Kent Community Safety Partnership
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MEDWAY COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review

Beth

2018

Overview Report

Author: Alan Critchley

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 24th July 2023

"*Beth was a beautiful woman inside and out, although at times she could be quite headstrong she was a loving mother and cared about her children above all else. Beth would help anyone she knew if they were having problems both practically and even just a shoulder to cry on. Her sense of fun and enjoyment, her humour are the things we miss, she was the person I loved spending time with most and nearly 4 years on its still raw and I cannot come to terms with the fact that I will never see her again, when you say bye, love you good luck with the job interview you don't believe that will be the last time you ever see them.*

Beth was also very clever when she went through the various court hearings to get her children back, she had minimal legal advice she did everything herself, represented herself in court and gradually won her children back by following the judge's direction at every hearing as legal aid was not available and in Beth's words any money I have is for my children to pay a lawyer or barrister is just not affordable. Beth wanted to help other women who found themselves in the same position unable to fight their ex-partners in court due to lack of funds.

Beth was a good friend, a caring sister, a loving mother and a daughter whose death made the world a darker place for all who knew her, her smile could light up a room and if upset a look that could kill at fifty places."

Beth's Mother

CONTENTS

1. Introduction 1
2. Confidentiality 2
3. Timescales 3
4. Methodology 3
5. Terms of Reference 4
6. Involvement of Family Members and Friends 7
7. Contributing Organisations 9
8. Review Panel Members 10
9. Independent Chair and Author 11
10. Other Reviews/Investigations 12
11. Publication/Dissemination 12
12. Equality and Diversity 12
14. Chronology 15
15. Overview 36
16. Analysis 46
17. Conclusions 53
18. Lessons to be Learnt 54
19 Recommendations 55
Glossary A-1

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1. Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Beth, a resident of Kent, prior to her murder in October 2018. On that day Beth was known to have arrived home in the evening and was in contact with friends up to 22:00 that night. That was the last time that Beth was heard from.

1.2 This DHR examines the involvement that organisations had with Beth who was white British and in her mid-40s at the time of her murder and Richard who was white British/Spanish and in his late 30's, between June 2014 and Beth's death.

1.3 The key reasons for conducting a Domestic Homicide Review (DHR) are to:

a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

1.4 This review was commissioned on 20th August 2020, by the Kent Community Safety Partnership after the Core Group Panel confirmed that the case met the criteria for conducting a DHR. That agreement had been ratified by the Chair of the Kent Community Safety Partnership.

1.5 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 18th August 2020. It agreed that the criteria for a multiagency review DHR had been met and this review will be conducted using the DHR methodology.

That agreement has been ratified by the Chair of the Kent Community Safety Partnership and the Home Office has been informed.

1.6 This report has been anonymised and the personal names contained within it are pseudonyms, except for those of DHR Panel members. The pseudonym for the victim was chosen by her mother. Others were chosen by the Independent Chair and agreed by the mother of the victim.

2. Confidentiality

2.1 The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

22 Dissemination is addressed in section 7 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by Beth's mother.

2.2 Details of the deceased and perpetrator:

Name (Pseudonym)	Gender	Age at time of death	Relationship to deceased	Ethnicity
Beth Jones	F	Mid 40s	Deceased	White British
Richard Lopez	M	Late 30s	Ex-Partner and perpetrator	White British/Spanish

2.3 The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	Relation to deceased:	Relation to perpetrator:
Beth Jones		Ex-Partner
Richard Lopez	Perpetrator	Ex-Partner
Lynne	Mother	

Pseudonym	Relation to deceased:	Relation to perpetrator:
Harry	Son	
Sam	Son	
Child A	Child	Child
Child B	Child	Child
Child C	Child	Child

3. Timescales

3.1 This review began on 18th August 2020 and was concluded on 24th July 2023.

3.2 This review has exceeded six months. It was conducted over the period of the pandemic and agency resources were prioritised in dealing with that. In particular the normal period for compiling IMRs was extended. This review was allocated to the Independent Chair in September 2020 and a meeting was held to agree the Terms of Reference on 4th November 2020. A briefing for IMR writers was held on 16th December 2020 with the agreement that IMRs would be complete by the end of March 2021. A panel to discuss the IMRs was convened on 4th May 2021.

3.3 Throughout the Independent Chair kept in touch with Beth's mother, initially through a Victim Support Service Case Officer and latterly directly. It was hoped throughout the process that one or more of Beth's friends would agree to be interviewed and this agreement was only obtained in August 2022. Advocacy Against Fatal Domestic Abuse (AAFDA) was offered to Beth's mother several times throughout 2021 as another line of support but was declined.

4. Methodology

4.1 The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Beth and/or Richard. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

4.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Beth or Richard during the period covered by the review.

4.3 In addition to IMRs, KCHFT and Surrey ICB provided a Summary Report and documentation about Beth and Richard.

5. Terms of Reference

5.1 The Review Panel first met on 4th November 2020 to consider the draft Terms of Reference, scope of the DHR and those organisations whose involvement would be examined.

5.2 Background

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 20th August 2020. It agreed that the criteria for a DHR had been met and, the Chair of the Kent and Medway Community Safety Partnership confirmed that a DHR would be conducted and the Home Office has been informed.

5.3 The Purpose of a DHR

a) 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;
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and 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;

e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

5.4 The Focus of the DHR

This review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Beth.
If such abuse took place and was not identified, the review will consider why not and how such abuse can be identified in future cases.

If domestic abuse was identified, this DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

The full subjects of this review will be the victim, Beth, and the perpetrator, Richard.

The timeframe of the review was from the point that Beth separated from Richard in June 2014 through to the time when she was reported as missing in October 2018. This time covers the period of their relationship when agencies were involved and the relationship was most obviously and openly in difficulty. Agencies were invited to provide information prior to the formal start date to provide context.

5.5 Specific Issues to be Addressed.

Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of the Beth, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic

violence and abuse victims or perpetrators and were those assessments correctly used in the case of Beth? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency forums?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

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

xiv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Beth?

6. Involvement of Family Members and Friends

6.1 The family contact for this DHR has been Lynne, mother of the victim. Since the homicide she has been supported by a Homicide Case Worker from Victim Support and all arrangements were made in the early stages through this worker. The Independent Chair of the review has held two secure video meetings with Lynne, both have been in the company of the Homicide Support Worker and Lynne 's partner.

6.2 Initially Lynne was unsure whether she wished to take part in the DHR process, but she agreed to it and has given very helpful information about her daughter.

6.3 The first call was an introductory one on 19th January 2021. Lynne was given the opportunity of having a specialist advocate throughout the DHR process but chose not to on the basis that she had support from her Homicide Case Worker. The Independent Chair talked through the DHR process with Lynne. It was agreed that the Independent Chair would ensure that Lynne was the family contact and that she would update Sam and Harry, Beth's older sons as appropriate. Lynne was offered sight of the Terms of Reference but declined.

6.4 A further, and longer meeting, took place on the 9th February 2021. Again, Lynne was asked whether she would like an independent advocate to support her through the DHR process, but she declined. On this occasion she gave full information about Beth as a person, her life with Richard and an account of the separation.

6.5 In March 2022 the Independent Chair met the victim's mother in her home to share the initial findings of the review. As one of the findings is that Beth had been subject to coercive control over the relationship with Richard it was felt that a face-to-face meeting was the best way to communicate and explain this. Through the Homicide Case Worker Lynne provided some information about Beth's moves and addresses during the period of the review so that the Independent Chair could better understand the timeline and the pressures upon Beth. The draft review in its entirety was shared with Lynne in March 2023. She was content with the review and its conclusions.

6.6 The Independent Chair had hoped throughout the review to speak to one or more of Beth's friends. The purpose was to gain a fuller picture of Beth's life over the review period. Police contacts who had worked on the case initially advised the Independent Chair that this would not be appropriate. After Beth and Richard had separated, Richard had targeted Beth's friends, sometimes for brief relationships. After Beth's murder her friends were left traumatised. The Independent Chair accepted the advice of the police with regard to this.

6.7 However in August 2022 at the instigation of the Independent Chair a police contact spoke to one of Beth's friends, "Jo" who agreed to speak to the Independent Chair.

6.8 She recounted that she had become friends with Beth when Beth's older children were small and the two had remained in contact until Beth's death. Jo described Beth in much the way that her mother had. That she was a lively, friendly and caring woman who valued her friendships and enjoyed dancing. "She would help anyone". Beth used to bring her children to stay with Jo and her children and the families had fun together.

6.9 Jo described how she was initially pleased for Beth when she met Richard but that she became increasingly concerned about what she heard from Beth. An example is that, quite early on in the relationship Beth used to stay with Jo. When the two went out to the pub Beth used to leave her phone at home because Richard tracked her whereabouts by her phone, and he did not like the idea of her going to a pub without him. Beth would describe Richard to Jo as "a pain in the backside".

6.10 There was also an occasion when Beth had asked Jo to reach her on one of her children's phones because Richard had disconnected her own phone, an example of coercive control.

6.11 The Independent Chair established that Jo understood the nature of coercive control and Jo felt that Beth had been subject to it throughout her relationship with Richard.

6.12 The Independent Chair did consider interviewing Richard, but decided against. Richard hasn't accepted his culpability and he hasn't disclosed the whereabouts of Beth's body. Given this entrenched stance it is difficult to see what he might have contributed to the review nor, it was felt, was it appropriate to give him a voice in the review.

7. Contributing Organisations

7.1 Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DHR Panel. The IMR authors and the senior managers were independent of any operational or supervisory involvement with Beth and Richard.

7.2 Each of the following organisations contributed to the review

Agency/ Contributor	**Nature of Contribution**
Kent Police	IMR
Children and Family Court Advisory and Support Service (CAFCASS)	IMR
The Education People	IMR
Kent Community Health NHS Foundation Trust (KCHFT)	Short Report
Kent & Medway Clinical Commissioning Group (CCG)	IMR
Note: As of July 2022 the Kent and Medway Clinical Commissioning Group (CCG) became the Integrated Care Board (ICB)	
Surrey Heartlands	Short Report

8. Review Panel Members

8.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Beth and/or Richard. It also included a senior member of the Kent Community Safety Partnership and an independent advisor from a Kent-based domestic abuse service.

