Dorset Community Safety Partnership

Domestic Homicide Review

“Sarah”

Executive Summary

Report Author

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1.0 Introduction

1.1 This domestic homicide review (DHR) was commissioned by Dorset Community Safety Partnership in response to the murder of Sarah by her former partner Kevin. (This report has been anonymised. The names of the victim and the perpetrator have been changed.)

1.2 Sarah had been in a relationship with Kevin for several months and when she attempted to end the relationship, Kevin responded by making threats to Sarah and threatening to kill himself. Kevin attacked and stabbed her to death as she was closing the hairdresser's salon in which she worked on 7th January 2016.

1.3 Kevin was arrested and charged with murder and on 22nd August 2016 he was convicted and sentenced to life imprisonment at Winchester Crown Court. The minimum term was set at 26 years.

1.4 This murder meets the criteria for a domestic homicide review to take place in that the death of a person aged 16 or over has resulted from violence by a person with whom she had been in an intimate personal relationship. As a result, Dorset Community Safety Partnership decided to commission this review.

1.5 A panel of senior representatives from local partner agencies was formed to oversee this DHR. Dr Nicky Cleave was appointed as the independent chair of the panel. She is independent of the partner agencies involved. David Mellor was commissioned as independent author of this report. He is a retired chief officer of police and has been the independent author for a number of domestic homicide reviews. He has no connection to Dorset. Membership of the panel and a description of the process by which the DHR was completed is shown within Appendix A.

1.6 Dorset Police referred their handling of their contact with the victim to the Independent Police Complaints Commission (IPCC) in January 2016.

1.7 The Coroner decided not to hold an inquest in this case.

1.8 All members of Dorset Community Safety Partnership wish to express their sincere condolences to the family and friends of Sarah.

2.0 Terms of Reference

Timeframe for the DHR:

Each agency was requested to review any involvement with Sarah and Kevin from 1st December 2014 to 7th January 2016.

Terms of Reference:

- Establish the facts that led to the incident on 7 January 2016 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.

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

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

In addition, for this review the following areas will be addressed either in the Individual Management Reviews and/or the Overview Report:

- The involvement of the Multi Agency Risk Assessment Conference.

3.0 Glossary

CAADA (Co-ordinated Action Against Domestic Abuse) **DASH** (Domestic Abuse, Stalking and "Honour"-based violence)*is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi Agency Risk Assessment Conference (MARAC) and what other support might be required. * now known as SafeLives DASH risk check list.

Independent Domestic Violence Advisor (IDVA)* Their main purpose is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members in order to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. *now renamed domestic abuse advisors (this applies to Dorset only)

Multi Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the area and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

Multi-Agency Public Protection Arrangements (MAPPA) were established by the Criminal Justice Act 2003 in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. The core MAPPA members are the Police, Prison service and Probation service in each area.

Restraining Orders - Section 12 of the Domestic Violence Crime and Victims Act 2004 provides that restraining orders may be made on conviction or acquittal for any criminal offence. These orders are intended to be preventative and protective but not punitive. The guiding principle is that there must be a need for the order to protect a person or persons from harassment or conduct that will put them in fear of violence.

The **Single Combined Assessment of Risk Form (SCARF)** form is used by Dorset Police to assess risk. Built into this assessment process is the DASH risk assessment process.

4.0 Synopsis

4.1 Sarah met Kevin in January 2015. He was a customer at the salon where she worked as a hairdresser. Sarah was going through a difficult time personally and Kevin became a confidante. Unknown to Sarah, Kevin was subject to a restraining order imposed for 5 years in April 2014. He had had an extra-marital affair and he responded angrily when the woman ended the relationship, turning up at her home, her place of work and abusing her verbally or via text messages. He also threatened and physically assaulted her. He threatened to tell his wife, with whom the woman worked, about the relationship and falsely accused the woman of stealing from her employers. In the statement she subsequently made to the police she said she was fearful for her life.

4.2 In March 2015 Sarah's GP made an emergency referral to the Community Mental Health Team (CMHT) due to her thoughts of deliberate self-harm and suicidal ideation. The CMHT decided to offer Sarah a service and between March and September 2015 Sarah was offered 21 appointments with various professionals from the CMHT, attending six, receiving five home visits, having ten telephone conversations and failing to attend twice.

4.3 Sarah's friendship with Kevin had progressed to a sexual relationship by May 2015. Kevin had assured her that his marriage was over and it was Sarah he wanted to be with. The following month Sarah sought certainty about her future and asked Kevin to choose between his wife and her, which he was unable or unwilling to do. At this point Sarah ended the relationship, following which Kevin began to bombard her with hostile text messages and turn up at her workplace. Sarah later described how she began to blame herself for Kevin's problems and their relationship resumed on an on/off basis.

4.4 In July 2015 Sarah's GP became aware that she had a new partner as a result of a request for emergency contraception. The GP recorded that Sarah had been together with this new partner for 6 months and her mood at this point was reported by CMHT as better.

4.5 In early November 2015 Kevin's wife found out about his relationship with Sarah and confronted him at the latter's home address. Over the course of the next few days Kevin told Sarah that he was leaving the marital home and moving into his workshop to live although it seems he may have continued to live in the marital home.

4.6 On 10th November 2015 Sarah went to Kevin's workshop to confront him about the situation resulting in a disturbance. Kevin called the police to allege that Sarah had assaulted him and damaged his property whilst Sarah also contacted the police very shortly thereafter to allege that she had been assaulted by Kevin.

4.7 In the account Kevin gave to the police, he said Sarah had kicked him in the testicles and damaged various work tools. He declined an ambulance. Sarah's account was that Kevin had twice slapped her around her head, threw her to the concrete floor several times

causing her arm to bleed. She also declined an ambulance. Sarah told the police that she had been in a relationship with Kevin, that he was married, but had told her he was leaving his wife. That day she had discovered that he was living and sleeping with his wife and so she had visited his workshop to confront him. She accepted that she had thrown some of his things around. She added that she had repeatedly tried to end the relationship, had blocked Kevin on her phone but that he had turned up at her home and harassed her.

4.8 The police ultimately categorised the incident as "neither party wished to make a complaint", although a crime of common assault was recorded due to Sarah's visible injuries. A Single Combined Assessment of Risk Form (SCARF) was completed which indicated a standard risk. (SCARF is used by Dorset Police to assess risk. The DASH risk assessment is incorporated into SCARF.) However, the form omitted mention of Sarah's children and the form was not shared with other agencies.

4.9 The incident was reviewed by the police safeguarding referral unit (SRU) and Sarah and Kevin were recorded on the police Niche record management system as having a relationship link. Niche is a Windows-based information storage system which had gone live in Dorset Police in May of that year.

4.10 During the following week Kevin was in contact with Sarah to tell her he was going to get her charged with offences in relation to the incident at his workshop.

4.11 During the late evening of 16th November 2015 the police were contacted by a friend of Kevin who expressed concerns for his welfare, saying that Kevin had been sending text messages of a suicidal nature and he had found Kevin's vehicle outside his workshop and had been unable to get any answer. The police attended and were shown text messages indicating Kevin's intention of harming himself. Sarah also attended this incident as she had also received text messages indicating Kevin's intention to self harm. However, Kevin then returned to the area carrying some milk and said he had no intention of harming himself. He was left with his friend and the police departed. The incident was not linked to the 10th November 2015 incident and no SCARF form was completed.

4.12 During the early evening of the next day (17th November 2015) Sarah phoned the police to report ongoing harassment from Kevin who was described as her "ex-partner". She was upset and crying and expressed concern about text messages both she and her daughter were receiving. She said she was upset by Kevin's threats to have her charged with the 10th November 2015 incident and his threats to kill himself. She said Kevin's wife had told her that he was subject to a restraining order for similar behaviour to another woman.

4.13 The police operator linked the call to the incident at Kevin's workshop the previous day and graded the call as "high" (immediate response) but it was nearly three hours before officers arrived at Sarah's home address where they were unable to obtain any reply. The incident was left open with an instruction that contact should be made the following morning. Telephone contact was not made until the late evening of 18th November 2015 and arrangements were made for Sarah to be visited on 20th November. However, this visit was never made.

4.14 A partial explanation for the police failure to visit Sarah is that on 18th November 2015 the officer who attended the incident at Kevin's workshop on 10th November received a call from Kevin to say that he had CCTV footage of the 10th November incident and wanted further action taken against Sarah. The officer then closed the incident from 17th November,

in which Sarah had contacted the police to express a number of concerns about Kevin's conduct, in order to deal with both the 17th November call from Sarah and the 18th November call from Kevin together.

4.15 On 20th November 2015 the police Niche system was updated to the effect that a statement of complaint had been taken from Kevin in respect of the 10th November incident. The officer in the case viewed the CCTV footage which showed Sarah throwing various items across the workshop before appearing to confront Kevin. A SCARF risk assessment was completed for Kevin which generated a standard risk. No further SCARF risk assessment was completed in respect of Sarah.

