North Hertfordshire Community Safety Partnership

Domestic Homicide Review

“Elaine”

Died May 2016

Overview Report (Amended)

Original Chair	Liz Hanlon
Original Author	Tim Beach
Chair of updated report	Mary Mason

Date of completion: August 2023

Contents	Page

1. INTRODUCTION

1.1
This Review arose from a homicide within the area of North Hertfordshire District Council (NHDC). The victim, Elaine, female, aged 26 years, died in May 2016. The perpetrator, Elaine's half-sister Maggie (aged 52), has been convicted of her murder. The key reason for undertaking a Domestic Homicide Review (DHR) is to seek any lessons to be learned when a person is killed within the family environment. Based on the available research this case was unique, or at least extremely uncommon, in that it involved adult siblings with the offender being a woman. All other perpetrators in the most recently published DHR research, in December 2016 by the Home Office, into Adult Familial Homicide (AFH a subset of domestic homicides), were male.

1.2
The DHR Panel set the scope of the review for all agency involvement with the victim and her sister, from the 1st January 2015 to the 1st June 2016.

1.3
These dates above were set by the Panel on the basis that this covered the critical period between the return of Maggie to the United Kingdom from the United States and the death of Elaine. During this period, a number of agencies had opportunities to intercede.

1.4
The Home Office were notified by North Hertfordshire Community Safety Partnership in June 2016 of their intention to carry out a DHR. The Hertfordshire Coroner was also notified that a DHR was taking place. The review was initiated in July 2016 when the first meeting took place of the DHR Panel, although following consultation with the police Senior Investigating Officer (SIO) and Crown Prosecution Service (CPS) the Overview process was pended until the criminal proceedings were completed in December 2016 and the statutory appeal period passed.

1.5
In May 2016 Elaine was found dead, by relatives, at her home address in Hertfordshire. She had sustained injuries to the head and face resulting in her death. In late December 2016 Maggie was found guilty of the murder following a trial at Crown Court. Maggie was sentenced to life imprisonment with a minimum term of 20 years. Both women were known to a number of agencies and their contact is subject of the Report. There was no significant inter agency work.

1.6
The Review highlighted the need, to focus and continue DA training across agencies particularly in relation to sibling relationships for compliance with existing DA policies (and ensuring they are not simply subsumed into general safeguarding advice); to fully record contact with potential victims and offenders and the need to ensure supervisory oversight and review of DA cases.

1.7
One of the fundamental questions for this and any other DHR was if there were existing protocols for the exchange of information about DA and if there were inter agency policies and procedures. There are long established structures and policies across Hertfordshire which have over a number of years been developed and trained jointly. Similarly, there are established Multi Agency Risk Assessment Conference (MARAC) and Independent Domestic abuse Advocate (IDVA) structures in place. In the view of the Panel any potential failings in this case relate largely to agencies not recognising the female sibling abuse as DA, or not recognising that the level of risk could have reached a threshold to enable information exchange and compliance with those policies. Had a referral been made to an IDVA, or MARAC been considered as a result of professional judgement to reflect the higher level of risk, then additional safety planning could have taken place. Elaine was never considered for referral to MARAC. Professional judgement may not have been exercised in recognising the potential risk because it was a female sibling relationship. That

relationship in the view of the Panel was likely to have influenced the decision making of a number of agencies.

1.8
Throughout this report, the names of the victim, perpetrator and others have been anonymised. The members of the Review Panel wish to record their condolences to the family and friends of Elaine.

Elaine: Victim
Maggie: Perpetrator
Robert: Perpetrator's brother/Victim's half-brother

2. METHODOLOGY - THE COMMISSIONING OF THE REVIEW

2.1
Community Safety Partnerships (CSPs) have a statutory duty to enquire about the death of a person where DA forms the background to the homicide and to determine whether or not a review is required. In accordance with the provisions of the Domestic abuse, Crime and Victims act 2004, Section 9, Domestic Homicide Reviews (DHRs) became a statutory responsibility on 13th April 2011.