8.2 The members of the panel were:

Agency	Name	Job Title
	Alan Critchley	Independent Chair
KCC Community Safety	Honey-Leigh Topley	Community Safety Officer
Kent Police	Ian Wadey	Detective Chief Inspector
Kent & Medway CCG	Musthafar Oladosu	Designated Nurse for Adult Safeguarding
Surrey Heartlands	Helen Milton	Designated Nurse Safeguarding Adults, Surrey Wide
Note: Since the completion of this DHR, Kent & Medway CCG Surrey CCG has become Kent & Medway Integrated Care Board and Surrey Integrated Care Board.		
KCC Integrated Childrens Service	Kevin Kasaven	Assistant Director Of Safeguarding, Quality Assurance & Professional Standards
KCC, Adult Safeguarding	Catherine Collins	Strategic Safeguarding Manager
CAFCASS	Deborah Bean	Service Manager
Medway NHS Foundation Trust	Bridget Fordham	Head of Safeguarding
Area Council	Maxine Quinton	Community Safety Officer
The Education People	Claire Ray	Head of Service

Agency	Name	Job Title
KCHFT	Andrea Svinurai	Safeguarding Assurance Lead
Choices	Jackie Hyland	Independent Domestic Abuse Specialist

8.3 Panel members hold senior positions in their organisations and have not had contact, involvement or management oversight of work with Beth or Richard. The panel met on four occasions during the DHR. The terms of reference were set on 4th November 2020. The IMR review meeting was held on 4th May 2021, followed by a meeting to discuss the first draft of this report on 14th September 2021. A second draft meeting was held on 12th October 2022 after further information was returned from agencies and family involvement. A third overview draft meeting was held on the 29th November 2022 where recommendations and actions were also agreed.

9. Independent Chair and Author

9.1 The Independent Chair, who is also the Author of this Overview Report, is a Social Worker. He has had no professional connections with Kent apart from authorship of a number of Safeguarding Adult Reviews and two previous Domestic Homicide Reviews. He is currently the Independent Safeguarding Chair for Dimensions UK, an organisation for those with Learning Disabilities and Autism.

9.2 The Independent Chair has a background in both Social Work and investigations. As well as the role with Kent he provided the safeguarding input into a Charity Commission Inquiry into safeguarding failings at the Royal National Institute for the Blind in 2018/19. He was also the joint children and adult safeguarding chair for Walsall Metropolitan Borough from 2015 to 2018 where he had the lead for Domestic Abuse policy implementation, review and audit.

9.3 He has completed both modules of the relevant Home Office training and has enhanced knowledge of Domestic Abuse through his work on Safeguarding Boards where he held agencies to account for their efficacy with regard to Domestic Abuse.

10. Other Reviews/Investigations

10.1 There were no other relevant investigations.

11. Publication/Dissemination

11.1 This overview report will be publicly available on the Kent County Council and the Medway Council websites.

11.2. Family members will be provided with the website addresses and also offered hard copies of the report.

11.3 Further dissemination will include:

a. The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Integrated Care Board and the Office of the Kent Police and Crime Commissioner amongst others.
b. The Kent and Medway Safeguarding Adults Board (KMSAB).
c. The Kent Safeguarding Children Multi-Agency Partnership (KMSCMP).
d. Additional agencies and professionals identified who would benefit from having the learning shared with them.

12. Equality and Diversity

12.1 The nine protected characteristics under the Equality Act 2010 have been reviewed and due consideration given as to whether or not these were applicable. Sex is relevant in that Beth was a white British woman was murdered. Women are far more likely to be subject to domestic homicide than men. The Home Office publication, "Tackling Violence Against Women and Girls", published July 2021 makes the point that 7.3% of all women in the UK have been subject to Domestic Abuse of some kind.

12.2 Data from the Home Office Homicide Index for the year ending March 2016 to the year ending March 2018 show that the majority of victims of domestic homicide were female (74% or 270). This contrasts with non-domestic homicides where the majority of victims were male (87% or 849).

"Of the 270 female victims of domestic homicide for the year ending March 2016 to the year ending March 2018, the suspect was male in the majority of cases (260). Of the 96 male victims of domestic homicide in the same timeframe, the suspect was female in 46 cases, and male in 50 cases. [1]."

12.3 Further, the Home Office analysis of Domestic Homicides *(Ref Office of National Statistics 2016)* found that 97% of female domestic homicide victims were killed by men whilst only a third of male domestic homicide victims were killed by a woman. The summary of the research available to this review is that a woman is far more likely to be a victim of domestic homicide than a man, as happened in this case.

12.4 Richard's part-Spanish heritage was not considered to be relevant to the review.

13. Background Information

13.1 Beth was described by her mother as *"beautiful and friendly, she attracted male company".* She was also both *"capable and determined"* and someone whose friends confided in. Beth had been an accounts manager with a national bank before she met Richard. She later retrained as a beauty therapist.

13.2 She had two older boys from a previous relationship, Sam and Harry, who are both adult at the time of this review. Lynne has assured the Independent Chair that neither wished to take part in this review and that she has kept them updated.

13.3 Richard met Beth through on-line dating in 2004. Richard lived in Spain with his English mother and Spanish father. At the time they were funding Richard to become a commercial pilot. Beth moved out to live with him shortly after they met. Beth's idea was to open a "petting zoo" for children in Spain.

13.4 Beth and Richard's first child together, Child A, was born in 2006 in Spain. When Child A was aged nine months the couple returned to the UK. Richard's parents

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[1] *https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019*

came over shortly after and began to assist in childcare for the couple. More so once the twins, Child B and Child C were born in 2012.

13.5 Beth and Richard separated in 2014 with Richard remaining in the family home. Beth moved on several occasions before finally moving back in with Richard in May 2018. They were not in a relationship at this point but were co-parenting.

13.6 It is reported in the Police IMR that in late September/early October 2018 Beth secured well-paid employment that would allow her a sufficient mortgage to buy Richard out of the home. The mortgage at this point was in Richard's name and he had therefore had sole control over the house. Buying Richard out would have given Beth a degree of independence from Richard and this loss of control, on Richard's part, may well have been the catalyst for the homicide.

13.7 Later in October 2018 Beth returned home from work. She was in contact with friends via her mobile phone until 22:00 but was not heard from again. Friends reported that Beth appeared happy. Richard reported Beth as "missing" some thirty-six hours after she was last heard from, this was done after pressure from Beth's older sons. In spite of exhaustive searches by the police, family and community Beth's body has not been found.

13.8 Richard was charged with Beth's murder in December 2018, one of the few perpetrators to be charged in the absence of a body and was found guilty at trial in October 2019.

13.9 It was established at the trial that Richard had taken Beth or Beth's body from the house overnight in October 2018 to an unknown place. Richard had pleaded "not guilty" but was found guilty by a unanimous verdict and sentenced to a life sentence with the judge commenting, *"It was, I'm sure, a planned and calculated operation that developed as it became clear that Beth's plans were to raise a mortgage and buy out your stake in the property. If she succeeded in that aim, you risked surrendering control of your family home to her".*

13.10 Richard's father committed an offence against a child in 2014. The nature of this offence and the outcome have been made known to the Independent Chair of this review but there is no need or relevance to repeat the information in this

review. The nature of the offence has relevance to the narrative and to the response of agencies.

14. Chronology

14.1. This section focuses on the timeline agreed for the review period, 1st June 2014 when Beth and Richard separated to the, believed, date of death. For context, some information from prior to June 2014 is included.

14.2. Beth and Richard met through internet dating in 2004. They initially went to live in Spain with the intention of Beth running a "petting zoo" and Richard becoming a qualified pilot.

14.3. Their first child, Child A, was born in Spain in 2006. The couple returned to the UK in the summer of 2007.

14.4. Beth gave birth to twins, Child B and Child C, in 2012.

14.5. According to Beth's mother the plan was for Richard to become a *"house-husband"* and to care for the children whilst Beth returned to work. The Independent Chair of this review was told that Richard, increasingly, struggled with this and left the child care to his parents who had moved to the UK shortly after the birth of the twins.

14.6. On 15th May 2012, the Health Visitor met both Beth and Richard at a *"New Birth Visit".* Beth reported that she was on medication for mental health issues and that she had previously been under the care of a mental health facility in Dartford. No maternal mood assessment was undertaken, and no enquiries made regarding domestic abuse. It is acknowledged that the latter might have been difficult given that both parents were present. The former should have been undertaken, especially given Beth's report of her mental ill-health. **(Missed opportunity).**

14.7. On 6th June 2012, the Health Visitor rang and spoke to Richard. An offer to weigh the twins was declined and there was no apparent enquiry of Beth with regard to her mental health.

14.8. The paternal grandmother took the twins to clinic on 25th September 2012 saying that she cared for the twins whilst the parents worked. She informed the Health Visitor that Beth was coping well with the twins on weekends. She further reported that Beth had bi-polar and was on medication. This is the first mention the Independent Chair has seen of "*bi-polar*" and there is no known evidence that Beth had been diagnosed with bi-polar but if she had it could have been flagged as a vulnerability. As it was this seems to have been left as a potential concern with no support offered or validation attempted.

14.9. On 9th June 2014 Richard contacted the police to say that he and Beth had separated the previous month and that she intended taking the children to her parents in Portsmouth. Beth contacted the police on the same day asking what rights she had as she had been locked out of the house and was unable to see the children. She also went to see the Health Visitor. She is recorded as being *"tearful"* and told the Health Visitor that a friend was staying with her, and that the friend's daughter had been sexually assaulted by a man on the "*Sex Offender List*". The details of this report are confused, and Beth was advised to report the issue to Social Services. Given their own safeguarding duty the Health Visitor should have elicited the full details for professional curiosity and made their own referral to ensure that Social Care were aware and had full information.

14.10. On the following day Beth contacted the Social Care Central Duty Team. She informed them that she and Richard had decided to separate but that they were still sharing a house. She reported that things were getting too difficult and that she had planned to take the children to her mother in Portsmouth. She said that Richard had locked the twins in a room with his mother and had locked Beth out of the house. Beth was advised to seek legal advice as this was likely a private law matter.

14.11. On 11th June 2014 Richard submitted a C100 private law application for a Child Arrangements Order in respect of the three children. He also applied for a Prohibited Steps Order to prevent the children being removed from their school or from his care. The Children and Family Court Advisory and Support Service (Cafcass) Family Court Advisor (FCA) screening the matter noted that the paternal grandfather presented as a risk to children. **(Expected practice)**

14.12. On the same date the education chronology records a member of school staff noting: *"mum and dad split, and dad given sole custody of the children. Poor attendance, mum bi-polar but often does not take her medication"*. Given the wording and emphasis it is likely that this information was from Richard and appears to have been recorded without query or triangulation.