4.16 On 23rd November 2015 the incident was reviewed by a supervisor. However, the review was carried out by the officer in the case who was temporarily fulfilling an acting sergeant role. He updated the incident to the effect that CCTV implicated Sarah who he described as "very much the perpetrator", adding that once a copy of the CCTV was obtained, Sarah would be interviewed. Unspecified safeguarding issues were considered at this point but any risks were considered to be mitigated by the fact that both parties lived apart.

4.17 On 2nd December 2015 the incident was updated to the effect that Kevin had re-contacted the police to say that he and Sarah had resolved their differences. As a result, he said he had no interest in pursuing a complaint. He added that the CCTV which allegedly incriminated Sarah had been over recorded. A retraction statement was to be obtained from Kevin and was posted to him on 18th December. Analysis of phone records for the subsequent murder investigation suggests that Kevin and Sarah resumed their relationship around 30th November 2015.

4.18 Sarah contacted her GP for the final time on 7th December 2015 when she phoned for advice on sexually transmitted infections and was advised to contact the genito-urinary medicine service.

4.19 After rekindling their relationship, Sarah visited Kevin at his workplace on an unknown date. As she was leaving, Kevin's wife arrived to ask why he wasn't at home. Sarah had apparently understood that he had left his wife and also challenged him. Kevin is said to have responded by locking the workshop door, smashing a bottle and holding it to his own throat whilst threatening to harm himself. Kevin's wife had left by this point. Apparently Sarah managed to defuse the situation and, once again, agreed to stay in a relationship with him.

4.20 On Thursday 24th December 2015 Kevin and Sarah argued about his plans for the Christmas period. At some point he threw a hair brush at her which broke on impact and caused minor reddening to her back. Late on Christmas Day (Friday) Kevin visited Sarah's address and pleaded with her to take him back but she refused. He then removed a bottle of schnapps from her home together with some tablets, threatening to kill himself.

4.21 On Saturday 26th December 2015 Sarah awoke to find Kevin standing at the end of her bed having let himself in through an open window. He was pleading for forgiveness but Sarah decided she needed to get him out of the family home as her daughter was present. She persuaded him to leave and give her a lift to collect her car. Whilst in his car it became apparent that Kevin was not taking her to collect her car. Instead he drove down country lanes at dangerous speeds threatening to crash and kill them both. Sarah tried to call the police but he snatched her phone. Sarah then pretended she needed to go to the toilet and

Kevin stopped the vehicle. Sarah used this opportunity to escape and hide in a field. Once Kevin left she began to walk home. Kevin later returned her phone to her family who were able to locate and bring her back home.

4.22 On Sunday 27th December 2015 Kevin's brother contacted the police to express concerns arising from text and Facebook messages sent by Kevin indicating an intention to self harm. Kevin was located in his workshop apparently unconscious as a result of an overdose and was conveyed to hospital. A suicide note was recovered which made specific reference to the breakdown of his relationship with Sarah. A SCARF form was later submitted but made no reference to Sarah. The suicide note was entered onto the police Niche system but although the note made reference to Sarah, she was not linked to the suicide note.

4.23 Kevin was taken to Dorset County Hospital where he denied taking an overdose although he said he had drunk a litre of Archers after taking a small amount of paracetamol and codeine tablets for a headache. The police advised hospital staff that they had commenced CPR after finding Kevin unconscious at his workshop. During a medical review Kevin said that he had felt life was "all getting too much" and he "wanted to be with his (deceased) parents". He disclosed that he had recently separated from his wife and was living alone but apparently made no mention of his relationship with Sarah. Kevin later said he no longer wished to end his life and he was assessed as "low risk due to forward planning and (unspecified) protective features". He declined a mental health review. No abnormalities were detected from his blood tests and follow up by his GP was to be arranged.

4.24 Later the same evening Kevin's sister contacted the police to say that he had discharged himself from hospital but that his family remained concerned for his welfare. (He had in fact been discharged by the hospital.) Once again he was found at his workshop and the police contacted the crisis team. Detaining him under the Mental Health Act was considered by the police and rejected on the grounds that he was not in a public place. (Police powers to detain under the Mental Act are limited to persons in a public place) The police followed up with a welfare check the following day and found Kevin to be safe and well.

4.25 On Tuesday 29th December 2015 the police SRU referred Kevin to other agencies for appropriate safeguarding measures as a result of the 27th December 2015 incident. The referral included a summary all information on Kevin held by the police including the earlier restraining order. On the same date the police received the retraction statement (see Paragraph 4.17) from Kevin and the 10th November incident was closed as "victim declines to support".

4.26 On the same date Sarah contacted the police via a 999 call to raise concerns about Kevin sending her messages by Facebook and text. She was advised this was not an emergency and she should re-contact the police on the non- emergency 101 number. Sarah responded by saying she had done that five weeks previously and had heard nothing back. (This comment related to the lack of response to her 17th November 2015 call – Paragraph 4.13) She did not call back on the 101 system.

4.27 Kevin continued to bombard Sarah with text messages including pictures of nooses and threats to kill himself. This culminated in Sarah's son contacting the police to seek help for his mother on Wednesday 30th December 2015. He said that Kevin was threatening

suicide and blaming his mother. Sarah was seen by officers the same day and provided a statement which has been used to inform this DHR.

4.28 Checks made within the police control room brought together the previous incidents involving Kevin and Sarah and as a result the critical incident Inspector recognised the escalation in risk which had taken place. Later that day Kevin was arrested on suspicion of stalking and harassment. In interview he accepted some allegations put to him but generally minimised his behaviour. He was granted police bail late the same day whilst further investigations were being completed including analysis of call data from mobile phones. Bail conditions were imposed including that Kevin should have no direct or indirect contact with Sarah.

4.29 Whilst in custody Kevin was assessed by a custody liaison nurse. Kevin told her that he wanted to commit suicide and kill his girlfriend. He did not identify Sarah as his girlfriend but also said he would not act on this disclosure. The nurse completed a risk assessment in which she concluded that Kevin posed a low risk to himself, others and the general public.

4.30 The police completed a further SCARF risk assessment in respect of Sarah, which took account of the threats by Kevin to kill himself and to kill her, which indicated that she was at high risk of domestic abuse. This prompted a request for an Independent Domestic Violence Advisor (IDVA) to contact Sarah with a view to referring her to a Multi-Agency Risk Assessment Conference (MARAC).

4.31 The mobile phones of both Sarah and Kevin were seized by the police to examine them for evidence. No replacement phones were provided to either party.

4.32 The SCARF risk assessment completed on Wednesday 30th December 2015 (Paragraph 4.30) was received the same day by Sarah's GP surgery and the details were entered onto her daughter's GP record but not entered onto Sarah's GP record.

4.33 A copy of the same SCARF was also received by Children's Services on 30th December 2015 as there were concerns that Sarah's daughter could be adversely affected by the conflict between her mother and Kevin. An assessment concluded that the risk to Sarah's daughter was medium. A "twenty four hour" decision was made that Sarah should be contacted to discuss the situation. However, this contact had not been achieved by the time of Sarah's murder on 7th January 2016.

4.34 The SCARF was also sent to the Maple Project on 30th December 2015. (The Maple Project arose from a merger of the Independent Domestic Violence Advisors service and the Police Domestic Abuse Officers to create a more joined up support service for victims assessed as of high risk of domestic abuse.) This service made several attempts to contact Sarah by phone and messages were left asking her to call them. Contact appears to have been hampered by the Maple Project ringing the family home (Sarah having left to go and stay with her daughter-in-law for a period) and by the fact that Sarah's mobile phone was in the possession of the police.

4.35 On Thursday 31st December 2015 Kevin's GP received the SCARF submitted by the police following the incident on 27th December 2015. (Paragraphs 4.22-24)

4.36 On Friday 1st January 2016 (public holiday) Sarah contacted the police for an update on what had happened to Kevin two days earlier. She also said that a member of his family had been texting Sarah's daughter asking that Sarah withdraw her 30th December 2015

statement. Sarah said that she was staying with her daughter-in-law and sought advice on whether it was safe to return to her own home as she no longer had her mobile phone. The police provided her with details of Kevin's bail conditions and made arrangements for a statement to be obtained from Sarah's daughter "next week". There is no indication that the police considered whether Kevin's alleged actions amounted to a possible breach of his bail conditions.

