**DOMESTIC HOMICIDE REVIEW**

**TEST VALLEY PARTNERSHIP**

**‘GLEN HEDGES’**

**Author – Graham Bartlett**

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# INTRODUCTION

## This report of a domestic homicide review examines agency responses and support given to ‘Glen Hedges’, an 84-year-old British male resident of Test Valley, prior to his death in November 2016 following injuries he sustained the previous day.

## In addition to agency involvement, the review examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

## The subjects of the review are[[1]](#footnote-1):

|  |  |  |
| --- | --- | --- |
| **Victim** | **Name** | ‘Glen Hedges’ |
| **Age** | 84 years |
| **Gender** | Male |
| **Nationality** | British |
| **Alleged Perpetrator** | **Name** | ‘Nadia Kowalski’ |
| **Age** | 38 years |
| **Gender** | Female |
| **Nationality** | Polish |
| **Relationship to Victim** | Described herself as Glen Hedges’ carer.  Mr Hedges had previously informed police that he has had a sexual relationship with Ms Kowalski |
| **Child of Alleged Perpetrator** | **Name** | ‘L’ Kowalski’ |
| **Age** | 6 years |
| **Nationality** | Polish |

## The review considered agencies’ contact and involvement with Mr Hedges, Ms Kowalski and Ms Kowalski’s child, ‘L’, between 16th November 2011 and the date of death The Panel chose these timescales as there was no known contact between the Mr Hedges and Ms Kowalski prior to July 2016 but there was significant relevant agency involvement with both over that five-year period, notably regarding Ms Kowalski being a victim of domestic abuse from previous partners, her alcohol use and the safeguarding arrangements around her and ‘L’ as well as Mr Hedges’ sex offender status.

## The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 states that a domestic homicide review must be held where the circumstances in which a person aged 16 or over has died and the death had, or appears to have, resulted from violence, abuse or neglect by—

## a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

## a member of the same household as himself,

## The purpose of a DHR is to:

## establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

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

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

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

## highlight good practice.

## The Test Valley Partnership decided, based on information received, that Mr Hedges and Ms Kowalski were in a sexual relationship, therefore the criteria for a domestic homicide review were met. Consequently, they commissioned this review.

## The Hampshire Safeguarding Adults Board considered whether the circumstances met the criteria for a Safeguarding Adults Review under Section 44 of the Care Act 2014. They decided that, given the circumstances and that a Domestic Homicide Review was being considered, a Safeguarding Adults Review would not be commissioned but relevant safeguarding considerations would be included in this review. It was agreed they would be represented on the DHR panel.

# TIMESCALES

## This review began on 13th November 2017 and was concluded in November 2018. The reason for there being a year between Mr Hedges’ death and the commissioning of this review was that the Crown Prosecution Service’s decision that the matter was to be charged as manslaughter was not received until 26th September 2017.

# CONFIDENTIALITY

## Whilst key issues have been shared with organisations, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of the report were approved by the Review Panel.

## The IMRs will not be published but the redacted overview DHR report and Executive Summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.

## The content of the Overview Report and Executive Summary is anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. All names contained are pseudonyms.

## Mr Hedges’ family have been given the opportunity to read a draft copy of this report and will be provided a final copy the day before publication.

# TERMS OF REFERENCE

## The specific terms of reference for this domestic homicide review were agreed as follows:

* Whilst Mr Hedges had no known contact with any specialist domestic abuse agencies or services, Ms Kowalski did. The DHR will review any history of domestic abuse involving Mr Hedges / Ms Kowalski and assess whether there were any warning signs of escalation or vulnerability.
* Whether there were opportunities for professionals to refer any reports of domestic abuse or sexual violence experienced or committed by either the victim or the alleged perpetrator, (towards each other or any other partner) to other agencies and whether those opportunities were taken.
* Whether the quality of any risk assessments undertaken were of a suitable standard and whether the thresholds for referral into Multi Agency Risk Assessment Conference (MARAC) were appropriate.
* Whether there were opportunities for professionals to ‘routinely enquire’ as to any domestic abuse or sexual violence experienced by the victim or alleged perpetrator that were missed.
* Whether there were opportunities for agency intervention in relation to domestic abuse regarding Mr Hedges or Ms Kowalski that were missed or could have been improved.
* Whether the nature of Ms Kowalski’s relationship with Mr Hedges was sufficiently explored, identified and/ or responded to especially whether she was exploiting him either financially or in any other way and/ or whether she was acting as his formal or informal carer.
* Whether the health, welfare and/ or wellbeing of Ms Kowalski’s child was sufficiently considered and/ or responded to during the period under review including, but not restricted to, her exposure to any form of abuse through domestic violence and Mr Hedges’ history of being a sexual offender.
* Whether either Mr Hedges or Ms Kowalski had care and support needs, whether as a consequence of those care and support needs either suffered abuse or neglect and if so the nature and quality of the single and/ or multi agency response to that, including how their wishes and feelings were taken into consideration.
* Whether there were any barriers or disincentives experienced or perceived by Mr Hedges, Ms Kowalski or their family/ friends/ others who were in contact with Mr Hedges and or Ms Kowalski in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.
* Whether family, friends or others who were in contact with Mr Hedges and or Ms Kowalski were aware of any abusive behaviour from or towards each other, prior to the homicide and what they did or did not do as a consequence.
* Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.
* Whether Mr Hedges or Ms Kowalski had experienced abuse in previous relationships during the time period under review, and whether this experience impacted on their likelihood of seeking support in the period under review.

In addition:

* The review will give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
* The review will identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the Test Valley.

# METHODOLOGY

## At a meeting of the Test Valley Community Safety Partnership on November 2017 a Domestic Homicide Review Referral from Hampshire Constabulary was considered and, based on its contents and the criteria set out in the Domestic Homicide Review Guidance[[2]](#footnote-2), this Review was commissioned.

## An independent reviewer was sought and appointed, terms of reference drafted and a panel appointed. At that first panel meeting on 31 January 2018, the Terms of Reference was agreed and decisions were taken over which agencies would be required to submit Individual Management Reviews (IMRs) and Chronologies and which would be asked to submit scoping documents.

## Subsequently, the IMRs and Chronologies were collated and drawn into a draft Overview Report. Various draft reports were shared with the panel, which met twice in person (and kept in contact liaison virtually), on culminating in the final draft which was signed off by the Community Safety Partnership in March 2019.

# INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

## Mr Hedges’ family have twice been invited to contribute to this review but have not responded to any communication. The police through Family Liaison Officers have tried to facilitate this but have been unsuccessful.

## This leaves a regrettable but unavoidable gap in the review as their perspectives are missing.

# CONTRIBUTORS TO THE REVIEW

## Initially, the following agencies were required to submit Summaries of Involvement to allow the panel an opportunity to understand the nature and scope of their involvement with Mr Hedges, Ms Kowalski and/ or ‘L’ during the time period under review.

* Access Care
* Aster Group
* Department of Work and Pensions
* General Practitioners for Mr Hedges and Ms Kowalski
* Hampshire and Isle of Wight Community Rehabilitation Company
* Hampshire Constabulary
* Hampshire County Council - Adults Health and Care
* Hampshire County Council - Children’s Services
* Hampshire Fire and Rescue Service
* Hampshire Hospital NHS Foundation Trust
* Home Group
* National Probation Service
* South Central Ambulance
* Southern Health NHS Foundation Trust (Community & Mental Health Services)
* Test Valley Borough Council - Community Safety
* Test Valley Borough Council – Housing Services
* Test Valley Borough Council – Revenue and Benefits
* Winchester Drugs and Alcohol Service

## Having reviewed the Summaries of involvement, at the initial panel meeting on the 31st January 2018, the following agencies were required to submit Individual Management Reviews and Chronologies:

* Andover Crisis and Support Centre
* Aster Group
* Hampshire Constabulary
* Hampshire County Council – Adults Health and Care
* Hampshire County Council – Children’s Services
* Hampshire Hospitals NHS Foundation Trust
* Inclusion (Formerly Homer) Drugs and Alcohol Services
* National Probation Service
* South Coast Ambulance Service
* Test Valley Borough Council – Housing Options
* Test Valley Borough Council – Revenues and Benefits
* West Hants Clinical Commissioning Group – Primary Care

Each of those agencies were required to:

* Provide a chronology of their involvement with Mr Hedges and Ms Kowalski during the relevant time period using the provided template.
* Search all their records outside the identified time periods to ensure no relevant information was omitted.
* Provide an Individual Management Review (IMR): identifying the facts of their involvement with Mr Hedges, Ms Kowalski and/or ‘L’, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency. Agencies were provided with an IMR template and asked to confirm the independence of the IMR authors.

6.3 Despite many agencies demonstrating their involvement, Homer/ Solent NHS Trust initially maintained they had no records of Ms Kowalski but after several months of trying did manage to provide incomplete and redacted clinical records but no analysis. This frustrated the review considerably.

# THE REVIEW PANEL

## Mr Graham Bartlett was appointed to chair the Domestic Homicide Review panel and be the author for this review. He is the Director of South Downs Leadership and Management Services Ltd. He Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards and, until recently, was the Independent Chair of Brighton and Hove Local Safeguarding Children Board. He has completed the Home Office on line training for independent chairs of Domestic Homicide Reviews and the Social Care Institute for Excellence Learning Together Foundation Course. He has experience of chairing and writing six Domestic Homicide Reviews and is currently lead reviewer for a serious case review and a safeguarding adults multi agency review. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or the Isle of Wight nor any connection with Test Valley Partnership.

## The panel comprised the following members:

* Graham Bartlett Panel Chair
* Andy Pilley Community Engagement Manager (Community Safety). TVBC / CSP
* Allan Appleby Head of Offender Management Delivery; Offender

National Probation Service, South West and South Central

* Andrew Lund District Manager, Hampshire County Council (HCC) - Children’s Services.
* Eliott Smith Safeguarding Adults Named Professional, Southern Health
* Glen Bowyer District Commander, Hampshire Fire & Rescue Service
* Insp Chris Taylor District Inspector, Hampshire Police
* Janice Broomfield Head of Revenue and Benefits,
* Karen Thorburn Housing Manger, TVBC
* Lande Newton Primary Care Commissioning Manager; NHS West Hampshire Clinical Commissioning Group
* Louise Thorpe Housing Manager, Aster Group
* Ruth Attfield Hampshire Constabulary
* Stuart Otterside Interim Head of Learning Disabilities, HCC - Adult Health and Care and Hampshire SAB
* Claire Davies Hampshire Hospitals NHS Foundation Trust
* Tonia Redvers You Trust / DV Specialist Rep.
* Yvonne Bradbury Andover Crisis Centre.
* Wendy De Brune Social \|Worker, HCC - Children’s Services
* Sophie Butt Safeguarding Board Manager, Hampshire LSCB
* Jacqueline Metcalfe Safeguarding Adults Lead, West Hampshire Clinical Commissioning Group

## Whilst all represent their own agencies, none were directly involved in the services provided or the supervision on those providing services to any of the subjects of the review.

# PARALLEL REVIEWS

* 1. There has been a criminal trial, as covered previously and therefore the only parallel review, the inquest, was concluded without a hearing as is usual in the circumstances.

# EQUALITY AND DIVERSITY

## Section 4 of the Equality Act 2010, defines protected characteristics as:

## age;

## disability;

## gender reassignment;

## marriage and civil partnership;

## pregnancy and maternity;

## race;

## religion or belief;

## sex;

## sexual orientation.

## There was an age difference between Ms Kowalski and Mr Hedges and she was variably escribed as his carer and his partner. Whilst their individual and combined presentations were complex, which is articulated in detail below, that age gap was not considered as an issue in and of itself, nor was Mr Hedge’s added vulnerability due to his senior years. These factors are considered in detail throughout the report and add weight to the importance of the safeguarding recommendations in particular.

## Despite the ethnicities of all those subject to this review, their needs did not seem to be influenced by their heritage. In addition, those professionals who had regular contact with any of the people involved regarded them having a high command of the English language, and being able to understand and engage with services when they wished to.

## As a precaution, when the police interviewed Ms Kowalski for the matters that led to this review, they arranged for an interpreter but no one else felt this was necessary in their more day to day dealings with her.