14.13. Beth contacted the allocated Social Worker on 13th June 2014 reporting that she had been *"thrown out"* of the 'home', that she was not having contact with the children and that Richard had been abusive towards her. The record does not detail whether safety advice was given or what, in this context "*abusive*" meant.

14.14. On the same day, a Strategy Meeting was held comprising of the Social Worker, police and a representative from education in response to Beth's referral. It was reported that the children were staying with their paternal grandmother until the weekend. The meeting noted that Beth had reported that she had been abused but did not record detail of the alleged abuse/abuser. The Social Worker then visited Richard at home. Richard expressed concern about Beth's mental health. It was also said at the visit, the information having come from Richard, that Beth had been abused as a child. Richard stated that he had an Interim Residence Order in respect of the children.

14.15. The Social Worker rang Beth following the visit, Beth expressed concern that Richard might have taken the children out of the UK and/or that they had been left with a "*paedophile's wife*", the paternal grandmother.

14.16. An outcome of the day was an agreed "Working Together" document that the paternal grandfather would have no contact with the children.

14.17. On the 16th June 2014 Beth attended her GP surgery. She spoke of her mental health and confirmed that she had stopped taking antidepressants a month before. The record confirmed that she had suffered from depression from time to time for years and had been an inpatient in 2009 with depression. Other, more serious mental illnesses, specifically bipolar and psychosis were recorded as not being an issue. She was not diagnosed with any mental ill-health at the time.

14.18. On the following day the Social Worker, again, visited the house and met the three children. Further discussions took place with Richard regarding the potential risk

posed by his father. The Social Worker also spoke to Beth the same day, there is no record as to whether Beth was questioned about her relationship with Richard and the comments that she had made at the time of referral that he had been *"abusive and aggressive".*

14.19. On the 18th of June 2014, a court hearing took place with the interim arrangement that the children lived with their father and saw their mother every Sunday, Monday and Wednesday or as otherwise agreed. An order was made for the disclosure of police and medical records and Kent County Council were directed to file a s7 report[2].

14.20. The Social Worker telephoned the GP on the 19th June 2014 regarding the order made the previous day. The GP said that Beth's mental health was not a concern with regard to her contact with the children and agreed to release a full report with Beth's consent, this was subsequently provided on the 30th June.

14.21. Cafcass undertook a safeguarding telephone interview with Richard on 20th June 2014. He updated the FCA on the written agreement, he denied being the survivor or perpetrator of domestic abuse but said that Beth had mental ill-health and could be aggressive when she was not on medication.

14.22. Beth was interviewed by the Social Worker on 23rd June 2014. She had attended a Children's Centre and was seen there with Child B and Child C. She reported that she did not have a mobile phone, Richard having "*cut it off*" **(probable example of Coercive control and/or economic abuse)**. Amongst other things Beth reported that she had been in hospital for an operation seven weeks before and that Richard had not visited, that Richard had wanted her to be sterilised prior to her falling pregnant with the twins. Once pregnant he wanted the pregnancy to be terminated. It is recorded that Beth mentioned moving to Portsmouth to "*get a reaction from him* (Richard*)".*

14.23. On 25th June 2014 Cafcass filed a safeguarding letter with the court. They had spoken to the Social Worker and to Richard but not to Beth (No mobile phone as Richard had disconnected it).

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[2] https://rightsofwomen.org.uk/wp-content/uploads/2021/07/Children-and-the-law-a-guide-to-Cafcass-and-section-7-reports.pdf

14.24. There was a strategy discussion on the 26th June 2014 that concluded the section 47 investigation which considered the children's safety in the light of the risk posed by the paternal grandfather. It determined that there were no substantiated concerns in respect of the paternal grandfather. It was noted that the ongoing difficulties between the parents was attributable to their separation but confirmed that a child and family assessment would be completed. The potential for coercive control was not considered. Coercive or controlling behaviour became an offence in 2015, and therefore there would have been less awareness in 2014.

14.25. Beth contacted the Social Worker on 1st July 2014 claiming that Richard was leaving the care of the children to others in the home. Likely his mother.

14.26. Beth contacted the police on 6th July 2014 to say that she had attended the address on 2nd July 2014 to see the children and that, on that occasion, Richard had been verbally abusive towards her and had pushed her. Richard was subsequently interviewed under caution and denied any assault. A DASH risk assessment was undertaken and was assessed as "Standard".

14.27. On 7th July 2014 Beth contacted the Social Worker to say that Richard was "controlling everyone" in the home. She also said that Richard was leaving the care of the children to others. The Social Worker subsequently rang Richard and discussed sleeping and care arrangements. Beth's allegations of control were not apparently followed up. Again, it is right to comment that Coercive Control was not properly understood in 2014.

14.28. Beth contacted the FCA on 17th July 2014 and reported that she was upset not to have been contacted regarding the safeguarding letter. The FCA told her that they did not have a number for her. Beth then updated on her concerns for the children, that others were caring for them and that she had been pushed and denigrated by Richard.

14.29. On the following day, the Social Worker visited Child A in school who was positive about contact with their mother. Child A also reported that Richard treats everyone like a slave in the home and expects everyone to do everything.

14.30. On the 21st July 2014 Richard wrote to the Social Worker stating that he would give up work to care for the children and that he was concerned about Beth's ability to care for them if she was not taking her medication.

14.31. Over the 24th and 25th July 2014 Cafcass received and evaluated the enhanced police information that they had received. Both Richard and Beth had offences against them including harassment, theft or interference with a motor vehicle and assault on a police officer (Beth). The alleged assault that Beth had reported on 2nd July 2014 was also seen. The FCA was concerned that this police information and the report of domestic abuse may increase the risk of further conflict whilst assessment was on-going by the local authority. There was no recognition from Cafcass at this stage that Beth might be a victim. Again, coercive control was not widely understood in 2014.

14.32. On the 30th July 2014 Beth was seen alone by the Social Worker, she reported that Richard had said that she is a "*shit mum*" and that she's never going to have the children in her care. With hindsight, Beth may have felt defeated at this stage due to the coercion and control that she had been subject to.

14.33. The medical report from the GP was received by the Social Worker on 5th August 2014. She had suffered from depression over the years and had taken an overdose in 1985. There was no evidence of bi-polar when seen on 14th June 2014 and there were no concerns about her ability to care for the children.

14.34. The Child and Family Assessment was completed on 6th August 2014. The key information it contained was that:

- Child A was negative about their father, that Child A does not want to live with him but did want to live with their mother.
- Child A said that their father *"treats people like slaves*" and that Child A's father did not do anything at home.
- The maternal grandmother was supportive of Richard in caring for the children.

There was an emotional impact on the children of the parent's separation.

14.35. The outcome was to recommend a Child in Need plan to enable work with the family to prevent any long-term emotional abuse. This was to involve the wider

professional network including the schools, though not health or the Health Visitor as checks had shown that there were no relevant concerns.

14.36. The Social Worker met Richard and Beth on the following day. She observed continuing animosity and negative communication. Richard expressed that he was concerned that Beth has anger problems now that she is not on medication.

14.37. On the 14th August 2014, the Social Worker visited Richard and the children. Richard reported that Beth was being negative toward him and showed the Social Worker text messages to illustrate this.

14.38. On 22nd August Richard contacted the police with concerns that Beth had made a number of false allegations about him. No offences were disclosed but it was noted that Richard suggested that Beth had tried to kill herself in 2003 and that she suffered with anger and depression. He suggested that the false allegations were an attempt by Beth to get "*custody*" of the children.

14.39. The Health visitor went to the home on 26th August 2014 for the two-year development check on Child B and Child C. The record documents that the paternal grandmother was the main carer, thereby substantiating Beth's allegation that Richard was delegating care. It was recorded that contact between Beth and the children was not going well. The paternal grandmother explained that a Social Worker was involved. **(This was a missed opportunity for the Health Visitor to ask more and to link with the Social worker).**

14.40. A Child in Need meeting was held on 16th September 2014 attended by both Richard and Beth. The plan focused on the educational needs of the children, health needs were to be met by parents and Beth was to seek help for her mental health if needed. It was said that the parents were not managing handovers well.

14.41. A private law hearing commenced on 25th September 2014 but was not finalised as Richard and Beth were unable to agree a plan. It was said that communication between Richard and Beth had deteriorated since the last hearing and also that Richard had a new partner. The Social Worker was to make further enquiries and to try to assist the parents further and to file an addendum report in November 2014.

14.42. Later that day Richard contacted the police to advise that he had "*gained custody*" of the children.

14.43. On the 10th and 13th October 2014 Richard contacted the police with allegations that one of Beth's older sons had committed criminal damage, this was disproved, also that they (Beth's older sons) knew of the concern regarding the parental grandfather.

14.44. The Social Worker visited Child A in school on 14th October 2014 to seek their wishes and feelings about contact with both their mum and dad.

14.45. A Child in Need meeting took place on 17th October 2014. No concerns were raised about the children, and it was said that contact between the children and Beth was going well. Handovers were still problematic.

14.46. Child A's school wrote to Beth on 5th December 2014 regarding pick-up arrangements for Child A. This appears to have been in response to a phone call from Beth. Her behaviour was described by the school in their records as "*aggressive, shouting and accusing*". She had apparently suggested that the school had acted unlawfully by going against the latest court order. The school confirmed that they had the order from June 11th 2014 and were abiding by that order.

14.47. The Social Worker again visited Child A in school on the 12th December 2014 and Child A was supported to write a letter to the judge. Child A said that they wanted to see more of their mum but asked the judge to decide on the arrangements. Child A also said that Child B and Child C should stay in both houses.

14.48. The school recorded receipt of a letter from Social Care confirming that they had no further role and that the matter was closed, all actions in the plan having been completed.

14.49. Both Beth and Richard made complaints to the police over the 19th and 20th of January 2015. Richard alleged that Beth had damaged his mother's car and Beth alleged that Richard had been verbally abusive to her with regard to the same incident. Beth further alleged that Richard used ecstasy and cocaine. Richard

was spoken to, and he alleged that it was Beth who was abusive and aggressive. A DASH risk assessment in respect of Beth recorded the risk to her as "*medium*" and Social Care were informed.