4.37 On Monday 4th January 2016 Sarah contacted the police to again report that Kevin had been attempting to persuade her to withdraw her statement by using a member of his family to contact Sarah's daughter by text. The police obtained a statement from Sarah's daughter which was uploaded onto the Niche system along with the text messages sent to her by a member of Kevin's family. It appears that the plan at this stage was for this matter to be addressed by the officer who had dealt with the arrest of Kevin on 30th December who was next on duty at 2pm the following day. However, there is no record that the officer was ever made aware of this development in the ongoing investigation. Nor is there any indication that the police considered whether this incident amounted to a further breach of Kevin's bail conditions. No SCARF was completed, nor were Sarah or Kevin linked to the incident.

4.38 Also on Monday 4th January 2016 Kevin's wife rang her GP to say that her husband had gone to his workshop, locked himself in and begun drinking heavily. She described recent similar incidents in which he had threatened suicide. She said that when she visited his workshop, it was in darkness and she could get no answer. However, a friend had subsequently visited the workshop and said that Kevin was in there. Kevin's wife said she was reluctant to involve the police and ambulance service again. The GP advised Kevin's wife to contact the police to force entry.

4.39 Later the same day the GP rang Kevin's wife back and was told that Kevin's friend had brought him back home where he was sleeping off the effects of alcohol and he was said to be prepared to see his GP the following day.

4.40 The next day (Tuesday 5th January 2016) Kevin saw his GP with his wife and his friend. Kevin disclosed that he was involved with the police as the "other woman" had said he was "bothering her" and that he had assaulted her. He also said that the police had possession of his phone as he had been texting the woman. Kevin's friend said he had found a noose at the workshop but Kevin said he would not kill himself because of the effect on his children. It was said that his suicide threats were cries for help. The GP noted that Kevin was not usually a drinker and was "sensible". Kevin said he had been to A&E and been seen by psychiatry after taking an "overdose" of alcohol with codeine. (Paragraph 4.23) Kevin said he would stay with his wife, avoid his workshop for a time and refrain from alcohol. The GP arranged for Kevin to be seen by a CMHT consultant psychiatrist that day. The GP apparently made a safeguarding referral in respect of Kevin's children. (Children's Services say they received a referral for one of Kevin's children which prompted them to request further information from the surgery which they received after Sarah was murdered.)

4.41 Later the same day Kevin was seen by a consultant psychiatrist who concluded that there "were no psychiatric concerns", and that Kevin "had got himself into a difficult situation". Kevin disclosed that he had been drinking up to ¾ of a bottle of spirits daily but said he would now cease drinking. However, he rejected an offer of medication to help him abstain. Kevin said he would not follow through on previous threats to self-harm and would not harm his girlfriend, who he referred to only by her first name, from whom he said he had parted. He was assessed as low risk of harm to others and risk to self was also assessed

as low if he stopped drinking. His risk to self would increase to moderate to high if his alcohol consumption continued. It was arranged that the psychiatrist would see him again the following week.

4.42 On Wednesday 6th January 2016 Sarah was seen by a trainee clinical psychologist from the CMHT for her first cognitive analytic therapy (CAT) session. Sarah disclosed that she had been in an abusive sexual relationship since May 2015 which had ended over the Christmas period. She related how her ex-partner had threatened to kill himself if the relationship ended. She described physical abuse including him throwing the brush at her and dragging her into a van. She said her ex-partner had recently been arrested and bailed. She added that although he was supposed not to contact her, he had communicated with her via her daughter to ask her to "drop the charges". It was clear to the psychologist that Sarah was a victim of domestic abuse and the discussion turned to her immediate safety. She said she was meeting with "victim support" later that day, was aware she could contact the police if necessary, had family locally and an (unspecified) place of safety to go to.

4.43 Also on Wednesday 6th January 2016 Sarah was visited at her home by an Independent Domestic Violence Advisor who provided advice on personal safety at home and work. Arrangements were made for her to be provided with a phone although the advisor did not have the authority to provide her with the replacement phone at that time. Sarah was also advised to contact her housing provider to arrange for the installation of additional home security.

4.44 The following evening (Thursday 7th January 2016) Kevin confronted Sarah whilst she was closing the hairdresser's salon at the rear of the premises. He had armed himself with a knife from his home and stabbed her twice in her chest, killing her. Kevin was subsequently arrested nearby having self harmed by cutting his wrist and taking an overdose of opiates.

5.0 Engagement with family and friends

5.1 Sarah's family and friends contributed to this review. They described Sarah as a "great mum who had brought up three children on her own". They felt that Sarah was vulnerable at the time she met Kevin as she was receiving support from CMHT and she was also trying to work through the effects of her previous relationships, some of which had been abusive. Her elder son said that Sarah "just wanted to be loved".

5.2 Sarah did not initially disclose her relationship with Kevin to her sons but her daughter, who lived with her, was aware of the relationship and said she had concerns from the beginning. Initially Sarah seemed happy with Kevin. Throughout the relationship Sarah appeared to downplay any negatives about Kevin and seemed to focus on the positives. However, she didn't want to be the "other woman" and she ended the relationship as soon as she realised Kevin had not left his wife.

5.3 The family said that Kevin wouldn't leave her alone after Sarah ended their relationship. They described how he would do things like leave her favourite takeaway coffee drink on her doorstep as a reminder he was watching her. He was also bombarding her with texts. The family said that Kevin tried to manipulate Sarah's daughter and daughter-in-law into putting pressure on her by texting them.

5.4 The family said that the failure of the police to attend on 20th November was very distressing for Sarah. She "locked herself away" and felt increasingly vulnerable. Her family saw how terrified Sarah became of Kevin. On 30th December Sarah's elder son felt that she

had a moment of clarity regarding Kevin and her son asked her to call the police again. Sarah told him that she couldn't, saying "they don't listen" and that "she was so tired." Her elder son therefore phoned the police on her behalf. When he rang, the elder son described how his mum had been let down by the police and said he told the police that Kevin was "going to kill my mum and kill himself. That's what is going to happen." The family said that by this point Sarah was "downtrodden and broken".

5.5 On the day of her death Sarah had returned to work after the Christmas/New Year holidays. Her family felt that she "had seen the light" in respect of Kevin and felt secure in the knowledge that the police had acted following her elder son's call on 30th December. They said she seemed "a different person" and much more hopeful. She cut her elder son's hair that morning and made him promise not to let her drop the case against Kevin.

5.6 Kevin was well known to a member of Sarah's family and a family friend. They saw him as a very manipulative person who "picked on vulnerable people". They said he seemed to have a lack of respect for women and that he behaved in a very manipulative way towards Sarah from early in their relationship. The family detected a pattern in Kevin's behaviour in that he was abusive and then blamed Sarah for his actions. If she didn't accept the blame, he would apologise but then he would repeat his abusive behaviour. They felt that he tried to isolate Sarah from her family.

5.7 The family had the opportunity to comment on the final draft of this report. Their comments are as follows:

- Kevin's threats of suicide were not taken seriously in terms of the threat to himself, or using the threat of suicide as a form of control over Sarah or the impact of his suicidal thoughts on his own family.
- They felt that if agencies had pieced together all of the evidence, including the previous restraining order and Sarah's vulnerability relating to her mental health, they would have graded the risk of domestic abuse as high from the outset.
- They felt that all victims of domestic abuse should be referred to specialist services. When Sarah was graded as a medium risk in November they felt she should have received specialist support as this would have allowed a specialist service to assess her which may have revealed a higher grading of risk.
- Overall they felt that agencies should take more time to assess risk otherwise it could become a "tick box" exercise. They also suggested that the DASH risk assessment should be signed by the victim to demonstrate that they agree with the outcome of the risk assessment.
- When a caller to the 999 number is told that their call is not an emergency call (Paragraph 4.26) they suggested that the caller should be transferred to 101 rather than being asked to re-dial.
- The family questioned the point of the bail conditions if Kevin breached them twice and the police didn't appear to take action. They also felt that domestic abuse cases should be given priority if an offender breaches bail due to the risks to the victim. If the bail conditions had been enforced the family wondered if this could have prevented the murder.
- They asked why Sarah wasn't given a panic button or access to an alarm when she was assessed as high risk on 30th December.
- They also asked why Sarah wasn't promptly informed of Kevin's bail conditions.
- They asked why no-one asked the family for their views regarding Sarah and Kevin in the events leading up to her death. They felt that they should have been involved

as they had an awareness of what they described as the "whole picture" regarding Sarah and the risk Kevin posed to her.

5.8 The family felt let down by the services designed to support them after Sarah's murder. The Victim Support National Homicide Service disengaged after the dedicated case worker allocated to the family left the service. They felt they had received good support from their GP but one of Sarah's sons experienced PTSD symptoms and felt that the support he had received in respect of this had been "poor". The family also expressed disappointment with Mosaic, a Dorset wide charity which offers support to bereaved children, young people and their families.

5.9 Kevin's wife was also approached and contributed to this review. It was clear that Kevin's murder of Sarah and his subsequent imprisonment had had a very significant impact upon Kevin's wife and family.