2.1.1
The act states that a DHR should be a review:
Of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by – A person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or a member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

2.2
The purpose of a Domestic Homicide Review (DHR) is to:

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 upon, and what is expected to change as a result;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic abuse and abuse homicide and improve service responses for all domestic abuse and abuse victims and their children through improved intra and inter-agency working.
e) Contribute to a better understanding of the nature of domestic violence and abuse; and
f) Highlight good practice.

2.3
This review arose from a homicide within North Hertfordshire Council Community Safety Partnership. The victim, a female aged 26 years, died in May 2016. The perpetrator, a family relation, her half-sister, aged 52, has been convicted. The key reason for undertaking the DHR was to facilitate lessons to be learned when a person has been killed within the family environment. To enable these lessons to be learned as widely and thoroughly as possible, professionals need to be able to fully understand what happened preceding the homicide, and

most importantly, what needs to change in order to reduce the risk of similar tragedies happening in the future and the Panel maintained that focus.

2.4
Chronologies were requested from:

- Hertfordshire Constabulary
- East and North Herts NHS Trust (ENH NHS Trust)
- North Herts District Council (NHDC)
- North Herts Homes (NHH)
- Herts Adult and Community Services
- People of Hertfordshire Want Equal Rights (PoHWER) and
- North Herts Centre for Voluntary Service (NHCVS).

2.4.1
Other agencies including General Practitioners and Probation were contacted but had no relevant information. The Chair and report writer liaised with the SIO in the case from the Hertfordshire, Bedfordshire, and Cambridge Major Crime Unit (HBCMCU) and the CPS. A decision was made that it may be detrimental to the court case to proceed with the DHR and therefore the review was put on hold until the completion of the criminal prosecution. The Home Office were notified by the Chair of the CSP of the delay in conducting the DHR. The review started again formally in late December 2016. During the December meeting all chronologies were reviewed, and Individual Management Reviews (IMR's) were requested from the Hertfordshire Constabulary, NHDC, ENH NHS Trust and NHH. All other agencies were also requested to identify any significant information and flag it to the Panel if relevant.

2.5
The findings of each individual IMR were confidential. At the beginning of the meetings of the Review Panel, attendees were required to sign a confidentiality agreement. The Overview Report is based on the information obtained from those IMR's and the wider DHR process. The reports were written by professionals who were independent from any involvement with the victim, family, friends, or the perpetrators. It was agreed that should actions be necessary by any of the agencies, the maintenance of, and strategic ownership of any action plan would be the overall responsibility of the North Herts Community Safety Partnership. Any recommended activity would be addressed accordingly through that partnership. The overall action plan would also be reviewed and monitored by the Hertfordshire Domestic Homicide sub group which reports to the Hertfordshire Domestic Abuse Partnership Board and in turn to the Domestic Abuse Executive Board (DAEB).

2.6
The independent Chair and Overview Report writer met with the IMR writers in late December 2016 and outlined to the authors the process for the development of the IMR, as follows:

- Securing agency records.
- Commissioning IMRs.
- Gaining consent to view records.
- Drawing up a chronology.
- Conducting a desk-based review which investigated the agency's involvement relative to the agency's policies and procedures; relevant partnership / multi-agency policies and protocols (e.g., those of the Hertfordshire Domestic Abuse Partnership); professional standards and good practice; and national and local research and evidence-based practice.
- Conducting interviews with relevant staff where appropriate and practical.
- Writing the IMR including analysing the information and making recommendations in compliance with current guidance.
- Ensuring the report was quality-assured through the process of countersigning by a senior accountable manager; the same guidance included advice on:

(i) Conducting parallel investigations of disciplinary matters and complaints which will not be reported which are internal agency matters.
(ii) Providing feedback and debriefing to relevant staff throughout the process.