14.50. Social Care record receiving a Domestic Abuse notification on 28th January 2015.

14.51. On the 27th February 2015, the police were present at Richard's house when Beth returned the children. Beth was recorded as being angry about this, but it appears that they were present for a welfare check concerning some allegations that Beth had made.

14.52. Richard contacted the police on 8th March 2015 after one of Beth's older sons approached Richard regarding the risk posed by the parental grandfather. The police spoke to both Beth and the son. Beth was described as "*rude*" to officers throughout the interaction.

14.53. Richard again contacted the police on 11th March 2015 alleging that Beth was refusing to return the children to him saying that one of them had said that Richard had smacked him. Having checked the court order they determined that they had no powers to "*recover*" the children from Beth.

14.54. The school record receipt of a final order on 21st April 2015. A Child Arrangements Order had been made outlining living and contact arrangements. Beth and Richard were to have shared care.

14.55. On the following day, the school recorded, in writing, a conversation between the Headteacher and Beth referring to Beth as "*delighted to have won her day in court"*. She asked that the school record who collects and drops off Child A on the days that Richard has him. The school agreed to this at the time.

14.56. The school spoke to Richard the day after who questioned whether it was within the school's role to record who collected and dropped off Child A. The Headteacher agreed to review this decision. Richard also provided the school with a two-week programme covering which parent had care of the children.

14.57. On 11th May 2015 Beth asked whether the school had kept records of who was bringing and collecting the children. The Headteacher explained that this was

problematic and that, if they did, the school would be getting involved in the parental dispute. The Headteacher subsequently sought advice from Kent County Council's Children's Safeguards Team who advised against keeping the records that Beth had requested as this compromised the neutrality of the school.

14.58. Child A's school also recorded a discussion with a member of staff from the twins' pre-school. They had considered complaining about Beth's behaviour to Social Care and asked whether Child A's school staff felt the same. The Headteacher confirmed that they did.

14.59. At the same time Beth asked for the complaints procedure for Child A's school saying that if the paternal grandmother was allowed to collect Child A, they were potentially allowing him to have contact with a paedophile (paternal grandfather).

14.60. In response to this Child A's Headteacher wrote to Beth on 13th May 2015 acknowledging Beth's concerns, clarifying that the paternal grandmother was permitted by the court order to support with handovers and attaching the complaints procedure.

14.61. Private law proceedings are recorded as having concluded on the 13th May 2015 with no further role for Social Care.

14.62. On 20th May 2015, the police attended Richard's home to conduct a welfare check, apparently in response to a suggestion that the paternal grandfather was in contact with the children.

14.63. Child A was not in school on 5th June 2015. Beth subsequently informed the school that Child A had been at another school for a "*taster session*". The school informed Richard of this.

14.64. On the 8th June 2015, another school confirmed that Beth had arranged for Child A to start there. On Richard showing them the Court Order the place was withdrawn. Beth responded by saying that she would return Child A to his current school on the following day but that she was considering home educating him.

14.65. Richard contacted Social Care on the 11th June 2015 asking for it to be noted that his wife, presumably Beth, was making allegations about his father without proof.

14.66. On 12th June 2015 Beth contacted Social Care to say that they were both living in the family home whilst Beth looked for somewhere else to live. Beth was finding it difficult because Richard was being aggressive towards her. She further made allegations that Richard's father is having contact with the children. The police attended the home but found no evidence of the presence of Richard's father. The referral was progressed to a Child and Family assessment with the main rationale being the acrimonious separation of the parents. There were also continuing concerns about any risk posed by the parental grandfather.

14.67. Beth contacted the police on 6th July 2015 alleging that Richard and his new partner had been subjecting her to harassment since April. This included verbal abuse, Richard driving past her place of work and taking photographs. A DASH risk assessment was undertaken during which Beth disclosed that Richard had put his hands around her throat. The risk was assessed as "*standard"*. The law on non-fatal strangulation has since changed and the Independent Chair of this review notes that the risk would most likely not be "*standard"* today. The officer spoke with Richard and his partner and gave them a verbal warning. Attempts were made to following this up by serving a written "*Harassment Warning*". This was a system in place at the time. If the behaviour continued it could lead to formal proceedings. Richard denied the behaviour and his partner refused to sign the papers. The officer continued to try to serve the papers but was not successful. That the papers were unsigned was immaterial, an unsigned warning could still have been used as evidence in a future prosecution.

14.68. On 28th July 2015 Beth applied for the current Child Arrangement Order to be varied and a Specific Issue Order to deal with Child A's schooling and future education. The FCA subsequently reviewed the information, received checks from the police and local authority and arranged safeguarding interviews.

14.69. The Health Visitor attempted to visit on 13th August 2015 as Beth had moved area. Whilst this was good practice. The notes say that Child A answered the door and told the Health Visitor that Beth and the twins were away in Portsmouth. This was not followed up.

14.70. On 29th August 2015 Beth reported to the police that she had heard that her ex-partner was not looking after the children, she asked the police to check on them. The police declined to do so and recorded that Beth had become "*abusive*".

14.71. The Cafcass FCA undertook a telephone safeguarding interview with Beth on 2nd September 2015. Beth continued with the allegation that the children were coming into contact with the parental grandfather. She also spoke of the Harassment Warning letter sent to Richard by the police. She also told the FCA that she was planning on moving Child A to a new school and asked that this be kept confidential. The FCA confirmed that she was unable to do that, and that the information would need to be disclosed to court. Beth became "*irate*" and ended the call.

14.72. The FCA interviewed Richard by phone the following day as a part of the same process. He confirmed that the children were not having contact with their father. He further confirmed that the police had spoken to him but said that no warnings had been issued. He also expressed concern for Child A's emotional welfare saying that he believed that Beth was involving Child A in "*adult issues*". He believed that Child A did not want to change schools and that Child A was happy where they were.

14.73. The District Judge made an order, of the court's "own motion", on 4th September 2015 reminding the parents of the arrangements agreed.

14.74. In early September 2015, a non-molestation order was served on Richard, Beth having complained that she was subject to behaviours from Richard and his partner that amounted to harassment.

14.75. The police were contacted by Beth on the 7th September 2015 to say that Richard had driven past her place of work in contravention of the non-molestation order recently made. Richard was subsequently arrested for breach. He then sought an amendment that would allow him to drive past the place of work in connection with his work as a taxi driver. No charges were made, and the incident was assessed as "*standard*" via a DASH risk assessment.

14.76. On the same date Richard contacted Child A's school to say that Beth was considering placing Child A in another school when they were in her care. Richard had been in touch with the proposed school and had shown them a copy of the Court Order.

14.77. Over the course of September and October 2015 Child A's school record a series of low-level concerns. That Child A might have come to school without breakfast, that Child A had a rash, that Child A might be stressed and that Child A had missed a day of schooling due to illness.

14.78. A County Court "*First Hearing Dispute Resolution Appointment*" (FHDRA) took place on 13th October 2015 with the FCA speaking to both parents individually. Beth explained her plans to move the three children to Portsmouth the following year. This was the first time that Richard had heard of the plans and indicated that he would oppose this. He also wished to contest the recent non-molestation order. The judge declined to get involved in discussions of passports and schooling. The FCA supported discussions between the parents about holiday contact.

14.79. On 30th October 2015 Beth made an application to the court for a Specific Issues Order to relocate the children to Portsmouth alongside a new Child Arrangements Order for the children to spend more time with their father. The matter was listed for the 14th December 2015.

14.80. An email was received by Child A's school on 4th November 2015 from Beth and saying that she would be moving to Portsmouth the following July, that the twins will not need their places and that Child A will also be moving.

14.81. The Headteacher of Child A's school contacted Social Care on the 12th November 2015 about the impact of Richard and Beth's hostile relationship on Child A. This did not meet the threshold for Social Care intervention and the Headteacher agreed to contact the parents to consider a referral to Early Help.

14.82. Child A's school excluded them from 2nd to 5th December 2015 due to behavioural issues. This potentially stemmed from the difficulties between their parents.

14.83. The Cafcass FCA spoke to both parents on 9th December 2015 in anticipation of the hearing listed for the 14th December 2015. Both repeated previous allegations made. Beth saying that communication was still poor with Richard and that he had refused to attend a mediation meeting. She also spoke of Child A being "*withdrawn, sad and aggressive*" at times. Richard spoke of the children being looked after by Beth's older, adult, sons. He said that he would oppose the move to Portsmouth and that he would wish the children to live with him if Beth moved.

14.84. At court on the 14th December 2015 the local authority were directed to file a further report to consider whether it was in the children's' interests to move to Portsmouth and, whether or not the move took place what shared care arrangements should be in place. An update from Child A's Headteacher was to be included in the report. The hearing was scheduled for 4th April 2016.

14.85. On the same date Richard reported being assaulted by an ex-partner (not Beth). The person was interviewed but not charged. Richard claimed to have taken out a Restraining Order against her.

14.86. On the following day, the 15th December 2015 Richard's ex-partner contacted Beth to say that Richard walked around the house naked, that he watched a lot of "*porn*" and that grandmother sleeps in the same bed as the three children. Beth contacted both the police and Social Care to relay this, and other, information. The police advised that Social Care were in the best position to deal with this. Social Care assessed the matter and took no action.

14.87. On 23rd December 2015 Cafcass closed their involvement.

14.88. On the 3rd January 2016, the police recorded intelligence on Facebay (Probably Facebook but "Facebay" is recorded on the "intel" report) social media site "outing" Richard's father as a paedophile, giving Richard's address and saying that he was "*going the same way*". The police visited Richard and his father and gave safety advice.

14.89. The following day Richard reported to the police that he was being harassed by an ex-partner (not Beth) on social media.

14.90. Richard and Beth were both interviewed by Cafcass on the 7th January 2016 in preparation for the next court hearing. No new safeguarding allegations were made.

14.91. The police were contacted by an ex-partner of Richard on 16th January 2016 complaining about a non-molestation order that he had taken out against her. She claimed that all contacts were initiated by him and that he was "*controlling*".

14.92. The Social Worker undertaking the current assessment as to whether Beth could relocate with the children to Portsmouth visited her in the company of the previous Social Worker on 19th January 2016. This ensured continuity with the previous Social Worker who knew the family well.

14.93. Child A's school reported on 27th January 2016 that Child A sustained a black eye in a football match when Richard was present. Richard is described as having a positive relationship with the school, attending parents' evenings and supporting Child A with their homework. By contrast Beth is described as having a "*turbulent*" relationship with the school however, that had improved, and she was supportive of Child A's education.