Engagement with the perpetrator

5.10 Kevin was offered, and accepted, the opportunity to contribute to this DHR.
The independent author interviewed Kevin in Winchester Prison. At the time he was only a few months into his life sentence and had not yet begun any programmes designed to assist him to face up to his crime and the consequences.

5.11 He appeared to wholly portray himself as a victim. He said he was "100% used and messed about". He added that in the days and weeks prior to the murder he "was in such a mess" and "didn't know whether (he) was coming or going".

5.12 He appeared to repeatedly blame his victims. Sarah was said to have "kept him on a string" whilst the woman involved in the restraining order was "trouble" who "took the mickey out of me". He asserted that all he wanted was to be "out of the relationship" with Sarah.

5.13 He seemed to minimise his behaviour throughout the conversation and appeared to resent being "painted as a bad person". He characterised the incident in his workshop on 10th November as an event in which Sarah "went bonkers" and "beat me up in bits and pieces". He said the police had thought he was guilty until they saw the CCTV footage of the incident. He said that Sarah had eventually made him call the prosecution off after telling him she was sorry.

5.14 He portrayed the Boxing Day incident in which he drove Sarah to a remote location as one in which they had been talking together in his car until Sarah had "lost her rag" and gone "into a frenzy". He said he was shocked by what Sarah and her family told the police about this incident which led to his arrest when he alleged that the police treated him "like an animal."

5.15 He denied drinking heavily in the weeks prior to Sarah's murder, advancing the theory that people may have assumed he was drinking heavily because his customers had given him bottles of alcohol for Christmas which were visible in his workshop. He added that he couldn't drink very much because of medical conditions.

5.16 When asked how the domestic homicide could have been prevented he said that he and Sarah "could have sat in a room with somebody". He added that Sarah had promised to

meet him at his GP surgery so they could both get help from his doctor together but she had failed to turn up.

5.17 Inviting the perpetrator to contribute to a DHR is an opportunity to see events through their eyes. Unfortunately, Kevin appeared to use the opportunity to construct a version of events which appeared entirely one sided and largely devoid of credibility. Throughout the conversation he appeared to be entirely focussed on his own needs at the expense of the needs of others. If this is how he presented to professionals in the weeks prior to the murder, then one might have expected Kevin's exclusive focus on his needs to have been an issue of concern.

6.0 Analysis

Key opportunities for assessment and decision making.

6.1 This case escalated quickly. The police became aware of the relationship between Sarah and Kevin, and the conflict within it, for the first time on 10th November. The murder took place 58 days later. During this period there were a number of opportunities for the police and other agencies to make assessments, reach decisions and intervene. In making assessments and reaching decisions there was some evidence of effective practice. However, effective practice was often undermined by inadequate practice.

6.2 The 10th November incident at Kevin's workshop (Paragraph 4.6 - 4.8) generated counter allegations which both parties decided not to pursue at that time. This was the first time the police heard allegations from Sarah that Kevin had harassed her after she had tried to end their relationship. These allegations may have been undermined somewhat in the eyes of the police by the fact that it was she who had attended the workshop and that there appeared to be some ambivalence on her part over whether she wished the relationship to continue. The SCARF was completed less than fully and apparently not shared with partner agencies.

6.3 The police IMR author says that Sarah's reluctance to make a formal complaint did not preclude further police action including Kevin's arrest given that she had a visible injury, was clearly distressed and that her allegations could have amounted to the offence of stalking.

6.4 However, the significance of the 10th November incident was in the manner in which Kevin subsequently persuaded the police to re-open his allegation of assault against Sarah by drawing their attention to CCTV footage from the workshop which incriminated her. When the police, having viewed the CCTV footage, re-opened their investigation Kevin was able use this to exert control over Sarah. With hindsight, it appears that Kevin may have manipulated the police.

6.5 On 16th November there was the first of a number of incidents in which the wife, sister and friend(s) of Kevin expressed concerns about his mental health, fearing that he may harm or kill himself. This incident and others were reported to the police but some incidents were shared only with Kevin's GP and the CMHT. Professionals invariably linked the apparent deterioration in Kevin's mental health to the ending of his relationship with his girlfriend – whose identity was not established by health professionals who came into contact with Kevin. However, they did not perceive his apparent mental health needs, in particular his repeated threats to self harm, as a potential escalation of the risk he posed to his girlfriend.

6.6 Indeed the potential risk to the girlfriend of a man threatening to kill himself as a result of expressed distress arising from the ending of his relationship with that girlfriend appeared to be either overlooked or downplayed throughout. As a result, this risk did not inform or sufficiently inform assessments and decisions in this case.

6.7 The police response to the 17th November telephone call from Sarah (Paragraphs 4.12 – 4.15) was the point at which their handling of the developing situation went badly wrong. Having correctly linked the call to the 10th November workshop incident, and graded the call as requiring an immediate response, the police attended her home address later the same day but were unable to make contact with Sarah. Contact was not made the following day, and when an appointment was made to see Sarah on 20th November the police did not attend. Sarah had mentioned Kevin's prior restraining order in this call to the police but this did not appear to be picked up on, neither was the safeguarding issue arising from Kevin allegedly texting Sarah's daughter.

6.8 These were failings which may have begun to undermine Sarah's confidence in the police as evidenced by her reaction to being told that her 29th December 999 call to report concerning texts from Kevin did not constitute an emergency, and that she should ring back on the non emergency 101 number - which she chose not to do. (Paragraph 4.26)

6.9 A key factor in these failings was a decision taken by the officer who dealt with the 10th November workshop incident to combine the call to the police Sarah made on 17th November with a call made by Kevin the following to say that he had changed his mind and wished to pursue his allegation of assault arising from the 10th November incident and had CCTV footage to support him in this. Inexplicably, and in contravention to Dorset Police's policy on domestic abuse, in combining the 17th November call from Sarah and the 18th November call from Kevin, the officer appeared to focus exclusively on investigating Kevin's reopened allegation of assault against Sarah, whilst entirely ignoring her far more serious allegations. It is understood that it has not been possible to gain a full understanding of the rationale behind this decision making as Dorset Police's referral to the IPCC understandably restricts opportunities to speak with officers at this stage. However, this review has been advised that the officer who combined the 17th and 18th November incidents with such unfortunate results was also the officer who took firm action on 30th December and arrested Kevin.

6.10 An immediate consequence of this approach was that a SCARF was completed in respect of Kevin but not Sarah which meant that any risks arising from the concerns she had expressed to the police in her 17th November phone call were effectively hidden from the police and other agencies. The view of the police IMR author is that had a SCARF been completed in respect of Sarah, it would have assessed her as at high risk of domestic abuse and triggered a MARAC referral.

6.11 As stated above Kevin was able to capitalise on this situation and make use of the re-opened assault allegation against Sarah as leverage to resume their relationship which seems to have happened on 30th November.

6.12 It is very unfortunate that when the handling of the incident was reviewed by a supervisor, this review was carried out by the investigating officer himself who by this time was temporarily fulfilling the role of acting sergeant. The adverse consequences of subsuming Sarah's 17th November call with Kevin's 18th November call went unchallenged as a result.

6.13 Two days after he resumed his relationship with Sarah (2nd December) Kevin retracted his allegation of assault saying that the incriminating CCTV footage had been recorded over. He said that he and Sarah had met and resolved their differences.

6.14 There followed a number of incidents which were not reported to the police or any other agency at the time. There was an undated confrontation between Kevin, Sarah and Kevin's wife at his workshop which culminated in Kevin smashing a bottle and holding it to his throat which went unreported.

6.15 Incidents took place on Christmas Eve, Christmas Day and Boxing Day which also went unreported. The Boxing Day incident was very serious in that Kevin entered Sarah's home without invitation whilst she was asleep and when she managed to persuade him to leave by requesting he give her a lift in his car to collect her vehicle, he deviated from the route and headed into the countryside driving at high speeds whilst threatening to crash the car and kill them both. Sarah only managed to escape after saying she needed to go to the toilet.

6.16 On 27th December the police were alerted to a further concern that Kevin might self harm. Although a SCARF was completed, no reference was made to Sarah despite the recovery of a suicide note referring to the breakdown of Kevin's relationship with her.

6.17 However, the police responded effectively when Sarah's son sought help for his mother on 30th December. Information from previously reported and unreported incidents involving Kevin and Sarah were brought together and the escalating risks to Sarah were appreciated for the first time. A statement was obtained from Sarah, following which Kevin was arrested and interviewed, later being released on police bail. Sarah was assessed as being of high risk of domestic abuse and was referred to the IDVA service.

6.18 However, the police once again undermined their effective work by taking possession of Sarah and Kevin's mobile phones. There was a legitimate reason for this action as police analysis of calls and texts may have increased the likelihood of a successful prosecution of Kevin. But to remove a mobile phone from a woman who had just been assessed as at high risk of domestic abuse and in respect of whom it had been noted that risks were escalating, without offering her a replacement phone, appeared likely to increase the risks she faced in the short term.