## Ms Kowalski did suggest that her being slapped by Mr Kowalski was a cultural norm. This may have triggered a more finessed response in to help her overcome this apparent tolerance of his behaviour but on that occasion, he was arrested, charged and convicted.

## None of the other characteristics relate to this review.

# DISSEMINATION

## The report has been disseminated to all members of the review panel, as listed above, plus the following people –

* Statutory Community Safety Partnership members of the Test Valley Partnership:
  + Insp Kory Thorne – District Commander, Hampshire Police
  + Cllr Phil North - TVBC / Chair of the Test Valley Partnership
  + Rikki Noble - Station Manager, Hampshire & IOW Fire & Rescue Service
  + Michelle Ennis - Deputy Designate Nurse – Safeguarding Adults; Hampshire, Southampton and Isle of Wight CCG.
  + Jude Ruddock-Atcherley - Strategic Domestic Abuse Manager; Public Health, Adults Health & Care, Hampshire County Council

# BACKGROUND INFORMATION

## On 26th September 2017 Ms Kowalski, was charged with the manslaughter of Mr Hedges following an incident which occurred on 15th November 2016. In May 2018 she was convicted of gross negligence manslaughter and imprisoned for four and a half years.

## At 08:16 hours on 15th November 2016, Ms Kowalski called the emergency services saying that Mr Hedges had fallen over in her home and there was blood everywhere. Ms Kowalski referred to herself as Mr Hedges’ ‘unpaid carer’. The ambulance crew attended and saw Mr Hedges covered in blood on the floor. There was a bucket, containing bloodied water, and mop in the hallway. Mr Hedges had a two-inch cut to his head which had stopped bleeding. There was dried blood on his clothing, head and face, leading to the ambulance crew to think he had been bleeding for a period of time. They asked Ms Kowalski why she had not called for assistance earlier but she did not reply.

## Police arrived shortly afterwards and saw blood dotted and smeared around the floor, on a settee, on bedding, in a child’s bedroom, on door frames and on towels. Ms Kowalski was arrested on suspicion of causing Grievous Bodily Harm to Mr Hedges.

## Mr Hedges was taken to North Hampshire Hospital where he told medical staff and a police officer that he had been kicked a number of times by ‘a lady’. He died the following day. A post mortem examination concluded that the head injury was consistent with contact with a broken plant pot found at the scene. Mr Hedges had noticeable bruising, also consistent with an assault. A medical expert said ‘If the blood loss from the scalp laceration had been prevented or reduced then his life could have been saved.’

## Following Mr Hedges’ death, Ms Kowalski was re-arrested on suspicion of his murder.

## A witness said the first time he went to Ms Kowlaski’s flat on the 14th November 2016 it was clean and tidy. He returned later, after several calls from Ms Kowalski, and found Mr Hedges lying on his side in the hallway. There was blood over him, in the hallway and on the living room floor.

## Mr Hedges and Ms Kowalski lived in the same road as tenants of Aster Group. They were not regarded by friends, family and neighbours as a couple but Mr Hedges told police they had been in a sexual relationship. She, on the other hand, described their relationship as her being his unpaid carer.

## Ms Kowalski had been a victim of domestic abuse from her two previous partners and struggled with her alcohol use. Both of these factors led to her child ‘L’ being made subject of Child Protection Planning on three occasions. Under voluntary agreements, her parents provided care for ‘L’ from time to time. Ms Kowalski has one previous conviction for two offences of driving with excess alcohol.

## Ms Kowalski had financial difficulties, primarily presenting through her struggling to pay her rent, occasionally leading to threats of eviction. She was provided with support in retaining her tenancy by Aster Group. Once, an unrelated man settled her substantial rent arrears on her behalf.

## In the summer of 2016, various agencies received information that Ms Kowalski may be financially exploiting Mr Hedges. While this was shared across agencies, the concerns were never fully explored nor resolved albeit Mr Hedges rejected this suggestion, implying that he was very happy with his relationship with Ms Kowalski.

## Mr Hedges had three previous convictions for seven offences including one for making indecent images of children in 2008 and two, more historical in nature, of possession of a firearm without a certificate in 1991 and GBH in 1983. He also has a 2007 caution for harassment.

## Until July 2016 there was no suggestion that he had ever been a victim of domestic abuse. Moreover, his intimate relationship with Ms Kowalski, such as it was, was not known to any professional or agency until he mentioned it to a police officer in September 2016.

## Concerns were raised from time to time about him having unsupervised access to children. Despite some denials and him minimising the incidents, these were investigated and nothing criminal could be proved. However, given his status as a Registered Sexual Offender, on one occasion a Child Abuse Warning Notice was served to prevent future contact. On others, for example, parents were advised of the contact and his background and he was asked to resign his presidency of the local Royal British Legion.

# CHRONOLOGY AND OVERVIEW

## Mr Hedges was British and lived in the UK all his life. Ms Kowalski is from Poland and moved to the UK in 2006.

## There was no evidence that Mr Hedges and Ms Kowalski met before she moved into the same road as him in May 2015. The first contact between the two known to professionals was in July 2016, four months before the incident which led to this review.

## To most professionals, theirs was not an intimate relationship although in September 2016 he told a police officer it was.

## In 2007, reports of domestic abuse (threatening calls and criminal damage) were made by Mr Hedges’ previous partner against him. Given her reluctance to support a prosecution, only the first instance was progressed with Mr Hedges receiving a caution for harassment. As these happened before the period under review and nine years before the incident, they have not been analysed further.

## In December 2008 Mr Hedges was convicted at Winchester Crown Court of four counts of possession and one count of making indecent images of children. Police had been informed by a computer shop that, whilst servicing his laptop, they found indecent images saved in his document folder. He never accepted his guilt for these offences, variously blaming other, deceased, people for accessing his computer then saying the pictures appeared innocent.

## He was sentenced to a 2-year Community Order and subject to a Sex Offenders notification requirement for 5 years. As a result, he became Category 1 (Registered Sexual Offender) under Multi Agency Public Protection Arrangements (MAPPA) for a five-year period. His initial sentence plan assessed him as posing a medium risk of serious harm to children within the community and a low risk to known adults, public and prisoners. His risk of reoffending was assessed as low. Given his consistent denials, he did not complete a Sex Offender Treatment Programme as acceptance of guilt is a pre-requisite to this.

## He was managed at MAPPA Level 1, initially by the Probation Service until December 2010 and then, on expiration of his Community Order, by the Police until December 2013.

## His supervision by the probation service was within guidelines. However, nothing is recorded regarding an ex-partner he claimed to have slept with in 2009. This is something the NPS IMR author considered should have been included. Additionally, although within guidelines, only one home visit was carried out when more would normally be expected.

## In July 2009, Ms Kowalski was convicted on two counts of driving with excess alcohol, both occurring within the same month.

## During the period prior to the review, police attended three domestic violence incidents where Ms Kowalski was the victim, one at the hands of a ‘housemate’ (August 2009) and two by her then husband (Jan Kowalski) (December 2009 and June 2011). Arrests were made at the first and third of these and her husband was cautioned for common assault following the June 2011 incident. This led to a Children’s Social Care initial assessment in respect of ‘L’, who had been born in October 2010. Given this was the first incident since ‘L’ was born, an appropriate decision was taken to take no further action but to monitor the situation.

## Towards the latter part of 2010 and the early part of 2011 concerns were surfacing about Mr Hedges’ contact with children, notably access he may have had through his presidency of the local Royal British Legion, and with relatives’ and neighbours’ children. These were managed through the MAPPA processes and Mr Hedges resigned his presidency. Efforts were made to obtain a Sexual Offence Prevention Order as officers considered that he was being less than honest over his access to children, but the application had been delayed in the force solicitors’ office. The review has been told that this process has since been streamlined leading to more timely applications.

## There is no record of how that perceived risk was shared with neighbourhood police officers, although it would have been discovered had they researched police systems in response to an incident. Following a 2017 review of inter-operability between Offender Management and frontline officers the review has been told there is now a new drive to manage the risk posed by managed offenders across the force commands.

## Over the period under review, police attended thirteen domestic violence incidents involving Ms Kowalski. At twelve of these she was the victim either from her ex-husband or another partner, Rob Duffy.

## These incidents were variously reported by her, her ex-husband, her mother and, on one occasion, a work colleague.

## In all but one, the police referred the incident through to Children’s Services in the agreed manner. Following eleven of these incidents Domestic Abuse, Stalking and Harassment (DASH) risk assessments were carried out recording risks graded as standard through to high.

## On occasions, counter-reports were made by Mr Kowalski where he would maintain that the argument or dispute had occurred due to Ms Kowalski’s excessive alcohol consumption and the impact this had on ‘L’’s care. Ms Kowalski, in contrast, would deny her drinking, yet was concerned Mr Kowalski may try to take ‘L’ away.

## In December 2011 Ms Kowalski reported being assaulted by Mr Kowalski, who was present at the time of the call. Seven minutes after the initial call, and before police attendance, she called back saying that she wished to cancel the call as it was ‘alright now’. The call handler told her that she could not cancel the call, that police would attend, to which Ms Kowalski replied that she had left the address, refusing to say where she was. Police located her at a friend’s house and found Mr Kowalski there too. He was arrested but Ms Kowalski refused to make a statement of complaint.

## A CYPR (child at risk) form was submitted in respect of ‘L’ who was present during the assault, as was a domestic abuse identification report, AD232r. The incident was assessed as standard risk. Ms Kowalski stated that Mr Kowalski had slapped her around the face and that in Albania, where he came from, this was an acceptable way to treat your wife. As Mr Kowalski admitted slapping Ms Kowalski, despite her refusal to co-operate, he was charged with battery and subsequently convicted and fined £65. Ms Kowalski was identified as a bronze repeat victim requiring further safeguarding action to be considered.

## In January 2012, a work colleague of Ms Kowalski reported he had spoken with her on the phone the previous evening and he could hear ‘a domestic going on between them.’ He said she had rung him that morning and, again, he had heard screaming in the background and possibly kicking. The male at the address had then telephoned him 6 or 7 times and threatened him as he seemed to think that there was ‘something going on’ between him and Ms Kowalski. The caller added that when he saw Ms Kowalski at work she told him how he kicked and punched her and that she had previously come to work with black eyes.

## Police attended and spoke with Ms Kowalski who was present with a friend and ‘L’. There were no recorded injuries or signs of a disturbance. ‘L’ appeared ‘safe and well’ and Ms Kowalski denied that any domestic incident had occurred, as did the friend. Mr Kowalski was said by Ms Kowalski to be asleep as he was working nights. An AD232r was submitted and graded as standard risk. There was no CYPR form submitted.

## From Housing records, it seems that Ms Kowalski separated from her husband around January 2012.

## In May 2012, police officers visited Mr Hedges following information circulating in the community that he had been assaulted nine days earlier. Mr Hedges maintained that he had heard a commotion outside and went out to investigate seeing a man arguing with two others. He said he did not know any of those involved but was punched by one of them. He believed he had been hit by accident hence making no report.

## That same month, Ms Kowalski was admitted to hospital with chest pains which she attributed to the break-up of her marriage. She disclosed during her treatment that she was using alcohol more. This information was shared with Children’s Services who took the view not to carry out an assessment as Ms Kowalski had parental support.

## In late May 2012, Mr Kowalski called police to report that he was visiting Ms Kowalski to see ‘L’. Ms Kowalski was demanding that he took ‘L’ as she did not want to keep her. Mr Kowalski was concerned that Ms Kowalski would report him to the police. He stated that he could not take his child as he could not accommodate her. Police advised him this was a civil matter and all the police could do if they attended was prevent a breach of the peace. Ms Kowalski then called police and an officer was deployed due to the history of violence in the relationship.

## Mr Kowalski told the officers he had recently split from Ms Kowalski and had moved out. He said he had taken ‘L’ out for the day but received around twenty calls from Ms Kowalski asking where he was, so he returned. He found that Ms Kowalski had been drinking and he did not know what to do. He could not take ‘L’ as he was staying in one room in his uncle’s house. Ms Kowalski stated that Mr Kowalski had threatened to take ‘L’ to Albania. Officers were concerned about Ms Kowalski coping with her situation but considered her not too affected by alcohol to be unable to care for ‘L’ at that time. There were no offences disclosed and police advised both parties to seek legal help to resolve their issues.