14.94. The Social Worker then visited Richard on the 30th January 2016 who confirmed that he would contest Beth's planned move to Portsmouth saying that it was not in the children's best interests.

14.95. The Social Worker again visited Beth on 5th February 2016. Beth confirmed her plan to move to Portsmouth as it was near her family and a house that she owned in Portsmouth. She reported the harassment order against Richard and said that she'd email it to the Social Worker. There is no record as to whether or not this was done.

14.96. Child A was visited by the Social Worker at school on the 23rd February 2016 to record their views about moving to Portsmouth. Child A is reported as saying that they did not want to talk about it but that they did not want to move school. The Headteacher confirmed that the parents are hostile towards each other.

14.97. The police check on Richard, part of the court proceedings, was received by the Social Worker on 16th March 2016. It confirmed that he was subject to a non-

molestation order, that he had breached it and that a number of non-crime domestic abuse incidents had been recorded.

14.98. In an email exchange between Beth and Child A Headteacher on 14th April 2016 the school confirmed that they had made a referral to Social Care because they felt that the family needed support.

14.99. Richard reported to the police on 5th June 2016 that his ex-partner (not Beth) had breached a non-molestation order. She admitted ringing him whilst intoxicated and the CPS agreed a charge.

14.100. Child A was again visited by the Social Worker on the 4th July 2016. Child A reported that they wished to remain in Kent. The Social Worker considered that Richard might have influenced Child A's views.

14.101. A private law hearing on 11th July 2016 agreed that Beth could move to Portsmouth from 28th August 2016 with the children. They would have fortnightly contact with their father.

14.102. Social Care closed their involvement on 15th July 2016.

14.103. On 6th September 2016 Child A started school at a Primary School in Portsmouth. Child B and Child C joined the school on 9th September 2016.

14.104. The school recorded on 30th January 2017 that Child A had pulled another child's trousers down. This was shared with Beth who said that Child A had asked their younger siblings to take their pants off. She also said that she believed that Child A's father and grandmother walked around naked in front of Child A. She further told them that the paternal grandfather was a registered sex offender.

14.105. All three children started at another school in Surrey on 6th February 2017. The reason for Beth's move is not recorded, though it may have been to move closer to a new partner.

14.106. On 8th March 2017 Richard issued an application to vary the Child Arrangements Order and the Specific Issues order. This had given Beth permission to move to Portsmouth. Richard reported in his application that she had moved again

thereby breaching the previously agreed order. The move had taken place sometime around the previous December and Richard had become aware when the children were accepted into their new schools in February. Safeguarding checks were to be provided by Cafcass and a hearing was arranged for 21st April 2017. On the same date Beth contacted the Surrey police to say that Richard's mother had lost her "*child carers licence*", that she was suspected of looking after children "*unlicensed*" and that she was suspected of grooming children for her husband. Surrey police contacted Kent who found no evidence of what had been alleged or that Richard's mother had been a child-minder. The matter was referred to Social Care.

14.107. A further private law hearing took place on 21st April 2017 with Cafcass now directed to file a s7 report. Beth said that she had moved from Portsmouth to North Kent to be near her current partner. Richard was concerned that Beth's current lifestyle did not give stability to the children.

14.108. In a phone consultation with the GP on 24th April 2017 Beth was prescribed antidepressants to help her manage a "*nasty child custody case*".

14.109. On 20th May 2017 Richard reported to the police that he had been harassed by a woman with whom he'd had a "*one-night stand*" in February 2017. A few days later, the 26th May 2017, the same woman reported Richard for abusing and assaulting her. She had apparently become pregnant and had been assaulted when Richard thought that she had not had an abortion as he had wanted. She reported the matter having received a harassment warning; she did not want any action taken but wanted to "*set the record straight*".

14.110. Over June 2017 Beth had contact with her GP on four occasions, twice in person and twice by telephone. She was feeling low, she had headaches and abdominal pain. She spoke to the GP of the difficulty of getting the children back, her struggles with her job and her low mood.

14.111. The Social Worker visited Child A in school on 4th July 2017. When asked what gives them a sad face, Child A said, "*knuckle sandwich*". It is not known where this came from or whether the Social Worker explored this further.

14.112. On the same day Beth emailed the Social Worker saying that Richard had asked others not to speak to her. He has been abusive and threatening when Beth has contact with another adult in the house. She said, "*Richard seems to be getting very angry and quite abusive and I don't know what to do*". The Social Worker tried ringing Richard and Beth but received no response. The Social Worker did speak to the paternal grandmother who reported that Beth was putting nasty messages on social media.

14.113. On the 14th July 2017, the FCA visited all three children who expressed a wish to be back in the family home and to be cared for by both parents.

14.114. The FCA spoke to Beth on 18th July 2017. She reported that the children were settled with her and her partner in their new schools. Her partner had asked her to marry him, and she believed that the children had a good relationship with him.

14.115. Richard spoke by telephone to the FCA on the 20th July 2017. He believed that the children wanted to live with him. He also queried whether they might be homeless if Beth's current relationship broke down.

14.116. The section 7 report was filed on 25th July 2017 recommending that the children lived primarily with their mother and spent time with their father.

14.117. The hearing subsequently took place on 11th August 2017. The judge asked that Child A be brought to meet her on 21st August so that she could explain the outcome to them.

14.118. Beth visited her GP on 23rd August 2017. She talked of multiple court cases which she had found upsetting. She was tearful and stressed, she was signed off work.

14.119. Cafcass closed their involvement on 10th September 2017.

14.120. Beth visited the GP on 4th October 2017. She reported that the antidepressants were helpful. She was apparently less stressed and more motivated.

14.121. The children's school record in an internal email exchange on 8th November 2017 that Beth had told the school that she was "*sofa-surfing*". She could not be

housed because she owned a property in Portsmouth but that she was unable to move there due to legal issues with her ex-husband (the older boys' father).

14.122. Beth registered with a new GP on 15th January 2018. She reported low mood, troubles with her ex-partner and a recent job change but that she was coping better on antidepressants.

14.123. The children's school submitted a MASH (Multi-Agency Safeguarding Hub) enquiry form to Social Care on 6th February 2018 regarding Child B's behaviour. Child B's behaviour change was apparently particularly noticeable when they returned from contact with Child B's dad. It was believed that the children were spending more time with the parental grandmother than with their father. The school had also not been informed about the risks posed by the paternal grandfather. The outcome of this was that Early Help was to be offered.

14.124. The school contacted Beth on 9th March 2018 regarding Child B's behaviour. She was asked to come to the school as Child B had been making a mess and throwing things around for 30 minutes. Beth was described as being "*short"* on the phone. On arrival she was said to have "*grabbed Child B*" and dragged them to the car. Beth threw Child B on the back seat and was heard saying on the phone *"this school rings me every fucking day".* She then drove off whilst on the phone. There was no record of any action taken.

14.125. On 4th May 2018, the school completed a Child Protection Expression of Concern form, one of the children having exhibited some concerning self-harm behaviour, possibly linked to the parental dispute.

14.126. The three children started at North Kent schools on 22nd May 2018.

14.127. The new school recorded notes of a telephone conversation between the new and old schools. The SENCO (Special Educational Needs Coordinator) from the previous school had said, *"Mum is volatile, blows hot and cold. Everything is about her. Take everything she says with a pinch of salt*". Child B was said to be "withdrawn". Concerns were raised about Child A. Child A had been seen by the Educational Psychologist who suggested Attachment Disorder with some possible language difficulties. It was added that the family had left the area

suddenly without warning. Beth had been living with a new partner for nine months. In her words, "*he has recently kicked her out as he had had enough".*

14.128. On 31st May 2018 Richard reported the woman with whom he had had a *"one-night stand"* in February 2017 had been stalking him. He said that she had befriended Beth with a view to gaining information about him. He described Beth as his partner. The officer spoke to Beth who was clear that she was not Richard's partner. She confirmed that they were co-parenting their children. She alleged that he had slept with four of her friends including the one he was making allegations against. No stalking behaviours were identified.

14.129. On 6th June 2018, a safeguarding file was started at the children's school reporting that Beth, Richard and the children living at the same address.

14.130. On the following day, the school had conversations with Beth and the Kent Social Worker to clarify the current situation with regard to safeguarding referrals. There had been a request from the Surrey MASH for information in February 2018 but that this had not been followed up due to a lack of parental consent. This was further discussed with Richard on the following day who confirmed that his father had been on the "*sex offender register"* and that the Working Together Agreement had been followed.

14.131. Child B started part-time at a North Kent Primary School on 11th June 2018. Child B became full-time on 22nd June 2018.

14.132. On June 18th 2018 Beth arrived late at school explaining that she had slipped and fallen downstairs. The school noted this with a comment that they would follow it up. There was, however, no follow up and it is not known whether this was a matter of significance or not.

14.133. On the following day Child B was recorded as being very upset at school. The action was for the Designated Safeguarding Led to take advice about severe attachment issues.

14.134. Over the remainder of June and July 2018 the school recorded several other issues where Child B was unhappy or uncompliant. On 22nd June 2018 Beth visited the school, she said that she had chosen not to work so that she could

support Child B until they were more settled. She also said that she felt let down by doctors and Social Care saying that she had been *“fobbed off and that she could really do with some support at home with Child B”.*

14.135. It was agreed by the school that the Early Help application would be progressed on 25th June 2018. In spite of this no action seems to have been taken to progress it.

14.136. On the 27th June 2018 Beth was described by several members of staff as *“rude”.* She was said to have been “*uncooperative”* about a consent form for the children’s school trip and that she objected, unsurprisingly, to being called “*Mrs Lopez*”.

14.137. Child B started at a new school in September 2018.

14.138. Beth rang her GP from Scotland on 26th September 2018 reporting an ear infection. She was advised that antibiotics could be prescribed but that she would have to attend the surgery. She did this the following day and was prescribed antibiotics. There is no reason recorded for her being in Scotland.

14.139. Child B’s school spoke to Beth on 4th October 2018 in relation to a school trip. Beth was described as *“quite abrupt*” and explained that she was living in Portsmouth for part of the week. Beth said that the paternal grandmother was not available on the day of the trip and, it was decided, two TAs would support Child B on the trip.

14.140. On the following day, a member of staff spoke to Richard who contradicted Beth and said that his mother was available on the day of the trip. It was recorded that he said, “*as you can tell communication between us is not good”.*

14.141. On 10th October 2018 Beth was reported as missing by Richard. A high-risk missing person enquiry commenced becoming a homicide enquiry six days later. Beth had been living in the family home at the time she had gone missing.