6.19 Whilst in custody, Kevin was seen by the pilot custody liaison nurse. He disclosed to her that he wanted to commit suicide and kill his girlfriend. He also said that he wouldn't carry out these threats. Kevin did not identify Sarah by name and the nurse did not elicit this information. She assessed that he was of low risk to himself and others. Authority to share information gained from the pilot custody liaison scheme with the police had been addressed in an information sharing agreement between the police and DHC. Additionally, the police advise that details of the assessment carried out by the custody liaison nurse was available to view on the custody record within the Niche system.

6.20 The police again undermined their effective 30th December response by twice (on 1st and then 4th January 2016) not considering whether Kevin's use of his family member to text Sarah's daughter to put pressure on her mother to retract her statement to the police might constitute a breach of police bail conditions.

6.21 Additionally, the officer dealing with the allegations Sarah made against Kevin on 30th December was not made aware of either of these potential breaches of bail conditions, or

alerted to the fact that a statement had been obtained from Sarah's daughter. Nor was a further SCARF completed.

6.22 Arguably the GP and the psychiatrist who separately saw Kevin with his wife on 5th January 2016 could have probed the situation they were presented with a little further. Kevin indicated that the recent ending of his relationship (with Sarah) was at the root of his distress. No enquiries appear to have been made as to the identity of Sarah and Kevin appears to have disclosed only her first name. She was in fact receiving a service from the CMHT and had herself been seen by the same psychiatrist some months earlier. The psychiatrist has subsequently reflected on his interaction with Kevin and concluded that it would have made no difference to have established the identity of Sarah as Kevin attended the appointment with his wife to whom he had returned. Kevin had told the psychiatrist that his affair was over which had been a big mistake. He presented as calm, did not express any violent intentions and had positive plans to return to work and help his family move house.

6.23 A challenge for medical professionals in circumstances such as these is how much of what Kevin disclosed could or should have been taken at face value. The presence of Kevin's wife was accepted as an indication that the relationship with Sarah was over. However, an alternative perspective of the presence of Kevin's wife was that it was an attempt to manipulate the situation. Kevin often presented to health services with his wife which may have created the perception that she was supporting, perhaps even rescuing him, whilst he may actually have brought her along to manipulate practitioners into believing he was trying to make amends and change his behaviour. His lack of compunction about using a family member (or possibly using their phone) to make threatening texts to Sarah's daughter reinforces the impression that he was prepared to exploit his family to meet his own ends.

6.24 Also accepted at face value was Kevin's commitment to stop drinking. It is questionable how genuine was this commitment given his rejection of help to abstain.

6.25 Ultimately Kevin was assessed as having no mental illness, was not considered suicidal and was considered not to have given any indication that he intended to harm anybody. However, his risk to self was considered to be moderate to high if he continued to drink alcohol. The risk to others of him continuing to drink did not appear to be considered. There is no indication that this risk assessment was shared with any agency or individual other than Kevin's GP.

6.26 Sarah's appointment with the CMHT trainee clinical psychologist on the day prior to her death appears to have been a missed opportunity to contact the Trust's safeguarding adult's team in accordance with Trust policy. Had contact been made the psychologist could have been supported to complete a DASH risk assessment which may have prompted a MARAC referral. The identity of Sarah's abuser does not appear to have been sought or established. (This review has been advised that the CMHT believe that this issue would have been raised and potentially escalated at their weekly review meetings. However, the next weekly meeting did not take place until after the murder.)

Agency compliance with domestic violence and abuse protocols, including information-sharing protocols.

6.27 The principle method of sharing information in this case was through police completion of the SCARF, in which the DASH risk assessment is embedded. This is an important information sharing process which was used inconsistently.

6.28 For example, the SCARF completed on 10th November omitted reference to Sarah's children, nor was that incomplete SCARF shared with partners. One reason the SCARF may not have been shared is that it disclosed a standard level of risk. There may be a need for greater clarity over whether a standard risk SCARF could generate a support service for domestic abuse victims.

6.29 No SCARF was completed in respect of Sarah's 17th November contact with the police nor was any SCARF completed following the reports of Kevin texting Sarah's daughter in apparent breach of his police bail conditions. And the SCARF completed following the 27th December self-harm concern in respect of Kevin was not linked to Sarah despite the presence of a suicide note referring to the breakdown of his relationship with her.

6.30 Sharing SCARF risk assessments with partner agencies is not the only means by which Dorset police communicate concerns to partner agencies. However, it was the principle means by which partner agencies received information from the police in this case.

6.31 Dorset Children's Services received a SCARF following the 30th December arrest of Kevin which raised concerns about the emotional impact of the domestic abuse being experienced by Sarah on her daughter who was living with her at the time. The Children's Services practice manager considered the SCARF in the context of one previous referral in respect of the young person and sought further information from the police and health via the multi-agency information sharing team (MAIST) which handles police and domestic abuse referrals.

6.32 The practice manager also requested the duty officer make telephone contact with Sarah and her daughter which was attempted without success on 31st December and repeated after the holiday weekend. (It is worth pointing out that the escalation of risks Kevin presented to Sarah took place over the Christmas and New Year period which would have had an effect on the staffing levels and continuity of most partner agencies.) Information requested from MAIST arrived on 4th January 2016 when a further unsuccessful attempt was made to contact Sarah. Further attempts at contact were due to be made on 7th January which was when Sarah was murdered.

6.33 Had contact been made a Child in Need (CiN) assessment would have been carried out. The Children's Services IMR author takes the view that the response was appropriate given the absence of any indication of immediate harm and the fact that the perpetrator was not living in the family home. However, Children's Services acknowledge that there was no consideration given to the perpetrator's family at this point or curiosity about whether he had children.

6.34 Children's Services were not sent SCARFs in respect of the texts sent to Sarah's daughter via Kevin's family member in an attempt to persuade Sarah to withdraw her complaint against Kevin.

6.35 The SCARF completed by the police following the 30th December arrest of Kevin was also shared with Sarah's GP but the details were only entered into the patient record of her daughter. No details were entered into Sarah's patient record. This omission may be linked to the method by which GPs receive the SCARF. The police send the SCARF to Dorset HealthCare who distribute the SCARF to the GP via health visitors and school nurses. This creates a risk of the SCARF being missed or delayed. In this instance the information from the 30th December SCARF was electronically recorded by a school nurse on Sarah's daughter's patient record and no notification was then sent to Sarah's GP.

6.36 Sarah saw her GP only two or three times during the period she was in a relationship with Kevin and did not appear to make any disclosures to her GP. Therefore, this SCARF represented an opportunity to follow up with Sarah to check on her health and wellbeing. Unlike the police, her GP was aware of Sarah's mental health issues.

6.37 The police do not share SCARFs directly with the CMHT as they do not have a secure email address to send that information to and they currently have no means of knowing who is "open" to the CMHT. Sarah had been a patient of the CMHT for some time and Kevin was referred to the CMHT two days prior to the murder.

6.38 As a result of no SCARF being completed following the 17th November report from Sarah, the opportunity to refer her case to MARAC was lost. The police IMR author is of the view that had a SCARF been completed, Sarah would have been assessed as high risk which would have led to a MARAC referral. At least one meeting of Dorset MARAC took place between 17th November 2015 and Sarah's murder.

Stalking and Harassment

6.39 Kevin's behaviour towards Sarah amounted to stalking in that he pursued a course of conduct which amounted to the harassment of another. He stalked Sarah by contacting her by text messages which at times were relentless and in which he threatened her and also threatened to take his own life. He also watched or spied on her which is evidenced by his uninvited entry into her house whilst she was sleeping. The stalking in this case was more serious because Kevin caused Sarah to be in fear of violence on two or more occasions and his behaviour caused Sarah severe harm or distress which had a substantial impact on her day to day activities including leaving her home to stay with her daughter-in-law for a period.

6.40 The College of Policing guidance on stalking and harassment (1) stresses the importance of looking for opportunities for early intervention. Early intervention in this case was precluded by the manner in which Sarah's 17th November call to the police was handled. The College of Police guidance also emphasises the need to conduct all relevant intelligence checks particularly previous history of offences including restraining orders. In this case the previous restraining order does not appear to have been considered by the police until 29th December. (Paragraph 4.25) The College of Policing also guidance states that "where stalking is part of a pattern of domestic abuse, it is often an indication that the situation is very high risk". (2)

6.41 It is worthy of note that supplementary questions in respect of stalking and harassment have now been added to the DASH risk assessment but they had not been introduced at the time of this incident.

The victim: obtaining and considering the victim's wishes and feelings.