## Following a referral to Children’s Services, an initial assessment highlighted no significant concerns. However, they were both advised to be mindful of not exposing ‘L’ to conflict and for Ms Kowalski to be careful that her alcohol intake does not become problematic. The case was closed.

## In July 2012 a Children Centre keyworker reported Ms Kowalski’s highly distressed emotional behaviour during a recent home visit by Children’s Services. Ms Kowalski had said Mr Kowalski continued to let himself into the property perpetuating a risk of domestic violence. She had shown the keyworker bruises on her arms.

## Given the bruises, for the first-time, suspicion was raised that Ms Kowalski was not being wholly honest about her situation. It does not seem the evidence of the bruising was shared with police. An initial assessment visit by Children’s Social Care that followed, on the face of it, went well with Ms Kowalski providing reassurance that she was able to cope and keep ‘L’ safe and that she was receiving support for her drinking. Children’s Services kept the case open for monitoring. During one of the monitoring visits in August 2012, Ms Kowalski assured the worker she was controlling her drinking. She was recorded as being four weeks abstinent and thus had been discharged from the Substance Misuse Service that she had been referred to by the GP in June of that year.

## In an unconnected incident, in August 2012, Mr Hedges was admitted to hospital with a head injury having fallen over while drunk.

## Following the one incident where Ms Kowalski was named as the alleged perpetrator, in October 2012, she was arrested to prevent a breach of the peace. This followed a minor verbal disagreement with her mother over her drinking. The officer said ‘L’ ‘did not seem distressed and she was clean and had clean bedding in her cot and looked cared for’. The officer added that they had ‘some concerns for ‘L’ if the grandmother was not about’ due to Ms Kowalski’s escalating drinking which had worsened over the previous 10 days. She had been drinking at least 7-8 cans of beer a day and that night had drunk about 10. The officer warned Ms Kowalski about her drinking.

## This was referred to Children’s Services and a DASH risk assessment was completed which assessed the level of domestic violence risk as standard. An initial assessment was authorised but the incident was subsequently minimised by both parties and regarded as a one-off incident, resulting in it being closed to social care.

## Throughout 2012, Ms Kowalski saw her GP for a range of issues including, stress, chest pains, a knee injury and her alcohol use.

## In May 2013, Ms Kowalski received a verbal warning from Aster Group after complaints over her excessive alcohol use.

## In June 2013, further concerns were emerging over the effect Ms Kowalski’s alcohol use was having on her ability to care for ‘L’. The Housing Support Worker reported that she had been given a written warning after her and a visitor had consumed alcohol to excess while she had been caring for ‘L’. During a barbecue, Ms Kowalski had gone out with a male friend while drunk to buy alcohol, leaving ‘L’ alone, sleeping in the room with the door unlocked. When she returned, half an hour later, she was questioned, became annoyed and left again. Ms Kowalski told the Housing Support Worker that ‘L’ was left in the care of resident in the room opposite. This resident did not confirm this version of events. The incident was referred to Children’s Services.

## ‘L’’s pre-school referred her to Children’s Services around the same time. Two days in a row, Ms Kowalski had been smelling of alcohol when she collected ‘L’, appearing confused and flustered. Given the history, a Section 47 Child Protection Investigation was considered.

## During the assessment visit, Ms Kowalski provided a very different account of the hostel incident but it was not clear if the pre-school incidents were raised.

## In July 2013, the pre-school referred a further incident. This time they advised that Ms Kowalski did not pick ‘L’ up from pre-school, but someone referred to as “uncle” did. On the way out, “uncle” twice fell down the hill outside. Staff went to assist him but he hurried away. Ms Kowalski was seen hiding in the passenger seat of his car and ‘L’ got in, sat on Ms Kowalski’s lap and they were driven off. As a result, this case also progressed to a Child Protection Investigation. Again, Ms Kowalski minimised and questioned the accuracy of the reports. Children’s Services updated Aster Group of this new information.

## During these investigations, Mr Kowalski raised his concerns of her drinking. The following month, August 2013, ‘L’ was made subject of Child Protection Planning (CPP) under the category of neglect.

## In an unconnected event that month, Mr Hedges attended Minor Injuries Unit with a left shoulder injury sustained five days previously. He said he had fallen onto shoulder and noticed bruising over the last 2-3 days. He had an X ray and was discharged with no follow up advised. There seemed to be no reason to question his explanation.

## During the child protection visits that followed ‘L’ being put on a CPP, her ad hoc contact arrangements came to light as did Ms Kowalski’s friendship with a 68-year-old neighbour, Henry Scott. He maintained they were due to get married while she denied any form of relationship.

## During one visit by the Housing Support Worker in August 2013, and another by Children’s Services in September 2013, Ms Kowalski seemed to have facial bruising. The Housing Support Worker did not speak to her about it as Ms Kowalski was not alone, but did refer it to the substance misuse provider as she also suspect alcohol misuse. When challenged by the social worker, Ms Kowalski denied the marks were injuries. Concerns continued over whether Ms Kowalski was being honest that the violence had stopped.

## That month, a social worker referred Ms Kowalski to the Freedom Programme[[3]](#footnote-3), a 12-week rolling support group for women who are or have been victims of domestic abuse, which aims to help them understand how domestic abuse effects children, how to recognise a potential future abuser and to help women build self-esteem and confidence. She did not complete her registration.

## Over the following months there were many contradictions between what Ms Kowalski was telling professionals and incidents where she was seen drunk. These included where she was reported to Aster Group as being drunk and asking the informant to buy wine, which she refused. The informant was also concerned that Mr Scott was harassing her. Given Mr Scott’s assertions of them being in a relationship it is not clear whether this was regarded as domestic violence, or if Aster Group knew he had said they were getting married.

## Ms Kowalski denied to the Housing Support Worker that she was drunk but said other visitors were drinking and loud and she had threatened to call the police. When they discussed Mr Scott’s harassment of her, Ms Kowalski said her mother had spoken to him and if this did not resolve the matter, she would inform the police.

## Around this time there were occasions she was either not available for or declined alcohol testing. Professionals were concerned as to the risk to ‘L’ that this level of deceit may be concealing. It was not clear what the escalation arrangements were regarding non-compliance with testing arrangements. Records show that, almost every time she was tested the results were negative but notes indicate that these tests were always announced and more random testing with very short notice should be considered. Nothing suggests this happened.

## In November 2013, shortly after ‘L’ was stepped down from a CPP to Child in Need, Ms Kowalski and ‘L’ moved to temporary accommodation following a multi-agency decision that she was engaging well. Shortly after that move, concerns around her drinking perpetuated and she failed one alcohol test. She maintained that was while she did not have care for ‘L’.

## Concerns reached such a level in November 2013 that Mr Kowalski was asked by Children’s Service Out of Hours Service to collect ‘L’ and look after her to protect her from her mother’s alcohol related behaviour. When he returned ‘L’ the following day, the flat doors were all open and Ms Kowalski was asleep covered in vomit, something she later attributed to food poisoning. He took ‘L’ away, a move sanctioned by social care. As a result, Ms Kowalski signed a working agreement regarding her alcohol use.

## That month the substance misuse service referred Ms Kowalski to the Freedom Programme. The providers spoke with her on the phone but, again, she did not enrol.

## In January 2014, reports from the school and the lack of apparent progress either with Ms Kowalski’s drinking or her candour about it, led to concerns in Children’s Services that ‘L’ may need to revert to a CPP and if so, the Local Authority would seek legal advice. Children’s Services said it would instigate Child Protection Investigation should it receive another report. Despite several reports that followed, this did not happen until August 2015.

## In January 2014, Ms Kowalski referred herself to the Freedom Programme but could not attend as there were no creche places available.

## When a further concern was raised in February 2014 that Ms Kowalski had dropped ‘L’ off while drunk, she decided to move ‘L’ to another preschool.

## In May 2014, following Ms Kowalski calling the police, Mr Kowalski was arrested for assaulting her. The absence of injuries and his denials led to him being released without charge but appropriate referrals were made. This led to ‘L’’s paternal aunt and uncle raising concerns about Ms Kowalski’s drinking, her fabricating incidents and her capacity to care for ‘L’. A DASH risk assessment concluded a medium risk to Ms Kowalski and safeguarding advice was provided with the appropriate AD232a form completed by the safeguarding officer. A CYPR was submitted to Children’s Services and a CA12 (adult at risk) form submitted to Adults Health and Care regarding risks to Ms Kowalski.

## Later that month ‘L’’s new pre-school referred to Children’s Social Care that Ms Kowalski had dropped her off while smelling of drink. When challenged by social workers, she denied she had been drinking also denying that she smelt of drink during the social work visit. She held up the number of breath tests she had passed as examples of her sobriety. She had cancelled one that day. The social worker suggested that may be due to her having been drinking. A safeguarding meeting which followed agreed a range of measures to help her to control her drinking while protecting ‘L’.

## An unannounced visit from substance misuse service later that month found her to be three times over the drink drive limit. This, together with information from a friend that she was ‘pulling the wool over the eyes’ of the substance misuse service, led to an agreement being reached that ‘L’ would be cared for by her grandparents over the weekend.

## In June 2014 Ms Kowalski saw her GP to request medical alcohol detoxification which had been advised by HOMER. A prescription was provided and she was reminded that she must remain alcohol free.

## In July 2014, concerns emerged that Ms Kowalski was avoiding professionals by not being available for visits, albeit these were unannounced. Conversely, other than a report of her being drunk while visiting her father in hospital, professionals reported that she was making efforts to control her drinking.

## Also, in July 2014, police were contacted by Children’s Services that Mr Hedges was having contact with a 14-year-old girl. This was an ongoing safeguarding issue and Children’s Services appeared to have assumed responsibility. There was no recorded contact between police and the girl, although it was possible that Children’s Services had asked appropriate questions regarding possible offences, but this was not recorded on police or Children’s Services records. There was no recorded contact with Mr Hedges, either by police or Children’s Services.

## Between July 2014 and February 2015 no concerns emerged. As a consequence, Weekly Children’s Service visits reduced to fortnightly then three weekly. Ms Kowalski was said to have made significant progress and started to show insight into her alcohol misuse and its impact on ‘L’. Substance Misuse Service reported excellent progress and she received a voucher in recognition. Overall, she appeared to be managing her abstinence well and there were no concerns raised from the school and no reports of her being drunk. Given similar information from all other agency checks, the case was closed with no further role for Children’s Services at that time.

## During this period, she enrolled on the Freedom Programme but only attended once. She was taken off the programme in early November 2014 for non-attendance.

## In January 2015, information was received by police that a 12-year-old boy, was visiting Mr Hedges at his home. He would stay for around twenty minutes leaving friends outside, returning to his friends with new clothes and tobacco. The boy was vulnerable with regular incidences of going missing. Police attended Mr Hedges’ address on the same day and spoke with him. He said that he knew the boy as one of a group of young people that had visited him since November 2014. He was a friend of the girl previously referred to. The boy said he had been introduced to Mr Hedges in October by the girl who, he thought, was Mr Hedges’ granddaughter. He said he would make tea and food for Mr Hedges who would give him tobacco in return. He said he had not been victim of any offence. His step-father was seen and agreed to ban him from visiting Mr Hedges. A statement was obtained from the step-father to this effect which allowed for a CAWN (child abduction warning notice) to be served on Mr Hedges. A CYPR form was submitted to Children’s Services.

## In May 2015 Ms Kowalski moved to the same road as Mr Hedges.

## In August 2015, Ms Kowalski’s mother called the police following a domestic dispute between Ms Kowalski and her new partner, Mr Duffy. When they arrived, Ms Kowalski minimised the incident and advice was given. Referrals were made to Children’s Social Care and to Ms Kowalski’s GP which, given the recent closure of the case, triggered an assessment. During the visit she denied anything had happened and that her mother was making trouble. No further social work action was taken. A DASH risk assessment scored Ms Kowalski at standard risk of harm. She informed Aster Group that month that her partner had moved out.

