**DOMESTIC HOMICIDE REVIEW**

**TEST VALLEY PARTNERSHIP**

**‘GLEN HEDGES’**

**Author – Graham Bartlett**

**November 2018**

**Executive Summary**

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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 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.

# 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

# 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.
* 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.

# 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.

# 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.

# 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.

# KEY ISSUES

## 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**

# CONCLUSIONS LESSONS LEARNED, AND RECOMMENDATIONS

**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[[2]](#footnote-2). 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.

## While frequency of incidents is not, by any means, the only factor determining risk[[3]](#footnote-3), 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[[4]](#footnote-4).

## 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[[5]](#footnote-5) 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.**

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1. All names of parties subject to the review and those connected with them are pseudonyms. [↑](#footnote-ref-1)
2. http://southamptonlsab.org.uk/making-a-referral-to-mash-for-high-risk-domestic-abuse/ [↑](#footnote-ref-2)
3. http://www.safelives.org.uk/sites/default/files/resources/Dash%20without%20guidance.pdf [↑](#footnote-ref-3)
4. 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-4)
5. Hampshire, Portsmouth, Southampton and Isle of Wight Safeguarding Adults Boards [↑](#footnote-ref-5)