6.42 Sarah was a white British woman who had apparently suffered physical abuse from her father and domestic abuse by an ex-husband. She had been known to her local adult CMHT since 2000 when she was diagnosed with anxiety and depression, chronic fatigue and excessive daytime sleepiness. Following a period of contact with the CMHT during 2013, Sarah was discharged to the care of a "steps2wellbeing" service provided by Dorset Healthcare Trust. However, she did not engage with this service and so she remained under the care of the CMHT until she was discharged to the care of her GP in October 2013.

6.43 In March 2015 (ten months prior to her murder) she was again referred to the CMHT by her GP as a result of thoughts of self-harm and suicide. The CMHT then provided her with a service until her death. Just prior to her death she began cognitive analytic therapy.

6.44 During the period when the risks she faced from Kevin began to escalate, the potential fragility of her mental health was unknown by any service she was in contact with except for her GP - with whom she had limited contact during this period – and the CMHT. The CMHT appear to have only become aware that Sarah was at risk from domestic abuse on the day before her death. Prior to this disclosure, it is thought that Sarah may have been reticent about sharing concerns arising from her relationship with Kevin with health practitioners.

6.45 Sarah disclosed the harassment and threats from Kevin to members of her family who interceded with the police on her behalf on 30th December which enabled the police to gain a much more comprehensive understanding of the risks she faced. It is noticeable that it took her family to intervene on her behalf for this fuller picture to emerge. It seems Sarah's faith in the police may have been eroded by their handling of her 17th November and 29th December calls.

The perpetrator: knowledge of the risks he presented to women.

6.46 Kevin is a white British male. He suffered acute pancreatitis which appears to have been alcohol related from the mid 1980's until the early 1990s. No mental health history was known until concerns began to be expressed on his behalf by relatives and friends about his excessive alcohol consumption and threats to self harm and commit suicide from November 2015.

6.47 He and his family appear to have been under some strain in the months prior to the murder. Kevin, his wife and four children were living in a two bedroomed house and may have been under threat of eviction. Additionally, his wife was having to cope with the impact of the second highly intense extra-marital relationship entered into by her husband within three years.

6.48 Kevin had not come to the notice of the police for many years prior to a relationship he entered into with the female which led to the imposition of the earlier restraining order. Kevin met this young woman through a garage where both she and his wife were employed. When the woman tried to end their relationship he became angry and after offering her a gift in an attempt to change her mind, became violent. After meeting her on a remote country road, he blocked her car in with his and threatened to tell his wife (with whom the woman worked) about the relationship. He then began turning up at her address and her place of work, and phoning and texting her with abusive comments. When he falsely accused her of stealing from her employers she decided to report the matter to the police. In her statement she described being fearful for her life.

6.49 Kevin was arrested and later charged. In April 2014 he was convicted of harassment but found not guilty of common assault and touching with sexual intent. The court fined him and imposed a restraining order for 5 years to protect the young woman from further harm.

6.50 Restraining orders are civil behaviour orders and so they would not be qualifying convictions for the purposes of MAPPA. Breach of a restraining order is a criminal offence so such a conviction could be a MAPPA qualifying conviction.

6.51 Kevin is not known to have breached his restraining order. If this is the case, then it proved an effective method of protecting the woman from his behaviour. However, it could be argued that a restraining order is less effective at protecting the wider public, particularly other potential victims from predators such as Kevin.

6.52 Stalking and harassment offences arrived on the statute book in November 2012 and so they were available for the police to consider when Kevin's victim reported her concerns to them. However, officers may have been less confident in using what was at that time new legislation.

6.53 Information about a restraining order does not appear to be routinely shared beyond the police, the victim and the perpetrator. And as the police became aware of the relationship between Kevin and Sarah and indications that his behaviour towards her was very similar to the manner in which he had behaved towards his earlier victim, it seemed to take the police some time to make use of the restraining order information. Sarah appeared to become aware of the restraining order from a conversation with Kevin's wife and shared this with the police on 17th November. However, Sarah may have advised the police of the past restraining order when the SCARF risk assessment was completed following the 10th November incident as she answered the question "Is there a history of violence with other partners or anyone else?" in the affirmative. However, the police do not appear to have considered the implications of the restraining order for Sarah's safety until 29th December when the police SRU referred Kevin to partner agencies following his self-harm threats on 27th December and shared details of his offending history including the restraining order.

6.54 It has been established that a restraining order is disclosable under the Domestic Violence Disclosure Scheme. (The aim of this scheme is to give members of the public a formal mechanism to make enquiries about an individual who they are in a relationship with or who is in a relationship with someone they know, and where there is a concern that the individual may be abusive towards their partner. If police checks show that the individual has a record of abusive offences, the police will consider sharing the information with the person(s) best placed to protect the potential victim.)

Good practice

6.55 The CMHT service responded to Sarah and involved her in the planning of her care and intervention. There is evidence to demonstrate that the service was flexible and accessible to meet the changing needs Sarah presented with. The team used various forms of communication pathways to engage with her. Steps2wellbeing continued to offer appointments despite Sarah's disengagement.

6.56 When Kevin presented to his GP on 5th January 2016, he was provided with an appointment with a psychiatrist the same day.

6.57 The actions of the police critical incident Inspector on 30th December in assessing the available information enabled the escalation in risks to Sarah to be fully appreciated for the first time.

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

7.1 In terms of considering whether the homicide could have been predicted, the test used is that it is considered that the homicide would have been *predictable* if there was evidence

from the perpetrators' words, actions or behaviour at the time that could have alerted professionals that they might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

7.2 In terms of the test used for preventability, it is considered that the homicide would have been *preventable* if there was evidence that professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are invariably things which could have been done to prevent any tragedy.

7.3 Beginning with predictability, Kevin expressed a desire to kill Sarah to practitioners on several separate occasions in the days prior to the murder. In general, practitioners appeared to conclude that the risk of him carrying out this threat was not high enough for them to propose or initiate urgent steps to safeguard Sarah beyond the referral to the IDVA service and MARAC made by the police on 30th December.

7.4 The police decided to grant Kevin pre-charge bail with conditions following his arrest on 30th December. The custody liaison nurse appeared to accept Kevin's undertaking that he would not act on his expressed wish to kill Sarah, and on 5th January 2016 Kevin's GP referred him immediately to the CMHT, where the consultant psychiatrist accepted Kevin's word that he would not follow through on his threats to harm himself and his unidentified girlfriend. The consultant psychiatrist assessed Kevin as low risk of harm to both himself and others although his risk to self would increase to moderate to high if his alcohol consumption continued. The effect of continued alcohol consumption on his risk to others did not appear to be considered.

7.5 Kevin's threat of suicide was not appreciated by practitioners as a factor which could increase the risk of harm he presented to Sarah. Threats from an offender to commit suicide have been highlighted by DASH as a high risk factor in domestic homicide. Research indicates that if a perpetrator threatens suicide, it is important for professionals to be alert to the heightened risk of homicide to others. (3)

7.6 In general practitioners appeared to take comfort from the impression that Kevin had accepted his relationship with Sarah was at an end and had decided to return to his wife. However, this appears to have been a false impression and Kevin may also have used the presence of his supportive wife as a means of reinforcing that impression and deceiving professionals who did not appear to pick up on the increased homicide risk to victims seeking to end a violent relationship. (4)

7.7 Kevin had very recently taken his desire to kill Sarah further than words. On 26th December he had taken her to a remote rural area against her will and driven his car at high speeds whilst threatening to crash into a tree and kill them both. He put Sarah in fear of her life and she only managed to escape on that occasion through quick thinking on her part.

7.8 Kevin did not comply with the constraints placed upon him. He breached his police bail conditions with impunity and may have been emboldened by the absence of consequences. (The review has been advised that he respected the terms of his earlier restraining order, however.)

7.9 Past behaviour is frequently a strong indicator of future behaviour. He was engaging in a pattern of behaviour towards Sarah which was strikingly similar to his treatment of an

earlier woman who broke off a relationship with him. This woman was also said to have feared for her life.

7.10 There was evidence from Kevin's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently. Additionally, Kevin had placed Sarah in fear for her life when he drove erratically at speed whilst she was a passenger on 26th December. Although Kevin was not known to have carried, or made threats with a knife, at the time he was making repeated threats to kill Sarah, the possibility of him carrying out his threats was an outcome with a higher degree of predictability than practitioners perceived to be the case.

7.11 Turning to preventability, the manner in which the police handled Sarah's call on 17th November (Paragraphs 4.12 to 4.15) appears to have been a turning point. Had that call been dealt with in accordance with force and multi-agency policy, it is likely that Sarah would have been assessed as at high risk of domestic abuse and referred to MARAC. However, the manner in which the call was actually handled, being merged with a call from Kevin to renew his allegation of assault arising from the 10th November workshop incident (Paragraph 4.14 to 4.16), resulted in Sarah's concerns being completely overlooked.