## The following month a neighbour called the police on hearing a heated argument and both Ms Kowalski and ‘L’ sobbing. On arrival, both Ms Kowalski and Mr Duffy denied anything other than an argument. ‘L’ seemed safe and happy. Aster Group recorded that the argument continued into the early hours, after police had left, and a neighbour heard a very loud bang that sounded like something being thrown against the wall. No further action was taken but social care referrals were made. A DASH risk assessment scored Ms Kowalski at standard risk of harm.

## The following month, October 2015, an abandoned 999 call from a male caller seemed to suggest a domestic dispute between Ms Kowalski and Mr Duffy. When they were eventually traced, they denied anything had happened so no further action was taken, other than a Children’s Services referral which also did not lead to further action. A DASH risk assessment scored Ms Kowalski at standard risk of harm.

## Five days later Ms Kowalski’s neighbour and her mother reported a domestic abuse incident between Ms Kowalski and Mr Duffy which had been going on for four hours. When her mother had arrived, at Ms Kowalski’s request, Ms Kowalski had a severe laceration to her head. It was believed that Mr Duffy forcibly pushed Ms Kowalski’s head against the bathroom wall, causing the subsequent injury. Police transported Ms Kowalski to hospital as, according to the police, ambulance services did not make the call a priority and therefore had no unit to attend. The ambulance service has no record of this call.

## Mr Duffy was charged and remanded in custody for GBH but was later acquitted at Crown Court, although a restraining order was made. There was a suggestion, a few days after the order was made, that it had been breached by friends of Mr Duffy visiting Ms Kowalski. This was deemed to have been a reasonable, if ill thought through, attempt to recover property.

## During a child protection visit following this incident, ‘L’ disclosed that Mr Duffy had assaulted Ms Kowalski. Ms Kowalski, however, minimized his violence and did not appreciate the risk this posed to her child. Given the recent history of domestic abuse and Ms Kowalski’s apparently not telling the truth during previous calls about whether Mr Duffy was at the address, a Section 47 investigation was triggered. During this, a joint police/ Children’s Services visit was conducted. A resident in the block of flats disclosed to police that, on three occasions recently, she has seen Ms Kowalski leave ‘L’ locked in the flat when she went to the local shops and that she has seen Ms Kowalski heavily intoxicated as early as 9.00am.

## This investigation resulted in ‘L’ being made subject to a Child Protection Plan under the category of neglect. A DASH risk assessment scored Ms Kowalski at high risk of harm leading to a referral to Andover MARAC.

## Following this incident, and others including information that Ms Kowalski had befriended an unnamed older man who was helping her and who she may be taking financial advantage of, various attempts were made by Aster Group anti-social behaviour officer to make both announced and unannounced calls on Ms Kowalski. They finally succeeded at the end of October 2015. The day after the visit, a significant rent payment was made on Ms Kowalski’s behalf through a cheque in the name of an apparently unrelated elderly man. He had gone to Aster Group office with Ms Kowalski to discuss her arrears and said 'let’s get it over and done with' then asked if he could pay by cheque. This method of settling arrears is not uncommon among Aster tenants.

## Over this same period, intelligence was received that Ms Kowalski was engaged to Nick Rees who was due to be released from a custodial sentence having been convicted of burglary. A CYPR sent to Children’s Services showed he had a prolific record for burglary and drug use and was subject of a MARAC with a previous partner in 2011 following an assault where he grabbed her around the neck

## In the early hours of 8th November 2015, Ms Kowalski’s neighbour contacted police to report a disturbance at Ms Kowalski’s home. Mr Kowalski was at the address intoxicated, demanding that Ms Kowalski gave ‘L’ to him. ‘L’ was not at the address but staying with her grandparents. Ms Kowalski’s 79-year-old neighbour, not Mr Hedges, who had been assisting with DIY, attempted to intervene. The neighbour and Mr Kowalski grappled with each other during which the neighbour fell to the floor and hit his head. Ms Kowalski received scratches on her arm where Mr Kowalski had grabbed her. Damage was also caused to property inside the address.

## Mr Kowalski was arrested and subsequently convicted of these offences and the matter was referred to Children’s Services. A DASH risk assessment scored Ms Kowalski at medium risk of harm but was reduced by Multi Agency Safeguarding Hub (MASH) to standard.

## In November 2015 Ms Kowalski’s case was heard at MARAC. Prior to this, the Independent Domestic Violence Advisor (IDVA) (believed to be from the YOU Trust but they have no records of Ms Kowalski) referred her to the Freedom programme.

## The MARAC heard that Ms Kowalski ended the relationship with Mr Duffy in August 2015 but he would not accept it was over. His behaviour was escalating, he was controlling as well as violent and had issues with alcohol. Police had previously referred Ms Kowalski to the IDVA and requested housing change the locks. Ms Kowalski had signed a contract of expectations with regard to her safeguarding ‘L’. Housing noted many neighbours’ complaints regarding domestic arguments at the property and that Ms Kowalski was in arrears with the rent.

## While there was a great deal shared about Ms Kowalski and her issues, the only action from the MARAC was for police to gain more information from Aster in relation to the neighbourhood issues/complaints and carry out joint visit with them. Due to the way by which MARACs are conducted the outcomes of these actions and whether they improved outcomes for Ms Kowalski or ‘L’ are unknown.

## In December 2015, following a further call from ‘L’’s pre-school regarding Ms Kowalski smelling of alcohol when she dropped ‘L’ off at school, Children’s Services visited Ms Kowalski at home. Upon leaving the address a Housing Association employee arrived. She said that Ms Kowalski had attended their office on a number of occasions obviously very drunk. She denied this.

## That month, Ms Kowalski attended the Andover Minor Injuries unit with a cut finger which she sustained while cleaning. A ring was removed due to swelling but there is no record of anyone considering or discussing domestic abuse. She also attended her GP as she was experiencing abdominal pains and feared she might be pregnant. Tests were negative but she did say that she had left Mr Duffy.

## Around Christmas 2015, concerns continued over Ms Kowalski’s supposed relationship with Mr Rees. While she denied it, others maintained that she was in a relationship. This included the National Probation Service. This information was first known to Aster Group in July 2013 but only that he was a man called Nick. They knew nothing of his background. The Housing Support Worker was in regular contact with Children’s Services during this period and reports raising any concerns that she was aware of. Given the ambiguity, Children’s Services made it clear that he was to have no contact with ‘L’. Later information suggested that Ms Kowalski and Mr Rees had been engaged for two years, since he was imprisoned.

## Following the MARAC, Ms Kowalski attended eleven of the twelve Freedom Programme sessions from January 2016 to March of that year.

## The Review Child Protection Conference in January 2016 agreed that the current situation remained extremely concerning. The history of domestic abuse was regarded as significant and it was felt that Ms Kowalski had placed ‘L’ at risk by entering her recent relationship given Mr Rees’ history of domestic violence and substance misuse. Despite Child Protection Planning, little change had been observed in Ms Kowalski’s understanding of the risks and her ability to prioritise ‘L’. In addition, there were still questions over Ms Kowalski’s alcohol use and the impact this has on her ability to care for ‘L’. It was unanimously agreed that ‘L’ remain on a Child Protection Plan.

## In January 2016, on advice from her social worker, Ms Kowalski attended a police station and applied for police to disclose background information regarding Mr Rees. The disclosure included convictions for two incidents of domestic violence, two incidents of criminal damage of an ex partner’s car and a window and harassment style incidents for which he was not charged.

## That month, Ms Kowalski reported that in December 2015 Mr Kowalski approached her in the street and asked her to lie for him in a forthcoming court case. There was no violence nor threat of it. Ms Kowalski maintained she only became aware she needed to report this to police at the review child protection conference. Given the incident happened some weeks previously and the court case was imminent, together with there being no violence or threat of it, the decision was taken to simply disclose it to the CPS and take no further action other than undertake further risk assessments.

## In February 2016, during a child protection visit, Ms Kowalski said that she attended court the previous day at Basingstoke in relation to Mr Kowalski assaulting her elderly neighbour but he had not attended, leading to a warrant being issued for his arrest. Ms Kowalski thought he may have left the UK and gone back to Albania. She said that she has not seen Mr Rees, adding that he had ended the relationship due to Children’s Services being involved and police not allowing him to live with her. There is no evidence that the police told Ms Kowalski or Mr Rees that but she may have inferred it or they may have done so informally. Mr Kowalski was eventually arrested under the warrant in August 2016.

## In May 2016, Ms Kowalski was admitted to hospital following seizures. She was prescribed Trimethoprim and discharged but did not keep any of the following neurological appointments.

## From May 2016 to November of that year, despite the man previously clearing her arrears, they rose to over £1300. Various interventions were made by the Debt and Benefit Advisory service and it was during these, in October 2016, that suggestions that Mr Hedges should apply for attendance allowance were made if she wanted to go through with her intentions to apply carers’ allowance in respect of him.

## In June 2016, the ambiguity over whether Mr Rees was in a relationship, or living, with Ms Kowalski continued. Reports ranged from him banging on her door, to leaving his rucksack through an open window to the possibility that they had resumed an on/ off relationship. Ms Kowalski denied any relationship when challenged. This was never considered as a possible risk to Ms Kowalski or ‘L’ and no safeguarding visits were carried out.

## At the end of June 2016, Information was received from the NSPCC regarding concerns for welfare of ‘L’ due to Ms Kowalski’s drug and alcohol use. Research identified that this was similar information to that received by ‘L’’s school. It was reported that due to Ms Kowalski’s abuse of alcohol, ‘L’ often misses school which Ms Kowalski justifies as due to illness. This was the first and only time Ms Kowalski using drugs has been suggested. There was no evidence she was. It was agreed, through the MASH, that Children’s Services would investigate this as a single agency. The outcome of this is not known as it does not appear in Children’s Services records.

## Two days after this information, Ms Kowalski collapsed and was taken to hospital. An Echo Cardiogram was normal, vasovagal (fainting) was diagnosed and she was referred back to her GP.

## On the 6th July 2016, several pieces of information were received by Children’s Services, Adults Health and Care and the police linking Ms Kowalski with Mr Hedges for the first time.

## A neighbour informed Adults Health and Care that she was concerned Ms Kowalski was financial abusing Mr Hedges. The caller described Ms Kowalski as being known to the police and a heavy drinker. She said Mr Hedges had no family, was also a heavy drinker and had the onset of dementia. She said that two weeks previously Ms Kowalski scammed another resident, getting him to spend thousands on a freezer and other goods for her. She felt Ms Kowalski was now targeting Mr Hedges.

## She continued to say that Mr Hedges was not supposed to be driving due to dementia and his drinking but, lately, he had been staying overnight at Ms Kowalski's property, going out early to buy alcohol and going to Ms Kowalski's to drink it. Later on, Mr Hedges would pick ‘L’ up from school. The caller said the staff in the shop said Mr Hedges would buy a bottle of water and get £50 cash back because 'Nadia needs it'.

## The caller was concerned that he had also cut off all his friends who previously took him shopping. She told Adults Health and Care that the police had been given Mr Hedges’ car registration number and were going to keep an eye out.

## Later the same day further information came from the same neighbour who had, by then, spoken with another. The second neighbour said that Mr Hedges had previously been in a relationship with ‘a lady upstairs’, that he was ‘a known drunk’ who used to ‘beat that lady a lot.’ It was also said that Mr Hedges started spending a lot of time with a young girl who was then aged 12. Near Halloween, the informant found ‘two young girls at Mr Hedges’ with their pyjamas on the floor.’ It was never clear whether it was the girls or their pyjamas that were on the floor. The two young girls, who were neighbours, had recently been spending a lot of time with Mr Hedges at Ms Kowalski’s. The caller was very concerned. Both these pieces of information were reportedly referred to the police the same day but they have no record of that being the case. Had they have been, it is highly likely the police and Children’s Services would have triggered a Section 47 investigation and considered the possibility of child sexual exploitation. As they did not, this was a missed opportunity.