14.142. In December 2018 Richard was charged with her murder. He was found guilty at trial in October 2019.

15. Overview

15.1. This section examines the agency responses to Beth's death individually. With the benefit of hindsight, it is clear that Richard was exercising coercive control over Beth, the judge made that clear in his sentencing, *"…if she succeeded in that aim (buying Richard out), you risked surrendering **control** of the family home to her".*

15.2. Although the information provided is not entirely clear the Independent Chair of this review believes that Beth moved four times after she had separated from Richard in 2014. On separating, she moved some three miles from the previous family home.

15.3. Beth's mother says that she moved in with her then partner, in Surrey at the end of 2016. However, Child A started school in Portsmouth in September 2016 staying there until February 2017. I suspect that she moved in with her then partner in February 2017 and stayed there until she and her partner separated, and she moved back in with Richard in May 2018.

15.4. Taking account of the moves, agency responses cover three counties; Kent, Surrey Heartlands and Hampshire.

15.5. Beth's life, and the lives of the children were unsettled during this period. This may have given fuel to the view that Richard was giving to agencies that Beth was not able to give a settled home to the children. However, looking back at this period and in that knowledge that Richard was exercising coercive control over Beth, her regular moves make sense in the context that she was the subject of abusive behaviour.

15.6. Richard's father admitted a sexual offence. Throughout the review period the risk he posed was regularly assessed. Beth made several allegations that he might be having contact with her children, but this was never proven.

Education Safeguarding Service

15.7. Over the review period only Child A was at school for the duration, moving to secondary school only a month before Beth's murder. Child B and Child C were at pre-school and then primary school.

15.8. Over the period Child A attended four different primary schools, Child B and Child C three. The Education Safeguarding Service note that this is unusual, that it would have impacted on the schooling and the ability to build relationships for all children and that it reflected a transient life style.

15.9. The version of "Keeping Children Safe in Education" applicable at the time of writing, (https://www.gov.uk/government/publications/keeping-children-safe-in-education--2) makes it clear that "*where children leave the school or college, the Designated Safeguarding Lead should ensure that the child protection file is transferred to the new school or college as soon as possible"*. The Independent Chair of the IMR notes that this was done but not necessarily to timescale and that there were some gaps indicative of missing information.

15.10. Information on the school files indicates that staff felt Beth could be difficult at times; staff refer to her as "*shouting and aggressive*". There is less information about Richard on the files but what is there shows him, in the main, to be recorded as *"positive and appropriate".*

15.11. All the schools attended were judged as "*Good*", this suggests that staff would have received adequate safeguarding training including indicators of domestic abuse.

15.12. Due to behavioural concerns regarding Child A and Child B, their respective schools made appropriate referrals to Social Care in the knowledge that the on-going parental dispute between Beth and Richard may have had an impact on the children. Where concerns are at a relatively low-level parental consent is required to make the referral and this was obtained by Child A's school on 12th November 2015.

15.13. A second referral was made to Surrey Social Care on 6th February 2018 this concerned behaviour exhibited by Child B. A MASH (Multi Agency Safeguarding Hub) referral was completed, and the school notes record that Beth spoke to a Social Worker in May 2018, around the time she moved back in with Richard. Parental consent for a referral was not received on that occasion and the contact progressed no further.

15.14. All schools have records of concern relating to Richard's father and the risk he posed to children and concerns expressed that he may be having contact with Child A, Child B and Child C.

15.15. Child A's school for four years had a good relationship with Richard, *"Mr Lopez has a positive relationship with the school; he attends all parents evenings and appears to be genuinely interested in how Child A is doing at school"*. They also raised two incidences where Richard had not acted appropriately, the first was telling Child A to hit someone back if they hit them, the second was regarding an occasion where Child A sustained a black eye in a football match in the presence of their father. How this was "*inappropriate*" was not recorded. The same report detailed that Beth had had a *"turbulent relationship"* with the school but noted that she *"now communicates in a positive way".*

15.16. The Education IMR author observes that the schools were, by and large, effective in the way that they managed and made referrals with regard to the parental dispute but that they did not make an effort to go beyond this and understand Beth's angry behaviour. The assumption was made that this was due to the parental dispute, but it was not explored further with her.

15.17. There was a missed opportunity to do this when Beth reported that she was late at school on 18th June 2018, saying that she had slipped at the bottom of the stairs. The school recorded that they were going to call Beth to follow this up, but they did not. Out of professional curiosity, and in the knowledge of the acrimonious parental relationship this should have been followed up. Richard and Beth had been back in the house together for a month at this point.

15.18. The written recording of handover notes from the DSL (Designated Safeguarding Lead) at the School with the previous school gives significant cause for concern with Beth being described as follows: *"mum blows hot and cold. Everything is about her. Take everything with a pinch of salt".* This language is judgemental and may have had an impact on how staff at the new school viewed Beth. The IMR author, rightly, also makes the point that this would be distressing reading should the children ever request to view their files.

15.19. Apart from the mention of falling down the stairs there was no mention in the files of the potential for domestic abuse and no disclosures or concerns raised by the

children. It is also the case that the children moved schools to such a degree that trust would not have formed which reduces the likelihood of any disclosure by the children. A child is more likely to disclose where they have had an opportunity to build up trust with school staff.

15.20. The schools focused on the concerns about the parental dispute. They could have asked more about the reasons for Beth's behaviour. They could also have explored the reasons for the school moves **(Learning point).** Agencies need to be mindful of the reasons for such moves and what can be learned from them.

15.21. The number of incidents involving Child A's behaviour, particularly over June 2018, are concerning. The analysis of this by the school focused on Child B's needs but it is likely, given what subsequently happened, that Child B's behaviour reflected concerns and behaviours in the family.

15.22. A further **learning point** is that where there is parental acrimony there is likely to be domestic abuse. The schools, rightly, remained neutral in the dispute but this does not stop them exploring causes with either or both parents.

Cafcass

15.23. The private law Child Arrangements Programme was introduced in 2014. This brought in a greater emphasis on parents exercising their parental responsibility with regard to their children. What follows from this is that courts have a lesser role where they believe that parents are capable of exercising their responsibility.

15.24. Cafcass were involved with Richard and Beth over five sets of court proceedings between 2014 and 2017. With the exception of proceedings in 2017 Cafcass' role was confined to undertaking safeguarding checks prior to the first hearing. Further assessments and reports were directed to KCC Children's Services.

15.25. In her first interview with Cafcass in July 2014 Beth described being *"pushed against a wall"* by Richard and being told she'd "*never get the kids"* during the time the couple separated. Two other incidents of pushing were reported to the police. She also reported verbal abuse, Richard describing her as a *"slag"* and as *"lazy"*. As a result of this the Family Court Advisor (FCA) commissioned Level 2 enhanced police checks, these showed that both Richard and Beth were both

reported to be victims of incidents, known as "involved party of a secondary police incident" (an incident not classified as a crime). In July 2014 Beth was also noted as the victim of Common Assault and Battery by Richard and one where Richard was seen as the victim.

15.26. A further application was made by Beth in 2015 to vary the Child Arrangements and to deal with a matter in Child A's education. Beth continued to be concerned about the presence of Richard's father in the family. Within the same proceedings the court made a Non-Molestation Order following Beth having received threatening texts from Richard. The judge spoke to both parents about the emotional harm that their dispute was having on the children.

15.27. At a hearing in December 2015 it was noted that Richard had breached the Non-Molestation Order by driving past Beth's place of work. This was reported in the next safeguarding letter filed but it did not give the FCA cause to further explore the reason Richard might have driven by Beth's place of work.

15.28. In March 2017 Cafcass did undertake a section 7 report, for this they interviewed both parents and saw the children. Child A expressed a wish to live with their father, but primary residence was given to Beth. The judge demonstrated good practice by meeting Child A to explain her reasons for this.

15.29. There were opportunities for Cafcass to make further enquiries with regard to domestic abuse. Beth reported a number of incidents around the time of separation and, later, the Non-Molestation Order was made.

15.30. It is unfortunate, particularly so with hindsight, that Cafcass submitted a Safeguarding Letter in June 2014 without input from Beth. Information had been obtained through a phone call to Richard and from Social Care. The reason that Beth was not contacted was because she had no phone. She suggested that this was because Richard had "*cut it off*". At this very early stage of the separation it was important that such a letter should be balanced. Beth's voice was absent from the letter, apparently, due to an aspect of Richard's controlling behaviour. The letter should have been delayed until Beth's voice could be included in a meaningful way.

Kent Children's Service

15.31. Kent County Council (KCC) were first involved in June 2014 when Beth contacted the (then) Central Duty Team to say that she and her son were homeless. She and Richard had decided to separate but to remain together in the house. This had become difficult and that she had been "*thrown out*". She also reported a potential risk from Richard's father who had committed a sexual offence against a child. A strategy meeting followed, and a Child and Family Assessment was undertaken. The assessment notes that this was an unsettling time for the children and that assistance would be given to reduce the emotional impact on the children through a Child in Need plan.

15.32. In parallel to this, private law proceedings were on-going with KCC reporting to the Family Court.

15.33. KCC were contacted by the Headteacher of Child A's school in November 2015 who was concerned about the emotional impact on Child A. A discussion with Richard, Beth and the school determined that there was no role for Social Care.

15.34. At this relatively early stage for the proceedings and assessment the focus was on the emotional impact of the separation on the children, not on domestic abuse.

15.35. A Domestic Abuse Notification was received by Social Care on 21st December 2015 giving details of a verbal altercation between Richard and an ex-partner (not Beth). As proceedings were continuing KCC undertook police checks which showed that Richard was subject to a Non-Molestation Order and that he had breached it. Social Care did not check whether this was in respect of Beth or Richard's ex-partner. Checking this would have provided a fuller picture.

15.36. The supervision notes accessed by the Social Care IMR author show that workers did not view the relationship between Richard and Beth as a high-risk one. The observations of the children with each parent, individual interviews with both parents and direct work with Child A reinforced this view.

15.37. The focus of Social Care was on the potential risk posed by the parental grandfather and on the emotional impact of the parental dispute on the children. The IMR does not identify that any opportunities were taken to speak to Beth specifically about domestic abuse, nor were there enquiries about the Non-

Molestation Order. Both of these gave an opportunity for exploring further with Beth and not doing so was a **missed opportunity**.

