Kent Community Safety Partnership
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MEDWAY COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review

Kitty Hurley

2020

Executive Summary

Author: Dr Liza Thompson

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 24th June 2022

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1 The Review Process

1.1 This summary outlines the process undertaken by the Multi-Agency Review panel in reviewing the death of Kitty Hurley, who lived in Kent.

1.2 To protect the identities of the deceased and her family members, the deceased is referred to in this DHR as Kitty Hurley – a name which has been chosen by her family.

1.3 Kitty was a white British female, who was in her late thirties when she died.

1.4 In January 2020, Kitty was killed by her partner Nick Brookes, and in September 2020 he was found guilty of her murder.

1.5 The DHR Core Panel met on 3rd March 2020 and agreed that the criteria for a DHR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that a DHR would be conducted. Agencies that potentially had contact with Kitty and/or Nick prior to Kitty's death were contacted and asked to confirm whether they had contact with them.

1.6 Those agencies that confirmed contact with Kitty and/or Nick were asked to secure their files.

2 Contributors to the Review

2.1 Each of the following organisations were subject of an IMR or summary report:

Agency/Contributor	Nature of Contribution
Kent Police	Independent Management Report
Town A Children's Social Care	Independent Management Report
Town A NHS Foundation Trust	Independent Management Report
National Probation Service	Summary Report
Kent and Medway Clinical Commissioning Group	Independent Management Report
Note: As of July 2022 the Kent and Medway Clinical Commissioning Group (CCG) became the Integrated Care Board (ICB)	

Town A Domestic Abuse Service	Summary Report *Domestic Abuse Specialist for the Panel*
Kent and Medway NHS & Social Care Partnership Trust	Summary Report
Turning Point	Summary Report
Kent Community Health NHS Foundation Trust	Independent Management Report
Victim Support	Summary Report

3 Review Panel Members

3.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Kitty Hurley and Nick Brookes. It also included a senior member of the Kent County Council's (KCC) Community Safety Team, and an independent advisor from a Kent-based domestic abuse service.

3.2 The members of the panel were:

Agency	Name	Job Title
	Dr Liza Thompson	Independent Chair
Kent County Council, Community Safety	Megan Bennett	Community Safety Officer
Kent Police	Christopher Rabey	Detective Inspector
Town A Children's Social Care	Rebecca Cooper	Head of Safeguarding and Quality Assurance
Town A Domestic Abuse Service	Jackie Hyland	Operations Manager
Victim Support	David Naylor	Area Manager
Kent and Medway Clinical Commissioning Group	Kirsty Edgson	Designated Nurse for Safeguarding Children

Kent And Medway NHS & Social Care Partnership Trust	Alison Deakin	Head of Safeguarding
Kent County Council Commissioning	Rachel Westlake	Senior Commissioner

3.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Kitty Hurley and Nick Brookes.

3.4 The panel met on five occasions during the review. The Independent Chair was appointed on 6th March 2020 and the Terms of Reference Meeting was held on 2nd April 2020. The review was paused for several months due to the global COVID-19 pandemic. The Independent Management Report (IMR) Review Panel Meeting was conducted on 3rd December 2020, where IMRs were examined. The panel also met on three separate occasions to scrutinise the overview report and its recommendations. These dates were 23rd April 2021, 16th July 2021, and the Overview Report Meeting attended by family members took place on the 11th February 2022.

4 Author of the Overview Report

4.1 The Independent Chair, and the Author of this Overview Report, is Dr Liza Thompson.

4.2 The Independent Chair is a SafeLives Accredited Service Manager who has worked within the field of domestic abuse for over ten years, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary sector and private sector agencies. Her doctoral thesis examines the experiences of abused mothers within the child protection system. She has independently completed specialist review Chair training with Advocacy After Fatal Domestic Abuse, is a member of the AAFDA DHR Network, and has completed Kent County Council training required to undertake the role of Independent Chair.

4.3 The Independent Chair has no connection with the Community Safety Partnership and agencies involved in this review, other than previously being involved in review panels as an independent domestic abuse specialist; and currently being commissioned to undertake Domestic Homicide Reviews and Multi-Agency Reviews.

5 Terms of Reference

These terms of reference were agreed by the DHR panel following their meeting on 2nd April 2021.

5.1 Background

5.1.1 In January 2020 police officers attended a property in Town A, Kent. They found the victim, who SECAmb believed to have been deceased for a number of hours.