## That day, the police received an anonymous call regarding an elderly male, called G, who was a heavy drinker who had become friendly with a younger female neighbour, also a heavy drinker. They had gone in G’s car to collect the woman’s child from school. The caller was concerned that G drives while drunk. The vehicle details given were incorrect but research identified that Mr Hedges had similar vehicle to the one described. Police went to the school but the vehicle was not there. It was later found parked outside Mr Hedges’ address unattended. They kept it under observation but it did not move. The information was recorded for future stop checks.

## The information regarding financial abuse was considered with the duty MASH manager and MASH police sergeant who confirmed there had been historical concerns regarding Mr Hedges and young children. The anonymous call regarding his drinking was linked. Checks showed that ‘L’ was known and open to Children’s Services and the information was passed on. The information was also passed to Adults Health and Care area office for their consideration and to inform Mr Hedges’ GP of concerns regarding his mental health and drinking.

## Inclusion confirmed to Adults Health and Care that Ms Kowalski was no longer a client of theirs having again been discharged following her successful completion of treatment about a year previously. She had attended structured group support but she had significant denied her drinking. A Family Intervention Team worker had planned to visit Ms Kowalski the previous afternoon but was told by Ms Kowalski’s mother that she had been called in to work.

## It was suggested that safeguarding regarding Mr Hedges be considered given the reports that Ms Kowalski was financially abusing him, that they were spending a lot of time together drinking and the concerns that Mr Hedges was allegedly collecting ‘L’ from school while drunk.

## The Team Manager’s response that day was ‘I think all being done by other agencies, just need to check GP being informed & ref to OPCMHt (Older People’s Community Mental Health Team).’ The Section 42 safeguarding process was not considered nor was a Care Act needs assessment.

## The same day, Adult Health and Care wrote to the GP as requested, also confirming there was currently no involvement for Adult Health and Care. This resulted in the GP inviting Mr Hedges to make an appointment to discuss the concerns over his mental health and drinking.

## On the 9th July 2016, police received information that Mr Hedges had been seen chatting to two children sitting in a car with two adults. This was thought as possibly him attempting to groom the children and parents. It was confirmed to be Ms Kowalski’s car and ‘L’ was likely to have been in the car. This information was cross-referred to the previous recent calls, but not checked further given an assumption that Ms Kowalski had two children – rather than just ‘L’ - and, as it was her car, that the children must have been hers.

## On the 11th July the original informant’s manager called Adults Health and Care and repeated the information provided on the 6th July.

## On the 13th July 2016, Mr Hedges visited his GP complaining of low back pain having fallen the week before. The presence of a previous T7 fracture was noted and Mr Hedges was prescribed some milder pain killers for the discomfort. It did not appear that the matters referred following the 6th of July calls, were discussed nor was there any suspicion of him being a victim of violence.

## The following day, at a Review Child Protection Conference, Ms Kowalski was asked about her relationship with Mr Hedges. Concerns were also raised over her history of alcohol misuse and whether she was drinking with Mr Hedges. Ms Kowalski was asked about the allegation of Mr Hedges driving ‘L’ to school whilst under the influence of alcohol. Ms Kowalski denied this and told the meeting that she was helping him as he was elderly and had some falls. Despite the new information, on a majority decision, ‘L’ was stepped down to a Child in Need Plan due to the efforts made by Ms Kowalski and availability of ‘L’’s grandmother for support.

## On the 26th July 2016, Police visited Mr Hedges regarding the information given on the 6th July. They found Ms Kowalski at the address who left, allowing the officers to speak to Mr Hedges alone. He stated that he was friends with Ms Kowalski’s parents and had met Ms Kowalski when he spoke to her regarding her child playing with other children outside the block and they had become friends.

## Ms Kowalski returned and explained she was applying to become a carer and was obtaining a DBS check. When she left again, the officers explained to Mr Hedges they were concerned he may be vulnerable to exploitation from Ms Kowalski. He denied it was an exploitative relationship saying it was his informed choice to continue to see her. They assessed he had the capacity to make and understand that decision. The officers expressed their concern, due to his previous conviction, that he was seen to be associating with Ms Kowalski’s child. A CYPR form was submitted regarding ‘L’.

## On the 3rd August 2016 police received further information from Mr Hedges’ neighbour about his relationship with Ms Kowalski, repeating earlier concerns but adding that Mr Hedges had recently been ill. They said that Ms Kowalski was telling people she was Mr Hedges’ carer despite being untrained and she was making him drive when he was unwell. She was said to have access to his belongings and money and he may pose a risk to ‘L’ as he had been left alone with her and, on one occasion, was ‘overly friendly.’ Although the police response was delayed, the matter was referred to Children’s Services that day, but did not trigger any role for them other than to monitor the situation and to provide advice that Mr Hedges should not be left alone with ‘L’.

## Police did not visit Mr Hedges until early September 2016. Mr Hedges disclosed that he and Ms Kowalski had some sexual contact and that he had paid for items such as her shopping, all of his own free will and without coercion. He said he would voluntarily give Ms Kowalski and ‘L’ lifts. He said he enjoyed Ms Kowalski’s company as he can often get lonely. He disclosed that Ms Kowalski had applied to be his carer and he was happy with this future arrangement. Mr Hedges was advised that Police would be making a referral to Adults Health and Care, which he was content with, acknowledging the advice given and agreeing to consider the situation. An adult at risk form was not submitted to Adults Health and Care.

## On 16th August 2016, Mr Hedges saw his GP regarding the concerns referred over his dementia and drinking. A dementia assessment showed there to be no problems and Mr Hedges denied drinking. Mr Hedges did report a loss of ten kilos in the previous ten months and also appeared anaemic. He was referred to the Geriatric Service at Andover War Memorial Hospital. This appointment highlighted no concerns.

## On 22nd August 2016, North Hampshire Magistrates Court issued a Restraining Order against Mr Kowalski to prevent contact with Ms Kowalski until further order.

## On the 29th September 2016, at a Child in Need monitoring visit, ‘L’ was sitting on Mr Hedges’ lap. Another (female) neighbour was also in the home. As this neighbour left, she surreptitiously asked the social worker to call on her after the visit. Ms Kowalski was asked about her alcohol consumption. She said she only drinks at the weekend and does not get drunk. She was also asked about Mr Hedges, who she says she is helping as he is ‘85 (sic) years old, lacks family, is lonely, that they are friends and she trusts him.’

## The Social Worker then went to the neighbour’s home. She held significant concerns regarding ‘L’ due to Ms Kowalski’s alcohol consumption and her contact with several older men. The neighbour believed that Ms Kowalski was gaining money from them. She said these men often went to Ms Kowalski’s home late in the evening. She also expressed concerns for Mr Hedges, saying she believed Ms Kowalski has gained £6,000 from him and let him pay for rent and food. She also disclosed that Mr Hedges had an interest in young girls and believed that ‘L’ could be at risk from him. She said she had already shared this information with the police but was sharing it again as she was very concerned about the situation as a whole It is not clear what happened as a consequence of her previous disclosure.

## On 11th October 2016, a debt and benefit advisor from Aster Group carried out a home visit to Mr Hedges regarding his attendance allowance and found Ms Kowalski there. The advisor reported that the meeting made her feel uncomfortable as Ms Kowalski was being over-friendly and in her personal space whilst Mr Hedges was ‘in charge,’ telling Ms Kowalski what to do, which she complied with.

## On the 17th October 2016, the police received a report of Mr Hedges drink driving. His vehicle was stopped and Ms Kowalski and ‘L’ were in the car. He provided a negative breath test. The police were concerned over the relationship between Mr Hedges and Ms Kowalski as he had been linked to other young families/children with whom he had no familial connection and they questioned his motives for forming these friendships. As a result of these concerns, Children’s Services called Ms Kowalski and advised her that ‘L’ was not to have contact with Mr Hedges, which she agreed to.

## Later that day, Ms Kowalski’s sister called police to raise concerns for the ‘L’’s welfare. She and her parents were becoming increasingly concerned over Ms Kowalski’s drinking and her capacity to care for ‘L’. The sister said, that evening she had seen Ms Kowalski pull ‘L’ by the hair. She was also concerned over Mr Hedges giving ‘L’ a lift to school in the mornings. Police had attended the address but received no reply. A referral was made for a single agency investigation by Children’s Services, who noted that they were to speak to Ms Kowalski about it.

## On 18th October 2016, an attempt for a Child in Need visit was unsuccessful. The opportunity was taken to visit Mr Hedges, however. He said he had seen Ms Kowalski that morning and she asked him to buy her some sanitary towels which he took to her home. He confirmed that Ms Kowalski was aware of his previous Registered Sexual Offender status. He maintained he was wrongly accused but said he had never looked after ‘L’ and understood the concern. He said that ‘it was a shame, she is cute as hell.’ He said Ms Kowalski was not his official carer but was waiting for her P45 so she could claim benefits to care for him.

## That day, police received a request from Children’s Services for information relating to Mr Hedges due to reports that he was a risk to children in the neighbourhood. The information requesting the disclosure stated it had “been alleged that he has had young children (not related to himself) at his address in their underwear”. This information did not seem to have been passed to police in any other form and the information request is the only reference of it. The police provided the information the same day.

## Later that day a Child in Need visit was made at ‘L’’s grandparents’ home. ‘L’ was spoken to and said she ‘didn’t like it when her mother drinks.’ She said ‘she doesn’t do it all the time’ but when she does her mother 'gets cross and sleepy.’ Her Grandfather had been to Ms Kowalski’s home that morning and found ‘L’ had not gone to school. As Ms Kowalski was sleeping, he brought ‘L’ home. Whilst there, Ms Kowalski telephoned and denied having a problem with alcohol. When questioned about the hair pulling incident the previous day, Ms Kowalski said that her sister sometimes lies.

## It was decided that the social worker and grandfather would go to Ms Kowalski’s address to inform her that ‘L’ would be staying with her grandparents for some time. On arrival they rang the bell and called several times. The Grandfather tried his key in the door but was unable to gain access.

## On leaving the property, a concerned neighbour approached wanting to give information that Mr Hedges and Ms Kowalski had been seen in a car, clearly drunk. Ms Kowalski had fallen on the ground and Mr Hedges could hardly open the door but they still went to the school to collect ‘L’. Furthermore, she said that Ms Kowalski had been involved with another older man, who it is alleged that Ms Kowalski had taken £6,000 - £7,000 from. She said Mr Hedges had paid £800 from Ms Kowalski’s rent arrears. Further she said that another man in a Mercedes had been going to her home and staying during the week. The neighbour said these concerns had been reported to the police. The police had no record of them in this form and detail.

## Following these events and information, a strategy discussion was held with the police which concluded that a single agency investigation would be undertaken by Children’s Services and a S47 Child Protection Investigation was initiated. Various information requests were made of the police in support of this. The safeguarding of Mr Hedges seems not to have been considered, possibly due to the decision taken earlier by the Team Manager in Adults Health and Care that this matter was not a safeguarding issue.

## On 21st October 2016, Children’s Services were due to meet with Ms Kowalski. She text to say she had a dentist appointment, despite previously saying she had a job interview. It appeared she was struggling to remember information she had previously provided. She later phoned to say she could not meet and was not at home. Her speech was slurred and it became increasingly difficult to reason with her but she denied she had been drinking. She did not appear interested in talking about the previous week’s incident only saying that ‘L’ was with her parents and would be staying with them for some time. She was advised that if she tried to take ‘L’ from her grandparents while she is drunk, they would call the police.

## At a Child Protection monitoring visit on the 26th October 2016, Ms Kowalski appeared sober but it was suspected that she had been drinking as she appeared flushed and anxious. She denied she had a problem with alcohol and disputed the reports from neighbours and family. She said she was the victim and accepted she was not a good judge of character but thought Mr Hedges was a “nice old man” who needed help with independence. She said that he no longer visited the house but she visits him as she had applied to be his carer. A Working Agreement was put in place including that she engaged with the Substance Misuse Service.