7.12 The police began to recover the situation on 30th December when a call from Sarah's son generated purposeful activity and the realisation that she faced escalating risk of domestic abuse. Sarah was assessed as being of high risk of domestic abuse which triggered the involvement of the IDVA service and the MARAC referral which probably should have taken place 6 weeks earlier.

7.13 This led to the arrest of Kevin who was granted pre-charge bail, often referred to as police bail, with conditions which included no direct or indirect contact with Sarah. Had the police been in a position to charge Kevin, retaining him in custody and placing him before the next Magistrates Court would have been an option. The next available Magistrates Court would have been the following day which was 31st December. Had this happened, one can only speculate on whether the Court would have decided to remand Kevin in custody or release on him on Court bail.

7.14 It is unclear whether the grant of police bail to Kevin on 30th December triggered a re-assessment of the risk he presented to Sarah, which Her Majesty's Inspector of Constabulary (HMIC) recognises as good practice. (5) However, the police were now in a stronger position to safeguard Sarah. Unfortunately, they undermined this position by making a number of errors.

7.15 Firstly they took possession of the mobile phones of Kevin and Sarah and did not provide her with an alternative phone or assess the risks of removing her phone. Taking her phone would have enabled the police to gain a full picture of the threats she was receiving from Kevin, but leaving her without her mobile phone risked isolating her from support and increasing her vulnerability. Sarah's family have advised this review that she located an old mobile phone for which she purchased a sim card on the day prior to her murder. The loss of her phone made it more difficult for agencies to contact her. The police themselves were unable to phone her to advise of bail conditions imposed on Kevin following his release from police custody on 30th December and the Maple Project made several unsuccessful attempts to contact her prior to arranging the 6th January 2016 meeting with the IDVA.

7.16 Secondly the police did not take decisive action when they were twice advised that Kevin may have broken his police bail conditions by using a family member (or their phone)

to text Sarah's daughter to try and persuade her mother to withdraw her allegations against him.

7.17 Thirdly, having taken a statement from Sarah's daughter following the second call to say Kevin had been using a family member to text Sarah's daughter, the police failed to ensure that this statement was brought to the attention of the officer who was investigating Sarah's allegations against Kevin.

7.18 Had the police taken prompt and decisive action to address Kevin's apparent disregard of his bail conditions it seems likely that he would have been rearrested which may have deterred him from harming Sarah. As it was, it seems possible that the lack of action in response to the apparent breach of bail conditions may have emboldened him further.

7.19 Other agencies made errors which prevented them from taking action which could have enhanced the safety of Sarah during the days prior to her death. The SCARF completed by the police on 30th December was not entered into her medical records. Had this been done it may have prompted contact with Sarah by her GP which could have led to further concerns for Sarah's safety being raised. Additionally, when Sarah was seen by the CMHT trainee clinical psychologist on the day prior to her murder and disclosed her fears of Kevin, safeguarding advice was not sought, as it should have been, which again closed off an opportunity to raise concerns on behalf of Sarah.

7.20 On the day before her death, Sarah was also seen by an IDVA who did not have authority to provide her with a replacement phone for making emergency calls.

7.21 The failures set out above should not have happened and would have been avoided had police personnel and health practitioners followed well established policies. Looking back, the initial failure of the police to appropriately handle Sarah's call on 17th November appears to have been critical. When the police partially recovered the situation six weeks later the risks to Sarah had clearly escalated further. However, there were conspicuous opportunities for the police, her GP, the CMHT and the IDVA service to intervene more effectively in the days immediately prior to Sarah's murder which may have enhanced her safety. Had policies been complied with, a fuller picture of the continuing threat to Sarah's safety seems likely to have emerged which could have generated further measures to protect her. It is therefore concluded that a number of agencies had sufficient knowledge, opportunity and legal means to take action to reduce the likelihood of the fatal attack on her.

8.0 Findings and Recommendations:

Assessment and Management of Risk

8.1 Lack of professional awareness of high risk factors is a very noticeable aspect of this case. Specifically, professionals appeared to lack appreciation of the increased risk that a perpetrator who is apparently suicidal may present to the victim, the increased risk a perpetrator may present to the victim when the latter is seeking to end their relationship and that the presence of stalking may indicate very high risk. It is recommended that raising awareness of high risk factors should be a prominent feature of the dissemination of learning from this case to partner agencies.

Recommendation 1

That Dorset Community Safety Partnership make use of this review as a case study to inform single and multi-agency training with a particular emphasis on understanding factors which increase the risk of homicide including threats of suicide by the perpetrator, attempts by the victim to end the relationship and the presence of stalking.

8.2 Risk assessment did not appear to be sufficiently holistic at times. In particular Kevin's risk to others was assessed as low by both the CMHT psychologist and the custody nurse. They both reached these conclusions on the basis of insufficient information about the risks he presented to Sarah. When health professionals assess the risks patients present to others, such assessments need to be properly informed to be of value to other professionals.

8.3 The custody nurse service is an important development which continues to evolve. It is suggested that the learning from this case is shared with the commissioners of that service so that they can consider the implications of this case for risk assessment.

Recommendation 2

That Dorset Community Safety Partnership shares this DHR report with NHS England and Dorset CCG as commissioners and Dorset HealthCare NHS Trust as providers of the custody nurse service (formally known as the Criminal Justice and Liaison Service) so that they can consider the learning from this case in the further development of that service.

8.4 Also, despite the police assessing the risks to Sarah on several occasions they did not become aware of her mental health history which arguably increased her vulnerability. The DASH risk assessment, which in Dorset is embedded within the SCARF, asks if the victim is feeling depressed or has suicidal thoughts. This is a question which could elicit valuable information about the victim's mental health but it is primarily focussed on how the victim is feeling at that time.

8.5 The *Standing Together* analysis of DHR cases (6) suggests that there is an important distinction to be made between risk identification and risk assessment. While risk *identification* involves knowledge and use of the DASH checklist and identification of risk factors, risk *assessment* requires more in-depth knowledge and represents an on-going, sustained process. The police in consultation with partner agencies may wish to consider enhancing the SCARF process to enable a somewhat broader risk assessment to be completed to ascertain if the victim has care and support needs which, in this case, could have highlighted Sarah's mental health history. It is understood that this is a piece of work which has been recently completed in Dorset which is an extremely welcome development. It is recommended that assurance is obtained that the enhanced SCARF process (now renamed as a Public Protection Notice (PPN)) is facilitating broader assessments including care and support needs.

Recommendation 3

That Dorset Community Safety Partnership obtain assurance that the Public Protection Notice (PPN) process enables a broader risk assessment to be carried out which includes the identification of any care and support needs the person may have.

8.6 The restraining order imposed by the courts in respect of Kevin's earlier relationship with a young woman appears to have been an effective means of preventing further harm and distress to the victim. Whilst effective in contributing to the safeguarding of an individual victim, restraining orders have much less impact on wider community safety.

8.7 However, once Kevin's relationship with Sarah came to the notice of the police and it became apparent that his behaviour towards her was strikingly similar to his behaviour towards his previous victim, there was the opportunity to make use of the restraining order to inform their assessment of the risk he now presented to Sarah. Indeed, the College of Policing guidance on stalking and harassment recommends that all relevant intelligence checks be conducted including restraining orders. However, the value of the restraining order intelligence did not appear to be fully recognised by the police until 29th December despite Sarah drawing it to their attention at least once.

Recommendation 4

That Dorset Community Safety Partnership obtains assurance that Dorset police make use of intelligence about a perpetrator's previous behaviour in assessing the risk that perpetrator may present to a current victim.

8.8 HMIC considers it effective practice is to consider the release of a perpetrator on bail as a trigger point for re-assessment of risk to the victim. This does not appear to have happened when Kevin was released on police bail on 30th December. It is therefore recommended that assurance is gained from Dorset Police that risk to the victim is reassessed at the point at which the perpetrator is released on pre-charge bail.

Recommendation 5

That Dorset Community Safety Partnership obtain assurance from Dorset Police that they reassess risk to the victim at point at which a suspected domestic abuse perpetrator is granted bail.

Information sharing

8.9 As previously stated the SCARF containing the embedded DASH risk assessment is a crucial process for sharing information about risk. However, this case discloses a less than consistent approach to the use of SCARF for information sharing. The police did not always complete or fully complete them and do not share them with community mental health services. Additionally, there may be a need for greater clarity over whether a low or medium risk SCARF could generate a support service for domestic abuse victims. And the process by which GPs receive SCARFs appears convoluted. Given the importance of the SCARF process it would be beneficial for the police and their partners to agree a standard process by which information is shared through the SCARF (now PPN) process.

Recommendation 6

That Dorset Community Safety Partnership works with other relevant partnership boards to agree a standard process for sharing information about risk through the SCARF (now PPN) process.