15.38. This review has seen nothing to suggest that anything was lost in the discontinuity of reporting in private law proceedings with the transfer from KCC to Cafcass.

Kent and Medway CCG

15.39. Richard was registered as a patient at the same surgery for the review period during which he was only seen on three occasions. There was only one potential missed opportunity when Richard told his GP that he was suffering from "*stress",* this was not followed up. However, it is fair to say, that there were no other indicators of problems that would have drawn Richard's GP to ask more.

Surrey CCG

15.40. The IMR in respect of Beth was completed by a practitioner in Surrey because Beth's last GP was in Surrey. Over the review period she was registered with four GP practices, two in Kent and two in Surrey. The IMR focused on Beth's registration with one practice where she was registered from March 2017 to January 2018. Although she was only registered with them for ten months she had eight contacts in seven months, some of relevance to this review.

15.41. Beth was very open with her GP about the difficulties that she was going through with regard to the court cases, the consultation notes are detailed and indicate that the clinicians offered appropriate care and support. There is nothing in the notes to suggest that domestic abuse was a factor or was considered as a factor.

15.42. It had been recorded that Beth and Richard had separated in 2014 and, notwithstanding the acrimony that followed, the direct risk of domestic abuse may not have been recognised by the surgery given that they were apart. Given that Beth appears to have developed a good level of trust with the surgery there was a **missed opportunity** in not asking her direct questions about whether she was subject to domestic abuse.

Kent Police

15.43. Over the period immediately following Beth and Richard's separation in 2014 the police were contacted by Richard and Beth on six occasions, five times by Beth and once by Richard.

15.44. Three DASH risk assessments took place in June and July 2014 and July 2015. Whilst answering the questions in the final DASH assessment Beth told the officer that Richard had once put his hands around her throat. The officer tried to elicit more information on this, but Beth would not say more.

15.45. DASH risk assessments are assessed as "standard" (Current evidence and risk indicators do not indicate the likelihood of serious harm), "medium" (There are identifiable factors of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances) and "High" (There are identifiable indicators of risk of serious harm- this could be life-threatening).

15.46. Two DASH assessments undertaken were assessed as "*standard*" and one, January 2015, as *"medium"*.

15.47. In July 2015 Beth contacted police and reported a number of behaviours from Richard and his new partner that could amount to harassment.

15.48. Following this the investigating officer contacted both Richard and his current partner to try to issue, what were at the time known as, "Harassment Warnings". This was a national practice which was discontinued in 2019 as it was considered to be ineffective.

15.49. In the event, Beth sought a Non-Molestation Order from the court and this was granted in September 2015. Richard was arrested for breaching this the following month for driving slowly by Beth's place of work. He was not charged, as an amendment to the order was allowed by the court for Richard to drive in the vicinity when he was driving his taxi in a work capacity. Coercive and controlling behaviour was not recognised as a crime in its own right until late in 2015 and police options were limited at this stage.

15.50. In 2016 a woman Richard had been in a relationship with complained that he had behaved in a controlling manner towards her. This followed Richard taking out a

Non-Molestation Order against her. When officers tried to follow up the allegations of controlling behaviour the woman declined to engage with the police.

15.51. A further, similar, incident took place in 2017. Richard claimed that a woman that he had a "*one-night stand*" with was harassing him. She then contacted the police to allege that he had been abusive towards her. She did not want this to be taken further.

15.52. During the homicide investigation both women spoke to the police, and both described Richard as '*controlling'*.

15.53. The IMR author makes the point that each incident over the review period was properly dealt with, given their practice and procedures at the time, and that each incident was sufficiently far apart not to raise alarm bells for them about the eventual outcome. The totality of the concerns, however, was there and current practice would, in all likelihood, have identified it.

15.54. Kent Police have confirmed that where an incident of domestic abuse was assessed as meeting the threshold of a crime that a referral would be made to VSS (Victim Support Service), and they would contact the victim to offer support. Over the course of the review period there were three such referrals made. These were in July 2014, April 2015 and September 2015. In the case of the first two VSS contacted Beth who declined further assistance. There is no record of the outcome of any attempted contact on the third occasion. There is no record of the outcome "medium" risk incident in January 2015.

15.55. Whilst this is true with regard to police practice the totality of the Non-Molestation Order, three DASH assessments and allegations of controlling behaviour from three women over the review period does raise concern about the risk posed by Richard. Kent Police, at the time of writing this, have recently introduced a new Domestic Abuse Risk Assessment (DARA) which makes it easier for survivors to report coercive control and for officers to identify it.

Kent Community Health NHS Foundation Trust

15.56. Kent Community Health NHS Foundation Trust provided the Health Visiting services for Child B and Child C. At the time of their birth in 2012 Beth was known to have suffered from previous mental ill-health having received in-patient treatment in 2009 and it would have been good practice to explore this with her. That was not done, nor was her GP contacted for any update.

15.57. A one-year review was not offered to the family, again it would have been good practice to offer this in view of Beth's history.

15.58. At the two-year review, the information obtained was from the maternal grandmother and was inaccurate. The report that Beth suffered from bipolar was incorrect and was not checked. In addition, as Beth was not seen her maternal mood was not checked directly with her.

15.59. Concerningly, the Health Visiting Service operated entirely in a silo and without professional curiosity. There was no contact with the midwife, the GP, the Social Worker or any mental health service. The Health Visitor does not appear to have been aware that the family were subject to a Child in Need plan, but equally there is no indication that the Health Visiting Service were told of the plan.

15.60. Also, of concern is that Beth was not asked whether she was subject to, or in fear of domestic abuse. The records do not say why this was not done and was a **missed opportunity.**

15.61. Overall records were poor and there was no illustration in the records about Richard's role in the family or how/whether he was concerned about Beth's mental ill-health and whether he supported her.

15.62. It was good practice that the new Health Visitor in August 2015 reviewed the records and tried to make contact with the previous Health Visitor.

15.63. Whilst there was some poor individual practice the systems were also poor and did not identify the practice deficiencies that were present. Since then a new Electronic Patient Record has been developed with various forms and prompts for practitioners. A Domestic Violence and Abuse policy was implemented in 2016 with a mandatory Domestic Abuse question to be asked. Finally,

supervision by District Managers now provides for more effective oversight of cases.

16. Analysis

16.1 Coercive control is a crime and is an indicator of future harm. Coercive control does not relate to a single incident, it is a purposeful pattern of incidents that occur over time in order for one individual to exert power, control or coercion over another. The abuse that Beth suffered from Richard was both coercive and controlling. Richard managed to get himself into a position where he was controlling most aspects of Beth's life including her finances, her friendships and her place of residence. This left Beth powerless, frustrated and angry.

16.2. In her book, "*In control. Dangerous Relationships and How They End in Murder*" published 2021 Professor Jane Monkton-Smith sets out eight stages of coercive control that can lead to homicide. Having read the material available to this review several of these stages are clearly present in the relationship between Beth and Richard.

16.3. The first stage is a history of control or stalking and evidence of this is absent from this review. This may be because information about Richard prior to 2004 was not available to this review or because that evidence is absent.

16.4. The second stage, "*The Commitment Whirlwind*" is there. Beth and Richard met on-line. She gave up her job and quickly went to live with him in Spain. The couple planned a life there and shortly after Beth fell pregnant. Beth's mother described how she visited Spain only a few days after Child A's birth and she found Beth to be dominated by Richard. She described him to the Independent Chair as having "*no redeeming features*". The description she gave was compelling. Richard dominated Beth and the conversation, he had also taken away her phone and therefore a means of her ability to communicate independently.

16.5. When Child A was aged nine-months Richard and Beth returned to the UK. The idea was that Richard would become a "*house-husband*" and Beth would work. Beth's mother described how this had not worked out with Richard reducing the amount of time that he had for child care.

16.6. Richard's parents moved to the UK to assist with the child care. This had the effect of further marginalising Beth from both the children and her own family. It is illustrated at its starkest by the visit from the Health Visitor September 2012 when the twins were four-months old. Beth was not present, and the paternal grandmother gave false information about Beth's mental health, that she was bi-polar. It is unfortunate that the Health Visitor took this at face value and did not exercise any professional curiosity.

16.7. The myth of Beth's bi-polar continued with a note on the secondary school file when Child A started in September 2018 recording that Beth was "*bipolar and not taking her medication"*

16.8. Beth was not party to the mortgage as she had another house and Richard had managed to arrange a 'First-time buyer mortgage' on the house they shared. This meant that Richard had complete financial control over the house. Taking all these factors into account Beth ceded control over the family to Richard at the beginning of their relationship. She was not an equal partner, either as a parent or financially.

16.9. At the same time Richard was the parent who presented in the best light to the schools. He was described as having "*a very positive relationship with the school; he attends all parents' evenings and appears to be genuinely interested in how Child A is doing*" (2016). For her part Beth was described as *"turbulent and aggressive"* (2016) and *"Mum is volatile, blows hot and cold. Everything is about her. Take everything she says with a pinch of salt*". (2018)

16.10. Research from Dr Emma Katz et al "*When Coercive Control Continues to Harm Children*" (2020) outlines three types of father following separation. Richard's characteristics align with those described as "*Admirable fathering*". He may well have been a loving father, but he seems to have taken care to come across to other agencies in a positive light to the detriment of Beth. Through this he demonstrated power, control and manipulation.

16.11. From the accounts given, the schools found it challenging to work with Beth. However, nobody asked why that was the case.

16.12. The evidence available to this review was that Beth was subject to coercive control from the beginning of the relationship, through the period where Richard and his parents dominated her life and the child-care through to her homicide and even afterwards as her murder was denied and her body remains unfound. The sentencing judge was clear in his comments that Richard had planned Beth's murder in *"a planned and calculated operation that developed as it became clear that Beth's plans were to raise a mortgage and buy out your stake in the property. If she succeeded in that aim, you risked surrendering control of the family home to her".*

16.13. Richard's failure to disclose the whereabouts of Beth's body is, of course, continuing to exercise control over the family even after her murder.

16.14. To those who worked with the family the clues to coercive control were not that apparent at the time. There was a Non-Molestation Order taken out by Beth in 2015, there were reports of "*controlling behaviour*" from two people that Richard had relationships with. Otherwise the police callouts from 2014 are probably no more than might be expected from a difficult relationship breakdown though, as said earlier, current practice might have identified the full risk to Beth. Equally both Child A and Child B demonstrated some behavioural difficulties at school that were attributed to parental hostility.