## On 1st November 2016, ‘L’’s school contacted Children’s Services as she had complained of a sore arm. When asked, she said her grandfather hurt it, and made a twisting motion. She was allowed to return home with her grandparents and a Child in Need visit to see her there followed. ‘L’ was not at home but out with Ms Kowalski and a family friend. It was pointed out that Ms Kowalski should not have sole care of ‘L’ until she addressed her alcohol issues. ‘L’’s Grandmother considered it safe as a family friend was with them and that Ms Kowalski had not been drinking, despite this not being part of the agreement. When they returned ‘L’ was seen alone and did not make any disclosures regarding her arm. It was agreed that this would be followed up by the school. The consequences of her not complying with the agreement were not considered but may have been taken into account at the forthcoming Children Protection Conference.

## On 9th November 2016, Mr Hedges was reviewed at hospital by an elderly-care consultant having originally been referred for weight loss. CT scans of his chest, abdomen and pelvis showed no change from the examination the previous year. Mr Hedges complained of swelling in his groin which was identified as an inguinal hernia. His weight had stabilised. The consultant wrote to the rheumatology consultant to suggest a haematology review.

## On 11th November 2016, ‘L’ was once again made subject of Child Protection Planning under the category of neglect.

## On the 12th November 2016, a neighbour of Ms Kowalski reported to the police that she and Mr Hedges had been having an argument outside Ms Kowalski’s front door. They were also shouting, singing, laughing and clapping and believed drunk. No police units were available to attend and no further calls were received.

## The same incident was reported to Aster Group. They were told that Ms Kowalski threw Mr Hedges to the communal landing floor at 4am and that he lay on the floor crying out for help before the Police were called. A Home Ownership Officer made a welfare call to Mr Hedges who seemed surprised but said he was fine. He said he was on his way home from town when he wandered in the wrong block by mistake. He said he had slipped and fallen, hurting his back and had called out for help to get back up. The officer asked Mr Hedges if Ms Kowalski was his carer and he said he did not have one. He said he had no injuries and was OK. The Officer left her contact details and advised to contact her if he needed to. The fact that the report mentioned Ms Kowalski throwing him to the floor was not passed on to any other agency.

## On the 14th November 2016, Mr Hedges visited his GP to see the practice nurse regarding his routine annual rheumatoid review. Mr Hedges reported drinking only four units of alcohol a week. He was not seen again in surgery.

## The incident which led to Mr Hedges’ death and this review happened the following day.

# ANALYSIS, CONCLUSIONS AND LESSONS TO BE LEARNT

## This Domestic Homicide was unusual as the fact and nature of Mr Hedges’ and Ms Kowalski’s intimate relationship was known to very few, if any, of those closest to them. It only came to professionals’ attention when mentioned by Mr Hedges to a police officer investigating reports that he was being financially abused by her.

## This was the only time when domestic abuse should have been suspected between the two, prior to the incident which led to his death.

## Because of Ms Kowalski’s house moves there is no evidence to suggest that she knew Mr Hedges until she moved into the same road as him in May 2015. Indeed, the first record of her and Mr Hedges having any contact with one another was in July 2016 when the reports of financial abuse first materialised.

## There were previous references to her befriending older men but, given the age these men were reported to be, it is unlikely any of these were Mr Hedges.

## Therefore, the significant history of Ms Kowalski suffering domestic abuse at the hands of previous partners, her chronic alcohol misuse, her failure to properly safeguard her child from neglect and emotional harm and her minimising and denial of such issues when challenged form the main thrust of this review

## The chronology, over the five years this review has examined highlighted seven themes under which analysis and conclusions can be made:

* **Multi Agency Working and Information Sharing**
* **Reporting**
* **Routine Enquiry and Professional Curiosity**
* **Working with Reluctant or Resistant Clients**
* **Risk Assessment**
* **Safeguarding**
* **Equality and Diversity**

**Multi Agency Working and Information Sharing**

## As would be expected, agencies in Hampshire and, more specifically Test Valley, work to a range of national and local guidance all designed to promote effective multi-agency working, proportionate information sharing and better outcomes for those at risk of harm and/ or abuse. None of these vary to any great extent to those elsewhere and all are fit for purpose.

## Overall the agencies who worked with or on behalf of Ms Kowalski, ‘L’ and Mr Hedges did so collaboratively, sharing information in an appropriate and timely fashion. The pattern was of timely recognition of concerns, swift identification of appropriate partners, robust information sharing and effective multi-agency working which sought to resolve or, at least mitigate the concerns. These are illustrated throughout the previous section of this report and should provide confidence that, in the main, all agencies have the appropriate mechanisms to work well together.

## There were a few examples when joint working or the sharing of information did not happen well enough but, the overwhelming times it did suggests that those rare occasions were the exceptions rather than the rule. The majority of this section will focus on those occasions when the otherwise effective system did not work so well but should not be read as anything other than exceptions to the more common arrangements.

## Of all those providing services to the subjects of this review, there was only one occasion when, arguably, domestic abuse between Mr Hedges and Ms Kowalski might have been recognised. The police were investigating a third-party report that Mr Hedges was being financially abused. During their conversations with him, he said that he had been ‘intimate’ with Ms Kowalski but denied being subject to any abuse. The allegations were not classified as domestic abuse, possibly because the alleged victim convincingly denied that to be the case. However, it is common for victims of domestic abuse to deny what is happening to them so, given his disclosure of a sexual relationship, this should have been recorded and investigated as domestic abuse.

**Recommendation 1**

**Hampshire Constabulary should remind officers and staff that domestic abuse can sometimes be revealed by taking a holistic view of the people and relationships they are faced with, considering factors outside those which have been reported/disclosed and in those circumstances, the appropriate recording, investigation and safeguarding should follow to the same level as if in response to a disclosure.**

## While the sharing of CYPR (Child at Risk) form and CA12 (Adult at Risk) forms between the police and Children’s Services or Adults Health and Care was almost always timely, there was a significant backlog in them being reviewed or actioned.

## In 2016, a significant number of CA12s were received by Adults Health and Care and not processed for some weeks. Often their content did not appear to meet the threshold for safeguarding duties and professionals regarded the volume to be symptomatic of a process rather than a real response to potential concerns. The recording proforma used by MASH to aid decision making, at this time, did not enable consistent risk management and subsequent decision making. The function of the CA12 and high-volume of referrals compounded this issue.

## This had already been recognised prior the review and there is now a single children and adult at risk referral form, the PPN1, introduced in November 2016. The review has been told this has notably improved practice. Although the PPN1s are police forms, they were designed with input from the MASH. One important inclusion is that it contains the DASH risk assessment, which the CA12s did not. This provides greater opportunities to identify any specific domestic abuse risks and provides “safe contacts” to call a victim back. It also includes checks on how the person wants to be involved, thus ensuring practice reflects making safeguarding personal.

## The changes within the MASH mean there is now apparently no backlog for reviewing PPN1s; they are reviewed with 24 – 48 hours, as opposed to the number of weeks which was previously the case. There is also much closer working between MASH and Contact Assessment Resolution Team as they are now based in the same building.

**Good Practice 1**

**Hampshire Constabulary and its four local authorities’ initiative to develop and implement one mechanism to refer cases of adults and children at risk is a strength leading to greater consistency and standard of referral and reducing backlogs.**

**Recommendation 2**

**That Hampshire Constabulary and its four local authorities assures themselves the implementation of the PPN1 information sharing arrangements are as effective as they seem. In which case the principles should be shared across other partnerships and with similar police services, agencies and local authorities.**

## There also seems to have been improved communication between Children’s Services and Adults Health and Care, the outcome being a more holistic, family approach being developed to deal with domestic abuse. An example of this being Adults Health and Care commissioning the involvement of a Family Intervention Worker for Ms Kowalski and ‘L’ and improved information sharing to housing.

## A trial in Southampton sees high risk cases assessed within 24-48 hours and a protection plan prepared[[4]](#footnote-4). Adults Health and Care, Children’s Services, Domestic Abuse services, Inclusion, health and police are involved with this. It is hoped this will reduce the number of MARAC cases, addressing risk in very early stages. If successful consideration may be given to this being rolled out across Hampshire.

**Recommendation 3**

**That the outcome of the Southampton trial to develop swift and robust multi agency domestic abuse plans should be monitored and, if successful, considered for adoption in other areas, including the Test Valley.**

## The sharing of information between Ms Kowalski’s pre-school, Aster Group, substance misuse teams and social care was, in the main, impressive. Clearly Ms Kowalski was on the collective radar due to her alcohol misuse, domestic violence and the resultant risks to ‘L’. Examples of swift referrals include when she was thought to have been drunk when collecting ‘L’, when she had behaved inappropriately while in drink and when she was missing, possibly avoiding, alcohol testing. These demonstrated a high level of vigilance which appeared to have her and ‘L’’s wellbeing at heart. Exceptions to this are discussed later.

**Reporting**

## Domestic Homicide Reviews often uncover that the victim, their family and friends either did not wish to or did not know how to report abuse. Families and friends often either do not want to act against the victim’s wishes or simply do not know how to make third party referrals. The reasons for victims not to reveal they are being abused are many-fold and well researched.

## It was a neighbour who recognised the abuse Mr Hedges may have been experiencing and took the initiative to report it to both police and Adults Health and Care. The evidence suggests Mr Hedges did not recognise that he may have been a victim, or at least at risk, of domestic abuse. There is evidence that he had been a perpetrator in a previous relationship but, when the possibility of him being abused by Ms Kowalski was raised he categorically denied it, although this was not framed as domestic abuse. A neighbour also took the initiative to report suspicions of Mr Hedges historically abusing a third party.

## He certainly appeared convincing in those denials, and whilst no one carried out a mental capacity assessment (despite the dementia concerns), he was considered to have capacity. The fact remains that these disclosures were not picked up as domestic abuse and if they had been he may have recognised it and support could have been provided in helping him seek support.

## The abuse of Ms Kowalski, on the other hand, was well known and widely reported. As well as herself, her mother, relatives, neighbours and professionals all reported her domestic abuse to the police and the housing association. Similarly, the fact and nature of Ms Kowalski’s alcohol misuse was widely known and reported, even if it was often denied or minimised by Ms Kowalski herself.

## On occasions Ms Kowalski would also minimise the severity of the abuse reported by third parties. Sometimes she absented herself from her flat or would not answer the door. On these occasions, follow-up by the police and other agencies was normally good and referrals made to other agencies. Ms Kowalski rarely provided statements to support the prosecution of her alleged perpetrators but sought help when she regarded a restraining order being breached. Notwithstanding her not supporting criminal charges, the police and CPS pursued them on occasions nonetheless.

## Ms Kowalski’s mother and sister both called police over her excessive alcohol consumption and, in her sister’s case, the risk to ‘L’. Neighbours also called, increasingly so in the months prior to the homicide, expressing concerns for ‘L’ due to her being present during domestic abuse and her contact with Mr Hedges as well as expressing annoyance at the noisy domestic incidents at Ms Kowalski’s home and that Ms Kowalski was exploiting Mr Hedges. There were occasions when they would take the opportunities to speak to professionals about these concerns when they saw them visiting Ms Kowalski.

## Mr Hedges engaged well with health professionals and, when required, police and probation services. Ms Kowalski engaged with professionals when she felt the need. Ms Kowalski’s only avoidance of services seemed to be in relation to the scale of her alcohol abuse being detected. After some false starts, she engaged well with the Freedom programme which demonstrated a desire to free herself from domestic abuse.

## From these examples, nothing to suggests there were any barriers or disincentives experienced or perceived by Mr Hedges, Ms Kowalski or their family/ friends/ or others in reporting abuse. While most used familiar reporting routes – the police and housing association – others referred to Children’s Services and Adults Health and Care. It is impossible to know whether reports would have been made if the abuse was subtler or if a child was not involved but, on the evidence of this review, knowledge and confidence was high, enabling people to make third party reports of domestic abuse.

**Routine Enquiry and Professional Curiosity**

## Again, given the almost universal lack of knowledge regarding any relationship between Ms Kowalski and Mr Hedges there was an equivalent scarcity of opportunities to routinely enquire as to the existence of domestic abuse between them.

## All their health presentations seem to have been accompanied by reasonable explanations and, in respect of Mr Hedges, when he visited his GP with physical injuries, they had no information to suggest he was, or recently had been, in a relationship to prompt them to question him further. His history of falls was well known.