Organisational systems

8.10 In their 2015 and 2016 assessments of Dorset police, HMIC concluded that the force responded well to victims of domestic abuse and was classified as "good" at protecting vulnerable people from harm and supporting victims. (7) This individual case disclosed an inconsistent approach to responding to Sarah's calls and protecting her from harm. There were several errors and omissions such as the subsuming the risks to Sarah's revealed in her 17th November call within Kevin's renewed allegation of assault, the failure to take positive action when Kevin appeared to disregard his police bail conditions, advice to Sarah that her concerns about stalking and harassment did not merit the use of the 999 system, SCARFs not completed or completed fully etc. These were all individual errors but there did not appear to be sufficiently robust arrangements for checking that the force's domestic abuse policy was being complied with. There appeared to be only two occasions when supervisors intervened. The critical incident Inspector intervened decisively on 30th December to recognise the escalating risks to Sarah but the other occasion on which a supervisor intervened was when the officer who merged Sarah's 17th November call with Kevin's 18th November call reviewed their own flawed decision making, whilst temporarily fulfilling the role of an acting sergeant.

8.11 Lack of compliance with domestic abuse policies was not limited to the police in this case. It is therefore recommended that assurance is sought that Dorset Police – and partner agencies –have systems in place to assure themselves that their staff comply with domestic abuse policies.

Recommendation 7

That Dorset Community Safety Partnership obtains assurance from partner agencies that they have systems in place to assure themselves that their staff comply with domestic abuse policies.

Flagging on Niche system

8.12 When Dorset Police introduced the Niche information management system in 2015 it was decided to proceed without the facility to flag individuals at risk. As result of the learning emerging from this case, the police have reintroduced flagging to the Niche system.

Recommendation 8

That the Dorset Community Safety Partnership seeks assurance from Dorset Police that the Niche system enables the police to effectively flag cases involving victims of domestic abuse.

Victim Care

8.13 It is suggested that the IPCC provisional recommendation to Dorset Police is strongly endorsed i.e. "On occasions where a victim of domestic violence has their mobile phone taken as evidence for the investigation, they should not be left without an ability to make emergency calls. The IPCC recommends that Dorset Police consider what arrangements can be put in place to guarantee victims have a means to communicate regarding their safety at all times". As a result of learning, since January 2017 Dorset Police have formed a partnership with Tesco Supermarket, whereby mobile phones are provided to victims of Domestic Abuse to ensure that they are not left without the ability to make emergency calls.

Recommendation 9

That Dorset Community Safety Partnership obtain assurance from Dorset Police that they have fully complied with the IPCC recommendation that victims of domestic abuse are not left without an ability to make emergency calls.

8.14 A custody officer is expected to be mindful of the need to ensure that affected individuals are notified prior to release of alleged perpetrators on bail so that mitigating measures can be put in place where required. The police were unable to contact Sarah to advise her of Kevin's bail conditions. Although her mobile phone had been taken from her, it is understood that Sarah furnished the police with her contact details including her intention to stay for a period with her daughter-in-law because she felt unsafe in her home. The absence of contact by the police necessitated her call to the police on 1st January 2016 to find out what had happened to Kevin. It is therefore recommended that assurance is obtained that victims of domestic abuse are promptly provided with information about perpetrator bail conditions.

Recommendation 10

That Dorset Community Safety Partnership obtain assurance from Dorset police that victims of domestic abuse are always promptly provided with information about alleged perpetrator bail conditions.

8.15 When Kevin was suspected of failing to comply with his pre-charge bail conditions the police did not take appropriate action. HMIC has consulted victims of domestic abuse and found that victims expressed disappointment at the lack of action taken when bail conditions were breached. It was said that this had a detrimental effect on these victims and their confidence in the police and criminal justice process.

Recommendation 11

That Dorset Community Safety Partnership obtain assurance from Dorset Police that any breach of pre-charge bail conditions by suspected perpetrators of domestic abuse will always be always dealt with effectively in order to safeguard victims.

Whole Family Approach

8.16 Taking a whole family approach to cases involving domestic abuse involves looking at the whole family with services for both adults and children taking into account family circumstances, responsibilities, strengths and needs for support. In this case the needs of the children of both Sarah and Kevin were not fully appreciated. Sarah's daughter was used by the perpetrator to apply pressure to her mother from 17th November and appears to have been the principle means by which Kevin applied pressure on Sarah to drop her complaint against him following his arrest on 30th December. Additionally, Kevin appears to have frequently used a family member to send threatening texts to Sarah via her daughter. And as previously stated, he appears to have exploited the support of his wife to present a picture to professionals which may have helped persuade them to under estimate the risks he presented to Sarah.

8.17 A previous Dorset DHR found that here was insufficient use of a whole family approach to the assessment and management of domestic abuse including effective joint working between services working with adults and those working with children.

Recommendation 12

That Dorset Community Safety Partnership obtains assurance from all partner agencies that they fully incorporate a whole family approach to their domestic abuse policies.

Domestic abuse is everyone's business

8.18 The Dorset HealthCare IMR author writes that it is an important learning point to remember that practitioners should never assume that someone else will take care of domestic abuse concerns. This is a vitally important point. In this case there were indications of a degree of passivity in the face of high risk of domestic abuse, for example when Sarah disclosed to the CMHT psychologist on 6th January 2016. And when domestic abuse policy was complied with, practitioners may have felt that they had done all they needed to do by complying with the processes. In the days before Sarah's death there appears to have been the opportunity to engage collaboratively with her to consider a wider range of options for safeguarding her to ensure she had effective means of communication and that every reasonable effort had been made to ensure her safety at home and at work.

8.19 It is therefore recommended that the dissemination of learning from this DHR emphasises the importance of professionals taking individual responsibility for addressing concerns about domestic abuse.

Recommendation 13

That Dorset Community Safety Partnership emphasises the responsibility of professionals for addressing domestic abuse concerns when the learning from this case is disseminated.

8.20 Sarah's family contributed to this review and expressed dissatisfaction with a range of services offered to them following the murder of Sarah. (See Paragraph 5.9) It is recommended that the Community Safety Partnership assess the adequacy of support available and raise any concerns with the relevant agencies.

Recommendation 14

That Dorset Community Safety Partnership assess the adequacy of the support available to adults, young people and children affected by a domestic homicide of a family member or friend and raise any concerns with relevant agencies.

References:

(1) Retrieved from https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/stalking-and-harassment/

(2) ibid

(3) (Menzies, Webster and Sepejak, 1985; Regan, Kelly, Morris and Dibb, 2007)

(4) Retrieved from http://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/One-Page-High-Risk-Factor-Definitons-for-Domestic-Abuse.pdf

(5) HMIC (Her Majesty's Inspector of Constabulary) Increasingly Everyone's Business

(6) Retrieved from http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf

(7) Retrieved from https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/peel-police-effectiveness-2016-dorset.pdf

Appendix A

Process by which the DHR was completed

The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (August 2013). The decision to undertake a DHR was taken by the Chair of the Dorset Community Safety Partnership on 9th March 2016 and the Home Office notified on the same date.

It was decided to delay commencing the review until completion of the criminal proceedings in September 2016.

Individual Management Reviews were completed by

- Dorset County Council Children's Services
- Dorset HealthCare NHS University Foundation Trust
- Dorset Police
- NHS Dorset Clinical Commissioning Group

Short reports were provided by South West Ambulance Service NHS Trust, Dorset Home Choice and Dorset County Hospital NHS Foundation Trust.

It should be noted that the Dorset Police IMR made substantial use of the witness statement made by Sarah on 30th December 2015. (Paragraph 4.34) This statement was a particularly valuable source of information about incidents which had not been reported to the police at the time and was largely corroborated by the police interview with Kevin on the same date.

Sarah's family and friends contributed to this review. Kevin's wife was invited to contribute to the review but declined. Kevin decided to contribute to the review.

The DHR was overseen by an independently chaired Panel which ultimately approved the DHR overview report and submitted it to Dorset Community Safety Partnership.

Membership of the DHR panel

The Domestic Homicide Review Panel consisted of

- Independent Chair – Dr Nicky Cleave
- Head of Quality Improvement, Dorset Clinical Commissioning Group
- Safeguarding and Quality Service Manager (Adults), Dorset County Council
- Safeguarding Adults Lead, Dorset Healthcare University NHS Foundation Trust
- Force Review Officer, Dorset Police
- Dorset Designated Safeguarding Manager (Children), Dorset County Council
- Temporary Detective Chief Inspector Public Protection (Adults), Dorset Police
- Head of Domestic Abuse Services, The You Trust
- Lead Officer, Dorset Community Safety Partnership
- Partnership Coordinator – Crime and Criminal Justice
- Independent Author – David Mellor

Administrative support was provided by Caroline Garrett, Dorset Police.