5.1.2 The victim's partner, Nick Brookes, was arrested for murder and was subsequently charged and remanded in custody.

5.1.3 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 3rd March 2020. It confirmed that the criteria for a DHR have been met.

5.1.4 That agreement was 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.

5.2 The Purpose of the DHR

The purpose of the DHR is to:

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

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

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

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

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

f) highlight good practice.

5.3 The Focus of the DHR

5.3.1 This review established whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Kitty Hurley.

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

5.3.3 This review also focused on whether each agency's response to the identification of domestic abuse was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. The review examined which methods were used to identify risk and any action plans which were put in place to reduce that risk.

5.4 DHR Methodology

5.4.1 Independent Management Reviews (IMRs) were submitted using the templates current at the time of completion.

5.4.2 This review is based upon the IMRs provided by the agencies that were notified of, or had contact with, Kitty Hurley and/or Nick Brookes in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse. Each IMR was prepared by an appropriately skilled person who did not have any direct involvement with Kitty Hurley and/or Nick Brookes, and who is not an immediate line manager of any staff whose actions were subject to review within the IMR.

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

5.4.4 Each IMR included all information held about Kitty Hurley and/or Nick Brookes from 1st August 2016 to 16th January 2020 – the earlier date being the period when Kitty and Nick met and started a relationship. Any information relating to Kitty as the victim or Nick being a perpetrator of domestic abuse before 1st August 2016 was also included in the IMR.

5.4.5 Any issues relevant to equality, i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation were identified.

5.4.6 The Independent Chair met with Kitty's father, step-mother, daughter and maternal aunt at the beginning of the review, and throughout the review process. All family members were supported by an advocate provided by AAFDA at each stage of the review.

5.5 Specific Issues Addressed

The following specific issues were considered within each agency IMR, and subsequently by the panel:

i. Were practitioners sensitive to the needs of Kitty and Nick? Were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

ii. Did the agency have, and follow policies and procedures for, Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Kitty and/or Nick? Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iii. What were the key 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 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?

iv. When, and in what way, were the victim's wishes and feelings ascertained and considered?

v. How accessible were the services to Kitty and/or Nick?

vi. Was anything known about Nick? Were there any injunctions or protection orders that were, or previously had been, in place?

vii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?

viii. Were procedures sensitive to Kitty as a woman with complex needs – namely mental health difficulties and problematic alcohol use?

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

x. Are there lessons to be learned from this case?

6 Summary Chronology

6.1 Prior to her death, Kitty confided in her daughter that she had been sexually abused when she was a teenager. There is nothing within the records pertaining to this incident. This would indicate that it was not reported to the authorities, which aligns with the information that Daisy shared with the Review Chair.

6.2 In 1992 and 1994, when Nick was a teenager, his mother contacted Children's Social Care asking for help with his behaviour. She attributed Nick's behaviour to the influence of his father, who was a violent alcoholic, and who had left the family home in recent years.

6.3 When Nick was aged 15, it is recorded in social workers' notes that he had 'deviant patterns of behaviour' and did not mix well with his peers.

6.4 Daisy was born when Kitty was aged 18, following a short relationship.

6.5 In March 2002 Kitty attended Accident and Emergency following a serious assault by her then boyfriend Mr X.

6.6 In 2006 the first allegation of domestic abuse was recorded against Nick where he assaulted his partner, Mrs A.

6.7 In 2009 Nick was handed a Community Order for the assault on his partner at the time, Mrs B.

6.8 In October 2011 Kitty first approached her GP about feelings of depression and stress.

6.9 In January 2012 Kitty disclosed to a GP that her mother had very recently announced she had breast cancer and that she had a few weeks to live. Three days later Kitty called the surgery to advise that her mother had passed away.

6.10 Kent Police recorded several incidents of domestic abuse perpetrated by Mr W against Kitty, which began in 2012.

6.11 In 2012 Nick was living with a partner, Mrs C, and her two children. In March 2012 the children's school made a child protection referral, as one of the children had disclosed that Nick had been violent towards their mother.

6.12 In April 2012, Children's Social Care received a Domestic Abuse Notification from police following an incident at Mrs C's home. Nick had been arrested for criminal damage and assault.

6.13 In June 2013 police made a children's safeguarding referral in respect of Daisy after Mr W seriously assaulted Kitty at home. This resulted in Daisy moving into Local Authority foster care.