## However, as discussed later, there were missed opportunities for professionals to enquire about the domestic abuse following the report of financial abuse made in July 2016. The lack of a safeguarding response to the concerns raised, represented a missed opportunity for the matter to be considered through the Safeguarding Adults procedures or other multi agency arrangements.

## The report made on the 3rd August 2016 seemed to have been minimised both in terms of the risk to ‘L’ and the risk that Mr Hedges posed to children. The swift report to the MASH was appropriate but it attracted no action because the strategy discussion with ‘L’’s social worker resulted in the police recording that ‘it would be unlikely that ‘L’ was left alone with Mr Hedges as ‘L’ virtually lives with her maternal grandmother’. No further action seemed to have been taken as a result of that comment, the previous history seemingly being missed. This was a missed opportunity to explore deeper into the concerns being raised by neighbours who, by now, appeared to be exercised by what they were witnessing. This is discussed further.

**Reluctant or Resistant Clients**

## Ms Kowalski’s denial and minimising of her alcohol misuse was well known and documented by all those who came across her. These denials were rarely accepted and, in the main, professionals were not distracted from taking appropriate action despite her insistence that she was not drinking. The exception to this was the substance misuse service who would focus on her successful alcohol test results rather than the occasions when she had avoided testing. Children’s Services had been told by a friend of Ms Kowalski in May 2014 that she was ‘pulling the wool over the substance misuse services’ eyes.’ This coincided with an unannounced alcohol test finding her three times over the drink drive limit.

## The safeguarding meeting that followed concluded that there was little to be done when she was in such denial but drew some reassurance that she was engaging with the substance misuse service. The quality of that engagement seemed not to have been understood as it did not appear to be promoting any improvement.

## Ms Kowalski was vehement in her denials that her alcohol misuse impacted on her ability to care for ‘L’, despite clear evidence to the contrary. Throughout the years of Children’s Services involvement, she did not engender any positive change and this triggered child protection investigations with ‘L’ being made subject of child protection planning. Even this did not change Ms Kowalski’s ways and, whilst there was some optimism through her completing the Freedom programme, her abuse of alcohol was consistent. The same was true of her vulnerability to forming relationships with violent men, her willingness to disregard professional advice and her minimising the effect that all of this was having on both her and ‘L’.

## More worryingly, despite Ms Kowalski sometimes reporting her own abuse, she would also deny or minimise it on occasions, even suggesting that minor assaults were the cultural norm in Mr Kowalski’s native Albania.

## On the occasion that her colleague reported hearing ‘a domestic going on’ when he was speaking with her on the phone, he was quite explicit what he had heard and the bruising he had previously seen. Her denials when police attended appeared to have been taken at face value. Some checks were carried out to ascertain ‘L’’s wellbeing and to see if there were signs of disturbance or injury but, other than a DASH risk assessment being carried out, little else was progressed. It certainly did not inform future responses.

## In August 2015, when Ms Kowalski’s mother reported a domestic dispute between Ms Kowalski and Mr Duffy, she minimised the incident and, although the subsequent referral to Children’s’ Services triggered a core assessment, her denials and minimisation again did not inform future police response to investigate further.

## The following month when a neighbour heard sobbing and a heated argument and both Ms Kowalski and ‘L’ sobbing again, Ms Kowalski and Mr Duffy denied anything had happened. Aster Group records show that the argument seemed to continue and, after police had left, something was apparently thrown against the wall. This subsequent information did not seem to have been shared with police or Children’s Services (who only received the police report) so the full picture was not appreciated.

## For the third month in a row, in October 2015, a third party reported a domestic dispute between Ms Kowalski and Mr Duffy. When they were eventually traced, they denied anything had happened so no further action was taken, other than a social work referral which also did not lead to further action. Later that month Ms Kowalski suffered serious injuries during a domestic incident.

**Recommendation 4**

**Hampshire Constabulary should ensure their mechanisms, which highlight repeat victims of domestic abuse, remind officers that all reports regarding such victims, whether direct or third party, should be investigated to the high standard aspired to in their policy, to uncover the nature and frequency of abuse.**

## On two occasions, professionals saw Ms Kowalski with facial bruising. A Housing Support Worker did not speak to her about it as Ms Kowalski had a friend present and thus was not safe to do so, but referred it to the substance misuse service as they were due to see her next. Nothing seemed to happen as a result. However, when challenged by the social worker on the second occasion, Ms Kowalski denied the marks were injuries. This prompted concerns that Ms Kowalski was being less than honest that the violence had stopped. It is not clear that anything happened as a consequence of these concerns. For instance, the police were not informed.

**Recommendation 5**

**That Test Valley Safety Partnership assures itself that reporting mechanisms to the police and the MASH are publicised such that all agencies are clear on how to make timely and proportionate referrals of any report or suspicion of domestic abuse to enable effective interventions and investigations.**

## Adults Health and Care were told in April 2016 by a police officer who knew Ms Kowalski that ‘she minimises a lot and knows the police system well enough to know what to say.’ Whilst this information was not included in the police IMR, it does suggest that at least one officer knew that Ms Kowalski’s denials were tactical yet nothing changed in the response to or investigation of these incidents.

## Her denials extended to whether or not she was having a relationship with Mr Rees. This seemingly came to the attention of professionals in late 2015 (although Aster Group knew his first name in July 2013) but despite all the intelligence, including from Mr Rees’ sister, Ms Kowalski continued to deny it until February 2016 when she said the relationship had finished due to the involvement of Children’s Services and the Police. When suspicions re-emerged in June that year, she denied it again.

## Ms Kowalski was demonstrably a person who would be prepared to deny or minimise issues affecting her and ‘L’, even in the face of clear evidence or consistent intelligence. Her denials over her alcohol use rarely impacted on the services or interventions put in place but the same could not be said over her domestic abuse denials. These were sometimes accepted, or at least little consideration was given as to what could be done differently as a consequence. On these occasions, the same policing response was provided each time and the same referral provided to Children’s Services. There was no escalation or additional intervention designed to support or safeguard Ms Kowalski despite her rejection of help at the time.

## This case would have benefited from some co-ordinated case management whereby all information, be that formally or informally held, could be shared, considered and a multi-agency plan effected. This was not in place so, outside of the majority of the Child Protection Investigations, some concerns were not acted upon in a collaborative way designed to protect Mr Hedges, Ms Kowalski and ‘L’, who each had their own needs.

**Recommendation 6**

**That Test Valley Safety Partnership develops plans that supplement existing multi-agency collaboration and case management arrangements so as to facilitate effective support and interventions in those cases that fall below thresholds for alternative procedures.**

**Risk Assessment**

## On twelve occasions Police attended domestic abuse incidents where Ms Kowalski was the victim of domestic abuse and one where she was the alleged perpetrator. At each of these a Domestic Abuse Stalking and Harassment Risk Assessment should have been carried out. The outcome of these assessments is shown:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Not Submitted** | **Standard Risk** | **Medium Risk** | **High Risk** |
| **December 2011** |  | X |  |  |
| **January 2012** |  | X |  |  |
| **May 2012** | X |  |  |  |
| **October 2012** |  | X |  |  |
| **May 2014** |  |  | X |  |
| **May 2015** | X |  |  |  |
| **August 2015** |  | X |  |  |
| **September 2015** |  | X |  |  |
| **October 2015** |  | X |  |  |
| **October 2015** |  |  |  | X |
| **November 2015** |  | X (reduced from Medium by MASH) |  |  |
| **January 2016** |  | X |  |  |
| **April 2016** |  |  |  | X |

## While frequency of incidents is not, by any means, the only factor determining risk[[5]](#footnote-5), and the assessments are said to have been completed appropriately according to the police IMR author, the pattern between May and October 2015 does raise some questions. In May 2015 no risk assessment was carried out. There followed calls in three consecutive months where the risk was set at standard, in accordance with MASH Guidance. These were all third-party reports and all were minimised by Ms Kowalski. Following this, Ms Kowalski suffered serious injuries and her alleged perpetrator was remanded in custody. Following that incident, the risk rose to high. This may suggest a reactive response to risk assessment rather than the forward-looking approach that might prevent such escalation.

## Hampshire Constabulary policy states that high risk domestic incidents elicit a response from the safeguarding team, whilst medium risk incidents are responded to by neighbourhood officers. Standard risk incidents receive no follow up safeguarding advice, unless the victim agrees to a Victim Support referral. In all of the above occurrences the response provided complied with policy but the question remains that had the three third-party reports in August, September and October been investigated more fully and some safeguarding advice had been provided, would this have reduced the risk of the serious injury occurring later in October?

## There is no doubt that the reports were ambiguous and came from different sources. The numerical threshold for the case to be graded as medium or high risk was not reached. However, the MASH Standard Operating Procedure allows for professional judgement to override the DASH assessment outcome. It may well have been applied in this case but Hampshire Constabulary may wish to assure itself as to how this element of their guidance is applied so that seemingly low level, yet recurring, cases are escalated to a level where a proactive safeguarding response is provided.

## As a result of the GBH, Ms Kowalski was referred to MARAC and she was provided with IDVA support (albeit it has been difficult to work out which agency led on this) which in turn led to her engaging with the Freedom Programme and the request for a change of locks. Aside from that, little positive activity was documented as coming from the MARAC, the only action being for the police to speak with Aster Group regarding anti-social behaviour reports.

**Recommendation 7**

**Test Valley Partnership commissions a review of MARAC arrangements to ensure that considerations and actions are focused on resolving or mitigating the identified or potential risk that predicated their referral into those arrangements.**

## The report that Mr Hedges may be subject of financial abuse did not trigger any risk assessments, certainly none that would have led to a MARAC. Adults Health and Care say that if they received concerns of a similar nature now, greater awareness of domestic abuse and the purpose of MARAC within the MASH team may change that. This is discussed in the next section.

## **Safeguarding**

## The risk that ‘L’ was exposed to through Ms Kowalski suffering domestic violence and through her drinking was well known to all agencies. Family and neighbours also linked these to ‘L’’s safety. The impact of her abusive relationships and alcohol misuse had been a significant concern throughout all services’ involvement with ‘L’.

## Hampshire Children’s Services had known ‘L’ since she was nine months old, the first contact coming from the police following a domestic incident between Ms Kowalski and Mr Kowalski. Since then there were 45 reports from the police, education, substance misuse agencies and neighbours to Hampshire Children’s Services about hers and her partners’ alcohol misuse, domestic abuse, concerns of the care afforded to ‘L’ and her being at risk from Mr Hedges.

## As a consequence of these reports, ‘L’ was assessed through a child and family assessment on five occasions. Often the reports would be taken together in those assessments. ‘L’ has been subject of child protection planning on three occasions and child in need planning twice.

## The child protection interventions were overseen by an Independent Reviewing Officer and staff worked within Hampshire Children’s Services Safeguarding Children Policy and Hampshire LSCB Child Protection and Safeguarding Procedures.

## Visits were held within timescales and were thoughtful in their approach, often taking extra steps to validate what the social workers were being told or to find out more. Examples being a willingness to speak with a neighbour who indicated she had something to say out of Ms Kowalski’s earshot and visiting Mr Hedges when Ms Kowalski was not at home.

## When faced with concerns regarding Ms Kowalski’s drinking, even out of hours, the system worked well in taking urgent steps to keep ‘L’ safe either by arranging for her to stay with her father or grandparents. When agreements appeared to be broken, social workers were quick to challenge and clarify what was expected. An exception to this otherwise good practice is not following through on a decision in January 2014 that any further reports would trigger a Child Protection Investigation. There were several reports but a Child Protection Investigation did not happen until August 2015. There appears to be an absence of rationale as to why it took seventeen months to take this next step.

## The maternal grandparents provided essential support for Ms Kowalski throughout Children’s services involvement. They safeguarded ‘L’ when necessary and provided a safe place for their child and granddaughter on occasions. This was recognised and used effectively to safeguard both in a familiar environment. They, and other family members did report their concerns to the relevant authorities; this is evident especially in the last four police reports sent the Children’s Services.

## However, ‘L’’s care arrangements were often informal and there was no evidence that legal measures were considered to provide her with greater certainty and protection. This would have seemed a natural step given the number of occasions she had to be cared for by her grandparents due to Ms Kowalski’s intoxication.