2.7
IMR authors were informed of the primary objectives of the process at the briefing in December 2016, which were to give an accurate as possible account of what originally occurred in the agency's contact with both Elaine and Maggie, to evaluate it fairly, and to identify areas for improvement for future service delivery as well as good practice. IMR authors were encouraged to propose specific solutions within their recommendations which were likely to provide a more effective response to a similar situation in the future. The IMRs also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes were required to better meet the needs of individuals at risk of or experiencing DA. Agencies prepared a chronology of their agency involvement and significant events during the specified time period. This was merged into a comprehensive, integrated chronology which was compiled and analysed by the Panel.

2.8
IMR authors produced a first draft of their reports which were quality assured within their own organisations through a signing-off process. The IMRs were then analysed by the Panel and discussed with the authors at the meeting on the 28th April 2016. Copies of IMRs had been circulated to all the panel members and this meeting was able to cross-reference significant events and highlight missing information. Authors then reviewed their IMR's which were again supplied to the Review Panel. There was a further meeting of the Panel on the 11th July 2017 at which the amended IMRs were further explored and additional work and material requested, and an early draft of the Overview considered. At the Panel meeting on the 4th October 2017 the draft Report and Recommendations were agreed subject to minor amendments together with a draft of an Action Plan. The Report and Recommendations were formally agreed at a further meeting of the Panel on the 19th November 2017.

2.9
Family members were contacted directly by the Chair during the review process with the assistance of the police Family Liaison Officer. A letter of introduction was hand delivered to a number of family members which outlined in detail the process, available support and information about the Chair and Overview Report Writer.
The Chair and Report Writer, met with:

- Robert, a brother of Maggie (and half-brother to Elaine) in June 2017. He confirmed he had received the TOR and the associated information.
- Other family members were also seen. A draft of the Report was shared with the family in hard copy on the 1st December 2017 for them to read and feedback on.
- The Chair and Report Writer met family members again on the 11th December 2017 to discuss the Report. There were no significant amendments requested and the family felt the Report was fair and accurate.
- Robert reflected again that he had been willing to appear as a prosecution witness for the burglary against Maggie but that his offer had not been taken up by the police. He confirmed he was personally happy to have his views reflected and attributed within the Report.

2.10
The panel made the decision that the review would focus on a limited time period with a rationale that the relevant abuse took place within that defined period of Maggie's return from the USA and there was very little access to reliable information from the US law enforcement records and this was the period in which there were potential opportunities to intervene.

3. FULL TERMS OF REFERENCE

3.1
This review was commissioned by Hertfordshire Domestic Abuse Partnership Board (DAPB) on behalf of North Hertfordshire Community Safety Partnership as a result of the death of Elaine in May 2016.

3.2
It was agreed that if it became apparent to the independent chair and Panel that the timescale in relation to some aspects of the review should be extended this would be discussed with and agreed by the review panel and informed to the chair of the DAPB.

3.3
The results of the review, including the panel's findings and recommendations would be shared with the family members.

3.4
Scope
The agreed dates between which the DHR considered agency involvement with the victim and family – and therefore the period for which agencies were required to provide information - 1st January 2015 and 1st June 2016

3.5
Purpose of the review is to:

- To gain an understanding of what DA Elaine suffered.
- Establish the appropriateness of agency responses to the health and social care needs and provision of support to Elaine and her family - both historically and immediately prior to Elaine's death.
- If and how agencies assessed risks to Elaine.
- Establish the appropriateness of agency responses and risk management in relation to Maggie.
- Establish whether single agency and inter-agency responses to any concerns about DA were appropriate.
- Identify, on the basis of the evidence available to the review, whether the deaths were predictable and preventable, with the purpose of improving policy and procedures in Hertfordshire across the various agencies areas of responsibility.
- To identify good practice that was in place.
- To establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where DA is a feature.

3.6
Key issues

- Did the agencies comply with established DA protocols and procedures as agreed with other agencies, including any information sharing protocols?
- Did the agencies have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used?
- Was the victim subject to MARAC?
- Contact and support from agencies: Were agencies sensitive to the needs of the victim and her family?
- Did actions and risk management plans relating to Elaine and Maggie fit with the assessment and decisions made?

