support services that could have assisted her. It would appear that Elizabeth did not make any disclosure or requests for assistance apart from the 2011 incident when Elizabeth requested contact from the Police Domestic Abuse Team.
- 11.11 There is no evidence to suggest that Elizabeth's Polish family connections had any impact on her ability to seek support for the domestic abuse she was experiencing in her relationship. The discussion with a close family friend of many years identified that Elizabeth would have been very unlikely to seek support as she was very proud and fully understood the English language. Unfortunately, despite several efforts to engage with the family, friends and colleagues of Elizabeth, where necessary using intermediaries with appropriate language skills, only one response was forthcoming and the

views of this family friend are reflected in the report. Contact was also made with a local Polish Association who had a link on their website promoting domestic abuse services but they unfortunately kept no records of use or referrals made.

- 11.12 The review of the information provided and the actions taken during the various interactions with agencies lead to the conclusion that the homicide could not have been accurately predicted. Policies and procedures in place at the time were followed and changes have been introduced across agency working arrangements aimed at reducing the risk factors in the future. These significant procedural changes include those highlighted in paragraphs 11.4 relating to Kent Police and 11.9, the introduction of a Safeguarding Lead General Practitioner at the Clinical Commissioning Group (CCG). The CCG is also engaged with the local Community Safety Partnership, Local Domestic Abuse Forums and appropriate MARACS therefore improving the sharing of information across primary care.

## **12.0 Lessons Learnt from the Review**

- 12.1 Police had records of two domestic abuse incidents, one in 2006 which related to a previous relationship and in 2011 with Elizabeth. At the time of the incident in 2011 Elizabeth disclosed further incidents involving Richard and herself. The re-assessment of the 2011 incident as a “standard” risk domestic abuse incident despite the arrest for an offence of Actual Bodily Harm together with the decision to write to Elizabeth offering support could be considered as a lost opportunity for agencies to try to more proactively link Elizabeth with some form of support service. However since 2011, Police practices have changed (see paragraph 10.1 & 11.4), improved and are subject to planned continuing improvement over the next three years. One major change that is particularly relevant to this review is that all victims are now referred to Victim Support who can offer a range of support and refer onwards to a community service provider.
- 12.2 Two referrals were made to Kent Social Services by Police following the incidents in 2006 and 2011. There was a degree of information sharing between Kent County Council Social Services and Health partners following the 2011 incident, and it appears from records that this information was communicated to those agency staff engaging directly with Elizabeth. The Health Visitor was unable to discuss domestic abuse with Elizabeth at her initial visit and it is not clear from records whether the discussion took place

at a future visit. Health Practitioners should be reminded of the importance of clear and accurate notes in record keeping and this is included as a recommendation at 13.5. The referral process was reorganised in 2012 and are dealt with now by a multi-agency central referral unit – see paragraph 11.8. During the review, it was confirmed that Health Visitors are now informed of Domestic Abuse Notifications (DAN's). These tend to be low level DA incidents only, with higher risk incidents being open to early intervention or the MARAC process. Where there is an unborn child in the family or a baby under one year, it is normal practice to inform Midwives as well. However the information sharing with the General Practitioner could be improved as this appears to be limited in this instance. Although there is now a CCG Safeguarding General Practitioner lead in place, it is felt that this area of information sharing across health practitioners should be strengthened and a recommendation is included in the report at paragraph 13.1.

- 12.3 Elizabeth had engagement with only a few agencies as a domestic abuse victim through her contact with the police and other than the police letter there is no evidence that any support services were signposted for her. She also came into contact with agencies through routine contacts relating to children's health care, general practitioner visits and Children Centre attendance, these could have been prime communication sites for domestic abuse support services if she was looking for support. It has been identified that there were a number of domestic abuse services available to both Richard and Elizabeth in their locality. These are summarised on <http://www.domesticabuseservices.org.uk/> where it can be seen that there is guidance regarding available support mechanisms, addresses, telephone contacts and also information relating to the role of agencies when reporting domestic abuse. This is just one channel that Elizabeth could have used to obtain support and potentially other opportunities have been identified during this review process with health and police staff that she came into contact with.
- 12.4 Richard was utilising a Tracking App on Elizabeth's mobile telephone without her knowledge which was subsequently disabled by a friend. This use of covert surveillance of adults is a form of stalking and is a risk factor in domestic abuse that is highlighted by domestic abuse support services and awareness should be highlighted to the wider community, as these App's are often preloaded on mobile telephones.

- 12.5 All health domestic abuse and other abuse training should include how to have difficult and sensitive conversations on domestic abuse with patients; training is currently being rolled out across Kent and Medway relating to Safe Enquiry and is available in an eLearning format [www.kdac.org.uk/health-professionals](http://www.kdac.org.uk/health-professionals)