## The concerns surrounding Mr Hedges and Ms Kowalski were not identified as clearly as ‘L’’s. It should be highlighted that the Care Act 2014 took effect on the 1st April 2015, therefore some of the agency involvement was under previous legislation. Ms Kowalski was opened to the Hampshire County Council Substance Misuse Team for Adult Safeguarding in May 2014 due to reports of domestic assault. Ms Kowalski, did not attend this meeting, and it appears no one was there to advocate on her behalf. Following the safeguarding meeting, a decision was made to close Ms Kowalski to safeguarding, due to her lack of engagement.

## The rationale given to this decision indicates that there was a lengthy discussion about the difficulty in supporting Ms Kowalski given her denials about her alcohol problem. It was felt that until she recognised there was a problem there were minimal interventions that professionals could offer to support her.

## Despite the safeguarding meeting, there did not appear to be consideration for an assessment of her social care needs. While there was nothing to suggest, based on the information recorded on her file, that she would be unable to protect herself against abuse/neglect nor that she had needs which arose “from or are related to a physical or mental impairment or illness,” this was never formally assessed. This was eleven months before the Care Act 2014 came into effect. However, prospective interventions seemed to have been thwarted by her lack of engagement with no evidence that more bespoke methods of engagement were considered that could reflect her wishes and feelings.

**Recommendation 8**

**Hampshire Adults Health and Care should satisfy itself that assessments of care and support needs under the Care Act 2014 and subsequent safeguarding plans, whilst taking wishes and feelings into account, demonstrate imaginative approaches to improve engagement and inform choices of those at risk.**

## Aster Group’s recognition of safeguarding concerns was strong but, with a more cohesive partnership around them, the context and concerns held regarding Ms Kowalski, Mr Hedges and ‘L’ could have been understood more fully. With effective multi-agency case management, the information Aster received that Ms Kowalski had befriended an older man, that Mr Scott was apparently harassing Ms Kowalski, Ms Kowalski’s carers’ allowance claim for Mr Hedges, ‘L’ answering the door to the Temporary Housing Officer and the contact after Mr Hedges had fallen just prior to the incident leading to his death may have taken on greater significance. Recommendation six covers this concern.

## The calls made to Adults Health and Care and the police in July 2016 which shared concerns of Mr Hedges being financially abused by Ms Kowalski, that he was suffering from dementia, that he was spending time with a twelve-year-old girl and that he was drink driving to collect ‘L’ from school were not responded to in a joined-up way.

## When the initial call was made to MASH, insufficient pertinent facts were gathered. Even so, the information that was recorded and passed on appeared to be have been diluted leading to essential concerns not being highlighted and acted upon as they should have been. For example, whilst concerns regarding alcohol intake and driving were responded to, the subtler issues around dementia, financial abuse and domestic abuse were not responded to sufficiently, if at all.

## The information regarding Mr Hedges spending time with the young girl seems to have been passed from Adults Health and Care to Children’s Services but it is not clear what happened as a result; it appears never to have been referred to the police. It is possible that the request Children’s Services made to the police in October 2016 for information on Mr Hedges was connected. If it was, it was a very late request and, in any case, had not been passed to police in any other form.

## The duty Adults Health and Care worker requested, via email, that the Team Manager consider further safeguarding action. It appeared that whilst the team safeguarding lead was also copied into this email the decision was made by the Team Manager for no further action from Adult Services. The rationale for this decision was weak, citing other agencies already being involved. The IMR author takes the view that this was not a customary style of management but isolated to this particular manager. This leadership style could have disempowered practitioners and inhibited their confidence in decision making.

## This highlighted inconsistencies in decision making processes by Team Managers including the escalation process from social care staff to the operational team management, along with the recording of team manager decision and evidence-based rationale. On this occasion, when an operational team manager’s decision was required, the recording did not satisfy the discharging of the Local Authorities duty under Section 42 of the Care Act 2014[[6]](#footnote-6).

## Whilst contact was made with Mr Hedges’ GP there was a missed opportunity to offer an assessment of his social care needs, given his age and the content of some of the concerns reported.

## Practice at this time had not embedded Making Safeguarding Personal, evidenced by there being no attempt, other than by the police in the course of the initial investigation, to seek Mr Hedges’ views or consider the use of an advocate in accordance with S67 & S68 Care Act 2014 to obtain his wishes in relation to the concerns raised. There was also no consideration whether to formally assess Mr Hedges’ capacity in accordance with the Mental Capacity Act 2005.

**Recommendation 9**

**That Hampshire Adults Health and Care audit managers’ safeguarding decision making to ensure that decisions reflect the nature of the presenting concerns, the vulnerability of the adult, their wishes and feelings, the principles and requirements of the Care Act 2014 and lead to appropriate and personalised support and interventions.**

## The police recognised the risk in some of the information but delayed their attendance for nearly three weeks during which time the abuse could have been continuing. The consequence of this was that no agency had the full picture, information was not triangulated between them and no effective multi agency safeguarding plan was established, led or discharged. This led to certain aspects of the information not being shared, acknowledged or investigated. This could have left vulnerable adults and children at continued risk from harm or abuse.

## Information regarding Ms Kowalski’s intention to become Mr Hedges’ carer, the disclosure of a sexual relationship, suspicions that she had befriended and was possibly exploiting other older men together with their wishes and feelings could have been triangulated and explored but were not. The information was treated as a series of episodes to be responded to in isolation rather than taken together and regarded in a person-centric way which may have got to the root of the relationship between Ms Kowalski, Mr Hedges and others.

## The volume of information being reported at different times to different agencies should not be underestimated but no-one considered it in the round nor stepped up to case-manage the situation. This was, without doubt, a report of a safeguarding concern from a member of the public. It was also a report of children potentially being at risk from a former Registered Sexual Offender, allegations of previous people being financially abused and drink driving.

## While it has been suggested this was due to one person making a flawed decision it highlights that the operation of the Safeguarding Adults Procedures and the resilience of the safeguarding partnerships may not be all that the Hampshire Safeguarding Adults Board and its constituent agencies would aspire them to be, that safeguarding is everyone’s responsibility. A variation of thresholds has already been identified by 4SAB[[7]](#footnote-7) and is a current workstream to standardise.

**Recommendation 10**

**The Hampshire Safeguarding Adults Board assures itself that, since these concerns being raised, training, awareness and compliance with safeguarding procedures has improved to a level that complex safeguarding information received from multiple sources to different organisations is pooled, analysed and responded to in compliance with its Safeguarding Procedures and the Care Act 2014.**

## Following the July and August concerns, while officers did speak to Mr Hedges at length, their delayed response meant that any abuse may have continued in the intervening weeks. They did not speak to Ms Kowalski about the concerns raised, they made assumptions about Mr Hedges being in a car with two children - no direct action was taken to identify the children or to speak with Mr Hedges about this - and they did not refer the August report to Adults Health and Care. These delays and omissions could have placed Mr Hedges and other children at continued risk.

**Recommendation 11**

**Hampshire Constabulary review its response policy to, and supervision of, non-urgent incidents so that those with an ongoing, albeit subtle, element of abuse are attended and investigated in a robust and timely way so that any such abuse can be identified, investigated and prevented.**

## Regarding the risk Mr Hedges posed to children, the agency response was variable. That risk was clearly identified by the police, but only with regards to particular children. On one occasion, in respect of one child, they served Mr Hedges with a Child Abuse Warning Notice. However, when combined with his previous Registered Sex Offender status and other incidents involving children, this should have resulted in an application for a civil order, such as a Risk of Sexual Harm Order or Sexual Offender Prevention Order (SOPO), to manage his behaviour.

## Following the report made in July 2014 that Mr Hedges was having inappropriate contact with a fourteen-year-old girl, he should have been visited by police, challenged about this contact and reminded of the risks involved in such contact. This too should have triggered consideration of applying for a SOPO in order to further manage his risk to children.

**Recommendation 12**

**Hampshire Constabulary, as part of their programme to achieve greater management of risk across commands, should develop awareness programmes so that all officers are aware of the available practical and legislative tools and options when managing sexual offenders in the community**

## During Mr Hedges’ supervision by the Hampshire Probation Service, whilst he complied with his reporting requirements, the detail of recording regarding these appointments was scarce. Whilst it may have been that an investitive approach was used at each appointment regarding Mr Hedges’ circumstances, activities and associations etc, this is not recorded within contact logs. As an example, one contact log indicated that he had self-reported sleeping with an ex-partner the previous week. There was no follow up as to identification of who this was. This is a concern as there is nothing to suggest that the Probation Service were satisfied this was an appropriate relationship given his previous offending.

## Only one home visit was recorded, in March 2009, three months after his order was made. Although this falls within policy, as Mr Hedges was assessed as a Medium Risk of Serious Harm, it has been suggested that good practice is for this initial home visit to have been within a month of sentence and then he be re-visited throughout the Order.

**Recommendation 13**

**The MAPPA Quality Framework Group satisfies itself that supervision arrangements, and the training and supervision of probation and police officers in respect of them, reflect best practice based upon the identified risks the offender may present.**

# Appendix A – Table of Recommendations

**Recommendation 1**

**Hampshire Constabulary should remind officers and staff that domestic abuse can sometimes be revealed by taking a holistic view of the people and relationships they are faced with, considering factors outside those which have been reported/disclosed and in those circumstances, the appropriate recording, investigation and safeguarding should follow to the same level as if in response to a disclosure.**

**Recommendation 2**

**That Hampshire Constabulary and its four local authorities assures themselves the implementation of the PPN1 information sharing arrangements are as effective as they seem. In which case the principles should be shared across other partnerships and with similar police services, agencies and local authorities.**

**Recommendation 3**

**That the outcome of the Southampton trial to develop swift and robust multi agency domestic abuse plans should be monitored and, if successful, considered for adoption in other areas, including the Test Valley.**

**Recommendation 4**

**Hampshire Constabulary should ensure their mechanisms, which highlight repeat victims of domestic abuse, remind officers that all reports regarding such victims, whether direct or third party, should be investigated to the high standard aspired to in their policy, to uncover the nature and frequency of abuse.**

**Recommendation 5**

**That Test Valley Safety Partnership assures itself that reporting mechanisms to the police and the MASH are publicised such that all agencies are clear on how to make timely and proportionate referrals of any report or suspicion of domestic abuse to enable effective interventions and investigations.**

**Recommendation 6**

**That Test Valley Safety Partnership develops plans that supplement existing multi-agency collaboration and case management arrangements so as to facilitate effective support and interventions in those cases that fall below thresholds for alternative procedures.**

**Recommendation 7**

**Test Valley Partnership commissions a review of MARAC arrangements to ensure that considerations and actions are focused on resolving or mitigating the identified or potential risk that predicated their referral into those arrangements.**

**Recommendation 8**

**Hampshire Adults Health and Care should satisfy itself that assessments of care and support needs under the Care Act 2014 and subsequent safeguarding plans, whilst taking wishes and feelings into account, demonstrate imaginative approaches to improve engagement and inform choices of those at risk.**

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**Recommendation 13**

**The MAPPA Quality Framework Group satisfies itself that supervision arrangements, and the training and supervision of probation and police officers in respect of them, reflect best practice based upon the identified risks the offender may present.**

1. All names of parties subject to the review and those connected with them are pseudonyms. [↑](#footnote-ref-1)
2. https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews [↑](#footnote-ref-2)
3. http://www.andovercrisisandsupportcentre.org.uk/home/freedom-programme/ [↑](#footnote-ref-3)
4. http://southamptonlsab.org.uk/making-a-referral-to-mash-for-high-risk-domestic-abuse/ [↑](#footnote-ref-4)
5. http://www.safelives.org.uk/sites/default/files/resources/Dash%20without%20guidance.pdf [↑](#footnote-ref-5)
6. Section 42 Care Act 2014 requires that each local authority must make enquiries, or cause others to do so, if it believes an adult with care and support needs is experiencing or is at risk of abuse or neglect as a result of those needs and cannot therefore protect. [↑](#footnote-ref-6)
7. Hampshire, Portsmouth, Southampton and Isle of Wight Safeguarding Adults Boards [↑](#footnote-ref-7)