- Were appropriate services offered or provided?
- Any additional information considered relevant: If during the DHR any additional information that was previously unknown becomes available that informs the review any action should be discussed and agreed by the independent chair and the review panel.

3.7
Key Lines of Enquiry:
The Panel for this DHR determined broad aims, which could be amended as information is gathered. Specifically, the Panel wished to determine:

1) What disclosures Elaine made to agencies and the circumstances behind them coming into contact with her?
2) If and how agencies assessed risks to Elaine and the risks represented by Maggie?
3) Were the agencies' responses good practice and proportionate concerning their knowledge?
4) Whether relevant agencies discharged their duties appropriately?
5) Lessons to be learned.
6) Good practice that was identified.
7) The effectiveness of inter-agency communication.
8) Any difficulties agencies encountered when working with Elaine that impact on the case.
9) Any difficulties agencies encountered when working with Maggie that impact on the case.
10) The accuracy of records and information imparted.

4. CONTRIBUTORS TO THE REVIEW

4.1
Hertfordshire Constabulary
Mr Mark Ross.
Review Officer BCHMCU.
The Reviewer was independent of any police involvement and had no line management responsibilities.

4.2
East and North Herts NHS Trust
Mr Enda Gallagher.
Falls Prevention Nurse/Adult Safeguarding Nurse.
East and North Hertfordshire NHS Trust.
The reviewer had not had any direct or line management involvement in the case nor knew the victim, perpetrator or their families.

4.3
North Herts District Council
Mr Martin Lawrence (Strategic Housing Manager) NHDC
The reviewer was not directly involved with the victim, the perpetrator or their families and was not the immediate line manager of any staff involved in the IMR

4.4
North Herts Homes
Ms Anita Khan, Director of Housing, NHH
Joined NHH in September 2016, after the homicide

The reviewer had not had any direct or line management involvement in the case nor knew the victim, perpetrator or their families.

4.5
Review Panel Members: no members of the Review Panel had any direct or line management involvement in the case nor knew the victim, perpetrator, or their families.

Name	**Position/Organisation**
Elizabeth Hanlon	Independent Chair
Tim Beach	Independent Report writer
Martin Lawrence	North Herts District Council
Bernadette Herbert	Lead Nurse Adult Safeguarding, East and North Hertfordshire Hospitals NHS Trust
Joy Leighton	Victim Support
Tracey Cooper	Head of Adult Safeguarding, Hertfordshire Valleys Clinical Commissioning Group, East and North Herts CCG.
Susan Pleasants	National Probation
Sarah Taylor	Partnerships Manager, Strategic Partnerships Team, Hertfordshire County Council
Jacquie Hime	North Herts Voluntary Service
Tracy Pemberton	Detective Chief Inspector, Hertfordshire Constabulary
Sarah Pateman	Stevenage Borough council
Shaun Holdcroft Anita Khan (from July 2017)	North Herts Homes
Anne Priest	PoHWER
David Scholes	North Herts CSP
Raj Chibber	Head of Assessments, Herts Children's Services
Lauren Hart	Refuge
Fiona Weatherall-Morris	CGL

4.6 Revised Review Panel Membership: no members of the Revised Review Panel had any direct or line management involvement in the case nor knew the victim, perpetrator, or their families.