6.14 Throughout 2013 to 2015 Kent Police were involved with Kitty on numerous occasions, each time due to serious attacks upon her by Mr W. Kitty was referred to domestic abuse services but did not engage with these, and declined to support any action against Mr W.

6.15 In August 2014, January 2015 and February 2015, Mrs C contacted police due to Nick's behaviour, which included threats to kill and harassment.

6.16 In August 2015, Kitty told her GP that she had been drinking heavily, and she was assessed as having an ongoing depressive illness. She was advised by the GP to attend the local drug and alcohol service.

6.17 Between January 2016 and August 2016 Kitty attended the GP on five occasions. Each time she complained of depression, disclosed heavy drinking and on one occasion discussed an assault upon her by Mr W.

6.18 Kitty and Nick are reported to have met in August 2016.

6.19 In December 2016 Nick attended Accident and Emergency asking to speak to someone about his mental health. He was asked to enter an assessment room to speak to someone from the mental health team but refused and left the hospital.

6.20 In February 2017 Kitty attended the Minor Injury Unit in Town B. She stated that she had fallen down the stairs some days before and was still in pain. It is recorded that she smelt of alcohol and, when asked, she stated that she had been binge drinking alcohol. She was accompanied by her partner, although his name was not recorded.

6.21 In August 2017 there are reports that Kitty and Nick were homeless following eviction.

6.22 In October 2017 police were called when Nick turned up at ex-partner Mrs C's home whilst intoxicated, demanding to see his children.

6.23 In October 2018 police were called by a member of the public reporting that a male had assaulted a female. Kitty was spoken to separately. She stated that she had not been assaulted and declined to answer the DASH risk assessment questions. In the absence of these questions, the risk was assessed as standard.

6.24 In November and December 2018 Kitty attended the GP complaining of heart burn, chest pain and an ongoing cough. She disclosed alcohol dependency, but declined referrals into specialist services, and did not attend follow up appointments for investigations into her health complaints.

6.25 In April 2019 Nick called the police, reporting an assault by Kitty. He stated that she had thrown items at him. The police attended and found both were heavily intoxicated. Kitty was arrested and under interview could not recall what had happened. Nick withdrew support for a prosecution. A DASH risk assessment was completed with Nick, and his risk level was assessed as standard. A Domestic Violence Protection Notice was considered but not pursued. Whilst Kitty was in custody, she reported that sometime in January 2019 she had been assaulted by Nick which had resulted in a blackeye. She told the police that she did not want to pursue a complaint against Nick, telling the police that "they had their moments". A DASH risk assessment was completed with Kitty and her risk level was assessed as medium.

6.26 In early July 2019 a third party reported to police that in the previous month, Nick had assaulted Kitty by kicking her in the back. Police called Kitty who stated that she had no knowledge of the incident and denied making this allegation. She declined to complete a risk assessment, and police assessed the incident as medium risk based on the history.

6.27 In late July 2019 Nick called the police to report that Kitty had spat in his face, punched him in the face and had come at him with a knife. Kitty was arrested, and Nick then refused to give further information to support this allegation. He had no injuries and Kitty denied the allegations. Both were intoxicated. A risk assessment was completed from previous information and found to be medium risk.

6.28 Nick called police in September, October, and December 2019. Each time he was recorded as the victim, both parties were intoxicated, and when police attended, Kitty and Nick denied any issues. These incidents were all risk assessed as medium risk.

6.29 On the day of Kitty's death in January 2020, Nick called his friend and told him that he had killed Kitty. The landlady was alerted and accessed the flat where Kitty was found deceased, having been strangled many hours before. Nick was arrested, and in September 2020 he was found guilty of Kitty's murder.

7 Conclusions

7.1 Homicide Timeline

7.1.1 The Homicide Timeline[1] is a tool which is useful to assist with the identification of factors which made Nick dangerous and Kitty vulnerable. This identification can help agencies to plan for future learning.

7.1.2 Within the overview report, The Homicide Timeline as a theory was layered over the facts of this case. It is evident that the facts reflect the stages of the timeline, and in particular the earlier stages of the timeline are well documented in Nick's case.

7.2 Responding to Victims with Complexities

7.2.1 Due to Kitty's experiences of male sexual violence at a young age, and the bereavement of her mother, she may have been distrustful of authorities and support services. She may have also normalised the abuse she was subjected to, and we know she self-medicated with alcohol. These factors would have made it hard for professionals to engage with Kitty on a meaningful level. We know she did not call the police when she was assaulted, either by Mr W or by Nick, and her family told the Review Chair that she would never ask for help.