16.15. I have no doubt that the parental acrimony was having an impact on the children and, of course, on both parents. However, I also have no doubt that this masked the coercive control that Beth was subject to. It is possible that Beth herself did not realise this. Monkton-Smith (op cit) writes about living with control. Beth was the one who was out of the family home for most of the period of the separation and she was, at times, living an unsettled lifestyle with several moves. Beth, her friends and family may not have been aware of coercive control or, if they had been, they may have looked at the dominant issues in Beth's life, the separation and the risk to the children from Richard's father.

16.16. Beth is likely also to have been subject to "*gaslighting*", a pattern of behaviour that makes victims of control feel that they are unstable. This is illustrated by the numerous references to Beth's mental health. Whilst she did suffer from some degree of depression for the majority of the review period, she was not taking

prescribed medication for much of the period and the depression may not have been that profound.

16.17. In answer to the question of why Beth presented to the school as she did it is highly likely that she felt powerless and as though she had no control over her life. The mental health charity MIND set out four common reasons why someone might feel "angry"

- Threatened or attacked
- Frustrated or powerless
- Like we're being invalidated or treated unfairly
- Like people are not respecting our feelings or possessions.

16.18. All of these were significant aspects of Beth's life, and it is not surprising that she felt, and expressed, anger in the way that she did given that she had lost a significant amount of her independence and her ability to make decisions about her own life. The **Learning Lesson** for agencies is to look behind someone's anger and to ask why they might be feeling as they are. The relevant body of work is Trauma-Informed practice, a strength-based approach that seeks to respond to the impact of trauma on people's lives.

16.19. A further **Learning Lesson**, stemming from this is for agencies to look beyond the presenting problem, even though it provides explanations, for what else might be there. In this instance the parental dispute was the focus of agency enquiries without looking for potential domestic abuse behind that. Whilst the separation did cause considerable difficulties for all parties the eventual tragic outcome highlights that domestic abuse was a very serious issue that was masked or confused with parental conflict.

16.20. Increasingly over recent years the Family Courts have promoted the importance of parents continuing to be parents and to make decisions in respect of their children post-separation. What follows from that is that the Family Court will only intervene in parental disputes where it is assessed as being in the best interests of the children to do so. On behalf of the court Cafcass will always attempt mediation. It is only if that is unsuccessful that a case will be put before a member of the judiciary.

16.21. Within court proceedings the dispute between the parents lasted for four years and had a significant effect upon the children, this was shown by assessment regardless of domestic abuse.

16.22. There were also missed opportunities within this period to identify Beth as the victim of domestic abuse or to explore with her the potential for this.

16.23. **Were opportunities missed for identifying DA/coercive control?**

16.24. Numerous examples have been identified. Some of these have been explored further in the following specific issues set for consideration in this review.

i. **Were practitioners sensitive to the needs of Beth and Richard, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was the risk to Beth fully understood? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?** Overall the outcome demonstrated that the risk to Beth was not fully understood. Apart from the first Health Visitor, those who worked with the family demonstrated expected practice in respect of the children and some aspects of the parental breakdown. There were however numerous missed opportunities in identifying that Beth was subject to domestic abuse. The qualification to this comment is that Coercive Control was not recognised as a crime until the 2015 Serious Crime Act created a new offence of controlling or coercive behaviour in an intimate or family relationship.

ii. **Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Beth and/or Richard (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Beth and/or Richard subject to a MARAC or other multi-agency fora?** All IMRs addressed the provision of domestic abuse police and assessment tools for the agreed timeline and confirmed that they were present, and that training was appropriate. Coercive Control was not widely

recognised at the beginning of the period and was not identified at any later stage.

iii. **Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?** Information sharing appears to have been appropriate albeit no domestic abuse was identified. Information sharing between schools was not always appropriate in terms of language and assessment.

iv. **What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?** This is addressed in the context that coercive control was not identified or widely known of. There were missed opportunities by the Health Visitor between 2012 and 2014 to follow up on Beth's mental health and, in June 2014, a missed opportunity to pass information to Social Care. There was also an over-reliance on information from the paternal grandmother which proved to be inaccurate. That Cafcass hadn't undertaken a safeguarding interview with Beth in June 2014 was unfortunate, particularly given that Richard had apparently removed her means of communication. The Local Authority (Social Care) assessments appear reasonable given that their focus was on the children but, notably, the potential for domestic abuse was not assessed.

v. **Did actions or risk management plans fit with the assessment and decisions made?** Yes, but in the context that domestic abuse was not identified.

vi. **Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?** As said elsewhere domestic abuse was not identified. There was a lack of professional curiosity with regard to Beth's behaviour and demeanour. For the main part Richard was the easier of the two for agencies, particularly the schools, to work with. The question as to why this was the case was not asked or examined.

vii. **When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes**

of the victim should have been known? Was the victim informed of options/choices to make informed decisions? See vi above. Beth was seen as being "*difficult*" and her wishes and feelings were insufficiently explored to find out what lay behind. She may not have disclosed domestic abuse, or even known that she was the victim of it but attempts to explore this were absent.

viii. **Were Richard and Beth signposted to other agencies?** VSS by the police but otherwise, no. However, there were no obvious opportunities for this to have become relevant.

ix. **Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?** At times there was a non-molestation order and Harassment Warning in place. Notwithstanding this there is no real evidence that Beth was seen as a victim.

x. **Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?** Some disclosures were made and a non-molestation order obtained. The response from agencies was in line with their thinking that the abuse Beth suffered was due to the relationship breakdown, that she was a victim of coercive control was not recognised and therefore not acted upon.

xi. **Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?** The relevant protected characteristic is sex. Richard's part-Spanish heritage was not considered to be relevant to the review and has not been addressed.

xii. **Were senior managers or other agencies and professionals involved at the appropriate points?** Yes, for supervision.

xiii. **Did any staff make use of available training?** At the beginning of the timeline there were no opportunities for training in Coercive Control. By the end of Beth's life such opportunities were available but there is no evidence that those working with Beth identified her as being a victim.

xiv. **Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?** There is no evidence that restructuring had a negative impact on those working with Beth and Richard.

xv. **How accessible were the services to Beth and Richard (as applicable)?** Given that domestic abuse was not identified this is not applicable.

17. Conclusions

17.1 Beth was subject to domestic abuse from the beginning of her relationship with Richard. This does not appear to have been identified by anyone, either in Beth's family or those professionals who worked with her. In part this is because coercive control was neither an offence nor well known at the beginning of the timeline of this review. In part it is because of a lack of professional curiosity about the way that Beth presented to agencies.

17.2 By the time coercive control was becoming known Beth had been assessed and "labelled" by agencies, notably the schools as "*difficult*" and the reasons for her presentation do not appear to have been reassessed or reconsidered in the light of developing information about coercive control. Coercive control reached the statute in December 2015 and training was rolled out to agencies after this. Public and professional awareness has also grown in the years since. It would have been possible for anyone working with Beth to have reassessed her presentation in the light of the growing knowledge, but this was not done.

17.3 It is also the case that the separation and concentration on the wellbeing of the children masked the fact that Beth was subject to domestic abuse.

17.4 This, in turn, leads to another potential problem. The schools and Social Care were concerned about the impact of the separation on the children. Children living in/with families where there is domestic abuse require further understanding to limit the harm on them. See, for example https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/domestic-abuse/. In the light of what we now know about domestic abuse in the parental relationship the emotional impact upon the children is likely to have been greater than was known at the time.

18. Lessons to be Learnt

18.1 That coercive control is deep, enduring and dangerous. There are always reasons why people behave as they do. Beth's "*difficult*" presentation was, in all likelihood, linked to her as a victim. It is noteworthy that Beth's response to abuse was multi-faceted and may not, even now coercive control is well known, be obvious to professionals. Professionals should always question why people behave as they do and not take presentation at face value.

18.2 Professionals should be alert to domestic abuse in all scenarios. In this instance the parental dispute, and the effects on the children masked the coercive control that Beth was subject to. Beth being perceived as "*difficult*" by some agencies compounded this. The Domestic Abuse Act 2022 has clarified the statutory definition of Domestic Abuse and has emphasised the importance of identifying coercive control. The Domestic Abuse Commissioner has further clarified this in her letter of April 2022 (https://domesticabusecommissioner.uk/wp-content/uploads/2022/04/2204-Letter-from-the-Domestic-Abuse-Commissioner-regarding-the-Reducing-Parental-Conflict-Programme.pdf).

18.3 Professionals working with victims of domestic abuse should look at issues through the eyes of the victim.

18.4 This is necessary to ensure that responses are appropriate to individuals and not simply the result of adherence to policy. An appreciation of the level of fear and vulnerability relies on understanding the circumstance of the individual.

19. Recommendations

19.1 The Review Panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1.	Coercive control legislation to be integral to the DA Workforce Training programme currently in development in Kent. The concept of controlling behaviour, its form and tactics to also be detailed in this training.	KCC Commissioning Cafcass
2.	Agencies to promote 'Making Safeguarding Personal' when working with service users and not looking at incidents in isolation; and that the potential for all types of domestic abuse is always explored when parents separate.	All Agencies
3.	All agencies to provide guidance/training for staff regarding 'victim blaming' language, taking into account a trauma informed approach that seeks to understand the root of behaviours / distress and respond to the underlying trauma.	All Agencies
4.	All agencies to provide assurance (via a sample audit) that their staff are compliant with their most recent Domestic Abuse / Safeguarding policies.	All Agencies

Glossary

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the Overview Report are listed in the order that they first appear.

Abbreviation/Acronym	Expansion
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
GP	General Practitioner
IMR	Independent Management Report
IOPC	Independent Office for Police Conduct
NHS	National Health Service
PSE	Police Staff Employee
VSS	Victim Support Service

Domestic, Abuse, Stalking & Harassment (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model was agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of 29 pre-set questions will be asked of anyone reporting being a victim of domestic abuse, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

Standard Current evidence does not indicate the likelihood of causing serious harm.

Medium There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.

High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

In addition, the DASH includes additional question, asking the victim if the perpetrator constantly texts, calls, contacts, follows, stalks or harasses them. If the answer to this question is yes, further questions are asked about the nature of this.
A copy of the DASH questionnaire can be viewed here.

Domestic Abuse (Definition)

The definition of domestic violence and abuse states:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:*
>
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*

Controlling behaviour is:

> *a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

Coercive behaviour is:

> *an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*