### **13.0 RECOMMENDATIONS**

- 13.1 Consideration to be given to widening the communication of personal information in relation to domestic abuse incidents following referrals from Social Services to all frontline health workers/agencies and relevant GP's that have direct contact with the victim. This will ensure that frontline health staff including General Practitioners are fully briefed when engaging with potential victims or perpetrators and can signpost appropriate support services and provide opportunities for disclosure during consultations.
- 13.2 Ensure that all Kent County Council Children's Centres display domestic abuse support services information and that staff are able to signpost to local services. This will enable those victims that feel unable to disclose their personal circumstances to be better informed of the support available.
- 13.3 Given the changes to the ethnic make-up of communities in the area concerned consideration should be given by the local Community Safety Partnership and Local Domestic Abuse Forums to providing domestic abuse support material in alternative language formats, therefore responding to the changing demographics in their area.
- 13.4 In liaison with domestic abuse support providers raise the awareness of the potential misuse of Tracking Apps that are routinely installed on mobile telephones and other devices with potential victims and service providers, the focus to be particularly in terms of Stalking and Harassment. The Kent County Community Safety Partnership to raise the profile of this subject at the Kent and Medway Domestic Homicide Review Lessons Learnt Seminars and at Community Safety Managers Information sessions.
- 13.5 Health Practitioners should be reminded of the importance of clear and accurate notes in record keeping. This will assist information sharing between the various front line health professionals. This recommendation should be reinforced as part of the wider information sharing recommended in recommendation 13.1

# **Appendix A –Terms of Reference**

## **Kent & Medway Domestic Homicide Review \*\***

### **Victim – Elizabeth**

#### **Terms of Reference - Part 1**

#### **1. Background**

- 1.1 On 30<sup>th</sup> April 2015, police officers attended following a report that Elizabeth was reported missing following a verbal argument. The body of Elizabeth was subsequently recovered from a field on the 11<sup>th</sup> May 2015.
- 1.2 Richard was arrested for murder on the 3<sup>rd</sup> May 2015 and was subsequently charged and remanded in custody.
- 1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 1<sup>st</sup> July 2015. It confirmed that the criteria for a DHR have been met.
- 1.4 That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

#### **2. The Purpose of DHR**

- 2.1 The purpose of this review is to:
  - i. Establish what lessons are to be learned from the death of Elizabeth in terms of the way in which professionals and organisations work individually and together to safeguard victims.
  - ii. Identify what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.
  - iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working.

- iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

### **3. The Focus of DHR**

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

### **4. DHR Methodology**

- 4.1 Independent Management Reports (IMRs) must be submitted using the templates current at the time of completion.
- 4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Elizabeth in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Elizabeth, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.
- 4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

- 4.4 Each agency required to complete an IMR must include all information held about Elizabeth from 1<sup>st</sup> January 2007 to 29<sup>th</sup> April 2015. If any information relating to Elizabeth victim, or Richard being a perpetrator, of domestic abuse before 1<sup>st</sup> January 2007 comes to light, that should also be included in the IMR.
- 4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Elizabeth or Richard. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).
- 4.6 Any issues relevant to equality, for example disability, cultural and faith matters should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.
- 4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

## **5. Specific Issues to be addressed**

- 5.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:
- i. Were practitioners sensitive to the needs of Elizabeth and Richard, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
  - ii. Did the agency have policies and procedures for the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case

of Elizabeth and Richard? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective?

- iii. Did the agency comply with information sharing protocols?
- iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- vi. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Elizabeth and Richard (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
- vii. Were senior managers or other agencies and professionals involved at the appropriate points?
- viii. Are there ways of working effectively that could be passed on to other organisations or individuals?
- ix. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Elizabeth and promote their welfare, or the way it identified, assessed and managed the risks posed by Richard? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- x. How accessible were the services to Elizabeth and Richard?
- xi. To what degree could the death of Elizabeth have been accurately predicted and prevented?

## **6. Document Control**

6.1 The two parts of these Terms of Reference form one document, on which will be marked the version number, author and date of writing/amendment.

6.2 The document is subject to change as a result of new information coming to light during the review process, and as a result of decisions and agreements made by the DHR Panel. Where changes are made to the document, the version number, date and author will be amended accordingly and that version will be used subsequently.

6.3 A record of the version control is included in the appendix to the document.

## Appendix B - Glossary

Abbreviation	Description
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment
IMRs	Independent Management Reports
EKUHFT	East Kent University Hospitals Foundation Trust
KCHFT	Kent Community Health Foundation Trust
GENESIS Database	This is a name for the IT System used by Police to create and store crime reports, secondary incident reports and criminal intelligence
STORM Records	This is the name of the IT System used by Police to manage incidents. STORM records all information received and actions taken in response to a call.
PNC	Police National Computer system
DNA profiling	The analysis of a small amount of genetic material from a blood or cellular sample, which is unique per individual as a fingerprint
DAU	Police Domestic Abuse Unit
CAIU	Child Abuse Investigation Unit
MARAC	Multi-Agency Risk Assessment Conference
RELATE	Organisation providing relationship counselling.
GP	General Practitioner
A&E	Accident & Emergency
SENCo	Special Educational Needs Coordinator
Children's Centre	The purpose of a children's centre is improving outcomes for young children and their families, with a particular focus on the most disadvantaged families in order to reduce inequalities.
DAN	Domestic Abuse Notification when a child is present when a Police Officer attends a domestic abuse incident.

<p>OP Encompass</p>	<p>Operation Encompass is a process where Kent safeguarding agencies share information about domestic abuse incidents to help protect any children involved.</p>
<p>CRU</p>	<p>Central Referral Unit – It consists of a range of statutory agencies who are or might be involved with vulnerable children, and with adults in relation of matters of public protection</p> <p>.</p>