7.2.2 Services to support victims of domestic and sexual abuse should be easy to access and should be situated in spaces where victims intersect with other services. This is particularly because many victims have complexities which increase their barriers to accessing support and therefore situating the services together may lead to interactions with other services.

7.2.3 Kitty appeared to be "stuck" with the culmination of her unresolved traumas. As her father described, she appeared emotionless and frozen. The offer of help for domestic abuse at the point where she was involved with services for other elements of her life, for example her mental health, the criminal justice system or at Accident and Emergency, may have been the catalyst for her to engage with services.

[1] Available < 10579_Monckton-Smith_(2022)_Home_Office_Report.pdf (glos.ac.uk)>

7.2.4 It is important that access to independent and specialist domestic abuse is as available as possible, especially for victims who are reluctant to disclose abuse and/or engage with services. This is particularly stark for victims like Kitty who are also struggling with a complex set of issues. Bringing together the various statutory and voluntary agencies a victim may access for non-domestic abuse related issues as a multi-disciplined approach, increases the opportunities of engagement with victims, whilst also upskilling a multi-disciplinary group of professionals to respond to disclosures of domestic abuse safely and effectively.

7.3 Risk Assessing, Information Gathering, and Information Sharing

7.3.1 Nick's history of violence was there to be seen. However, there was no trigger for his historic propensity for violence to be identified and shared within any multi-agency setting.

7.3.2 The reliance upon a victim being assessed as high risk to trigger an enhanced response, which includes allocation of an Independent Domestic Violence Advisor, is problematic. It is understandable that resources are finite and there will always be a need to allocate specialist support to those who most need it. However, previous Domestic Homicide Reviews have involved victims who have not been assessed via the DASH risk assessment tool as high risk. This indicates that the current process of assessing risk is not necessarily accurate as an assessment of potential homicide. As mentioned above, academics have raised this concern and have also argued that the future harm from an abusive partner can be identified more accurately and more simply than the full completion of a DASH risk assessment.

7.3.3 Research indicates that the historic behaviour of a perpetrator can be an accurate identifier of future harm. It also indicates that the stage of the Homicide timeline which identifies historic violence in a relationship as an indicator of future violence could be included in risk assessment processes.[2]

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[2] Medina Ariza, J, Robinson A, and Myhill, A "Cheaper, Faster, Better: Expectations and Achievements in Police Risk Assessment of Domestic Abuse" *Policing: A Journal of Policy and Practice*, Volume 10, Issue 4, December 2016, Pages 341-350, https://doi.org/10.1093/police/paw023

8 Lessons to be Learnt

8.1 Similar concerns have arisen from this review as those highlighted within Children and Social Care Ofsted inspections for the same period. This is namely an inconsistent application of thresholds, with too little challenge of information provided by other professionals and parents, limited consideration of relevant historical information and a lack of professional curiosity.

8.2 The response to children's safeguarding referrals considered each contact in isolation and did not consider the cumulative impact of domestic abuse. The focus on the welfare of the children was applied narrowly and the impact of parental behaviours on the children was not considered. This meant that there were limited

meaningful attempts to address with Kitty the impact of her drinking and relationships, and there was no engagement with Nick, despite repeated referrals in relation to his children and extensive knowledge about the risks he posed.

8.3 This review has highlighted the importance of social workers undertaking thorough assessments, including the use of chronologies and genograms, to ensure that the best information is gained, and that historic information is considered when assessing and analysing risk factors.

8.4 Similarly, this review has also highlighted that there needs to be more robust challenge of both parents and professionals by social workers. Throughout the trajectory of this family's story, the assessment of risk associated with repeated DANs (Domestic Abuse Notifications) was not questioned, and this led to no further action, even after there had been several repeat referrals. Specifically, there was limited recorded challenge of both significant adults. On the occasions when Nick's ex-partners stated that they had separated, this was accepted despite evidence to the contrary. Kitty minimised her issues with alcohol and the impact that this and her relationships had on Daisy. There is limited early evidence that this was meaningfully explored with her and there is only one recorded attempt to encourage her to access support.

8.5 Another key lesson to be learnt from this review is the importance of engaging fathers in Children's Social Care assessment and intervention. Throughout, there was a focus on Nick's children and their mothers, and he could be described as

‘invisible’ to services. He was not included in assessments, there was no exploration of his role as a partner or a father, and no support was offered despite significant information known about him over a long period of time in relation to five children.

8.6 Domestic abuse workers in Kent and Medway now provide support and advice to children’s social work teams and Multi-Agency Safeguarding Hubs (MASHs), providing an opportunity for social workers to discuss cases where domestic abuse is a factor. This inter-agency work encourages an ongoing dialogue between professionals, allowing information sharing and informal exploration of the factors discussed above, which provides opportunity for creative engagement with victims/survivors and perpetrators.

8.7 During their relationship, Kitty was largely invisible as a victim, but Nick was also invisible as a perpetrator of abuse. Nick used the police to report Kitty on several occasions, however no questions were asked about this. It is recognised that domestic abuse perpetrators report into agencies such as police and Children’s Social Care to control their partners. A wider research piece into the prevalence of perpetrators’ calls to police, to achieve the outcome of control, may be beneficial to assist with learning how to identify and counteract this misuse of police time. **(Recommendation 11)**

8.8 The use of a “repeat offender” indicator on police records would enable an accurate assessment of risk when dealing with domestic abuse perpetrators linked to more than two domestic abuse victims.

8.9 The historic lack of behavioural change programmes available for perpetrators in Kent and Medway has led to a culture amongst professionals where expectations are placed on victim/survivors to engage with services, with very little accountability expected from perpetrators. With the introduction of the OPCC perpetrator programme pilot, it is hoped that professionals will refer abusers onto the programmes, and in turn abusers will be held accountable for their behaviour. **(Recommendation 10)**

8.10 On most occasions, it was apparent that both Kitty and Nick were intoxicated when police attended. Whilst safety advice and signposting in relation to domestic abuse was extended to both Kitty and Nick over the relevant period, it is not apparent that any signposting to support networks in relation to addictions and/or alcoholic support groups was offered**. (Recommendation 1)**

8.11 Kent and Medway NHS & Social Care Partnership Trust to explore insertion of a section in their assessment around relationships, risk, signposting and guidance around domestic abuse for both victims and perpetrators. **(Recommendation 2)**

8.12 Minor Injuries Unit staff to record details of accompanying persons. **(Recommendation 3)**

8.13 There were missed opportunities for the Domestic Violence Disclosure Scheme to be utilised. The Domestic Abuse Act 2021 has placed the scheme on a statutory footing, and all statutory services should be encouraged to consider an application to the Right to Know route,[3] which allows the sharing of the criminal history of a domestic abuse perpetrator with their current partner. Had Kitty been made aware of the extent of Nick's historic violence towards partners, she may have taken firm steps to end her relationship with him. This is something that Daisy was sure her mother had been considering around the time of her murder. **(Recommendation 9a)**

8.14 Where victims, such as Kitty, are not engaged with Children's Social Care or an Independent Domestic Violence Advisor, there is a reliance on the Police to apply for information via the Right to Know route. Research into the source of Right to Know applications may provide insight into gaps in utilising the Scheme and may provide evidence to support awareness raising of the Scheme. **(Recommendation 9b)**

8.15 There appears to be a lack of proactivity employed by GPs to whom Kitty had disclosed enduring mental health and alcohol issues. Although referrals were made to local drug and alcohol services on occasions, on other occasions Kitty was signposted to refer herself. When the GP did make a referral into services, there is no evidence that GPs followed up the referrals they made, either with the agency they had referred to, or with Kitty at later appointments. Good practice

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[3] Duggan, M "Victim Hierarchies in the Domestic Violence Disclosure Scheme" *International Review of Victimology* 24(2) pp.199-127 Victim_Hierarchies_in_the_Domestic_Viole.pdf

would be for GPs to ask returning patients if they had self-referred to the services they were signposted to, and if they hadn't, there should be a conversation as to why they had not self-referred. A more proactive attempt to secure specialist support for Kitty may have encouraged engagement with services. Learning from this review should be shared with primary care practitioners to encourage adoption of this more proactive approach when signposting or making referrals. **(Recommendation 12)**

8.16 A multi-disciplinary approach to supporting victims of domestic abuse who also have issues with drugs, alcohol and/or mental health challenges would enhance the current provision of services in Kent and Medway. Currently, in some areas of Kent, the Kent Integrated Domestic Abuse Service, commissioned by Kent County Council, offers a Complex Independent Domestic Violence Advisor who supports victims with complex needs. **(Recommendation 6)**

8.17 The presence of an Independent Domestic Violence Advisor within health settings, such as Hospital Independent Domestic Violence Advisors in Accident and Emergency Departments, and IRIS Advocate Educators in GP surgeries, will allow immediate support provision to a patient disclosing abuse and will enhance referral pathways for healthcare professionals identifying the need for a referral into specialist services. **(Recommendation 7)**

8.18 The presence of an Independent Domestic Violence Advisor, or equivalent, at multiple points throughout the police response to domestic abuse, would provide independent support to the victim and be available to offer advice to police, links to other services, and would create space for police officers to carry out their role in relation to crimes committed. It would be of benefit to identify which points, where the interface between victims and police occurs, could be enriched by the presence of an independent domestic abuse professional. **(Recommendation 5 & 6)**

8.19 Where issues with domestic abuse, mental health and/or substance misuse are identified, non-domestic abuse specific services should do more to have in-depth discussions with both victims and perpetrators around risk, support, what healthy relationships look like and the support services available for both victims and perpetrators. **(Recommendation 2)**

8.20 Broader learning could benefit from research regarding the assessed level of risk in cases which result in a DHR. This could include a review linked to learning for MARACs, to enable an understanding of whether pathways into the MARAC process is relied upon too heavily when supporting victims. Learning from this research could assist with identifying broader categories of domestic abuse victims' needs beyond static risk levels. **(Recommendation 8)**

8.21 Non-fatal strangulation was used by Nick towards Kitty and had also been used on Kitty by previous partners on numerous occasions. As section 15.3 details, the Domestic Abuse Act 2021 introduced a specific criminal offence of non-fatal strangulation, awareness of which should be raised with multi-agency partners. This DHR will form part of a Kent and Medway learning event to raise awareness of the dangers of non-fatal strangulation and the newly introduced offence. **(Recommendation 13)**

9 Recommendations

The Review Panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1.	Officers dealing with both victims and suspects of domestic abuse incidents that have been aggravated by use of intoxicants consider signposting to relevant support groups in addition to domestic abuse support groups – this advice to be circulated via normal communication methodology within the organisation.	Kent Police
2.	CJLADS to explore an insertion into their assessment regarding relationships, risks, signposting and guidance associated with domestic abuse for both victims and perpetrators.	Kent And Medway NHS & Social Care Partnership Trust
3.	Minor Injuries Unit staff to record details of accompanying persons.	Kent Community Health NHS Foundation Trust

4.	Introduction of a risk indicator to flag on police systems when abuser has been in more than two relationships where they have perpetrated domestic abuse.	Kent Police
5.	Scoping exercise to be completed to identify advantageous points where independent domestic abuse professionals could be located within the police response to victims.	Kent and Medway Commissioning
6.	Gaps in provision to be identified through local needs assessment, with actions taken to address identified gaps – particularly around the co-existence of mental health, drug and alcohol misuse and domestic abuse.	Kent and Medway Commissioning
7.	The continuation and extension of healthcare based IDVAs, or equivalent, throughout the county. Exploration of a Whole Health System.	Kent and Medway Clinical Commissioning Group
8.	To utilise the DAC Office's newly developed oversight mechanism to understand what - if any - correlation there may be between DHRs and MARAC cases.	Domestic Abuse Commissioner Office
9.	a) Materials created to raise awareness of DVDA, including Right to Know route, to be accessed by professionals and victims. Materials made available on agency websites, and shared with all relevant boards, forums, groups and agencies to ensure widespread distribution.	Kent Police Kent and Medway Community Safety Partnerships
	b) Research question recommended: "Who applies for Right to Know route DVDSs?"	Home Office
10.	Evaluation of the OPCC perpetrator programme pilot, partly funded by the Home Office to assess impact, and if the	Office of the Police and

	outcome is positive, determine how the programme can be sustained beyond the current funding cycle, as a partnership approach.	Crime Commissioner
11.	A wider research piece into the prevalence of perpetrators' calls to Police, to achieve the outcome of control, may be beneficial for the VKPP to carry out, to assist with learning how to identify and counteract the misuse of police time.	Home Office
12.	Learning from this review will be disseminated to Primary Care colleagues through the Primary Care Health and Care Partnership Safeguarding Leads Forums	Kent & Medway Clinical Commissioning Group
13.	This DHR will form part of a Kent and Medway learning event to raise awareness of the dangers of non-fatal strangulation and the newly introduced offence.	Kent and Medway Community Safety Partnerships