Name	**Organisation**	**Job title**
Rebecca Coates	North Herts DC	Community Protection Manager
Hannah Morris	Stevenage BC	Head of Housing
Jeanette Thompson	North Herts CSP	Service Director, Legal and Community Monitoring Officer
Patricia Fletcher	North Herts Homes	Lettings and Temporary Accommodation Manager
Graeme Walsingham	Herts Police	DCI for Safeguarding, Crime Reduction and Community Safety Unit
Enda Gallagher	E&N Herts Hospital Trust (Lister Hospital)	Named Nurse, Adult Safeguarding
Karen Hastings	Hertfordshire Partnership Foundation Trust	Consultant Social Worker (Safeguarding Adults) / AMHP
Clare Griffiths	Hertfordshire Probation	Head of Service

Louise Bayston	Refuge (IDVA service)	Senior Operations Manager
Tracey Cooper	Herts Valleys and East and North Herts Clinical Commissioning Groups	Head of Adult Safeguarding
Keith Dodd	Adult Care Services	Head of Adult Safeguarding
Nicola Sharp-Jeffs	Surviving Economic Abuse	CEO and founder of Surviving Economic Abuse
Vicky Boxer	Spectrum CGL	Senior Social Worker
Katie Dawtry	Herts County Council	Development Manager, Strategic Partnership Team
Pragna Patel	Independent Consultant	Independent Consultant

5. REVIEW PANEL CHAIR AND REPORT WRITER

5.1

Chair - Liz Hanlon

A police officer for 30 years who retired in 2013. She was a member of the Hertfordshire Major Investigation Department which investigated murder and other complex crimes. She was the Senior Investigating Officer (SIO) for numerous complex and sensitive investigations including domestic homicides.

Police lead for Hertfordshire as a part of the Serious Case Review Board and the Police representative on all Partnership Case Reviews, Domestic Homicide Reviews and Multi Agency Serious Incident Reviews that have taken place both within and outside Hertfordshire. She had the responsibility of implementing the Domestic Homicide Review process within Hertfordshire and briefing all the Chief Executives on the process and responsibilities. She successfully completed training in relation to conducting DHRs and writing overview reports. Currently she is the Independent chair for the Hertfordshire Adult Safeguarding Board.

She is chairing and report writing two DHRs which occurred in Maldon and Clacton, Essex and also chairing a further DHR in Epping Forest, Essex.

She has no current supervisory role with any of the agencies contributing to the DHR nor had any direct or line management involvement in the case nor knew the victim, perpetrator, or their families.

5.2

Report Writer - Tim Beach

Suffolk Constabulary November 1979 – November 2009, police officer in various roles, including Area Commander, Ipswich (Chief Superintendent), Detective Superintendent with responsibility for Public Protection which included, Domestic Abuse Services, Safeguarding Children, Vulnerable Adults and Hate Crime.

Nationally accredited Senior Investigating Officer (SIO) for Major Crime and Firearms Commander for a number of years.
Independent Chair of Safeguarding Children Board, Barnet, London (August 2009 to November 2013)
Chair Domestic Homicide Review (DHR) Cambridgeshire County Council/ Constabulary 2009/10
Overview Report Writer, DHR East Hertfordshire (2012/13)
Overview Report Writer, DHR Watford BC (2013/14)
Chair DHR Watford, (2016/17)
Member of London Safeguarding Children Board, (representing Chairs 2010 to October 2013)

Chair of London Independent Safeguarding Chairs Group, (2010 to October 2013)
Independent Serious Case Review Report Writer for East of England for Multi Agency Public Protection Arrangements (MAPPA) 2010.
Local Government Association Peer Review - Cornwall Children Services – November 2011 and Cambridgeshire October 2013
Review of MAPPA arrangements - State of Jersey – 2011/12
MAPPA Serious Case Review – Jersey - July 2014
MAPPA Serious Case Review – Jersey - 2016
Completed the Home Office online course for DHR Chairs/ Report Writers, training for MAPPA serious case reviews and SCIE SCR report writing.

He has no previous or current connection with any of the agencies contributing to the DHR nor had any direct or line management involvement in the case nor knew the victim, perpetrator, or their families.

5.3
Updated review
The updated review was chaired by Mary Mason. Mary is an independent freelance consultant and has never been employed by nor has she any connection with Hertfordshire County Council or East Herts District Council. Mary was formerly Chief Executive of Solace Women's Aid (2003-2019), a leading Violence against Women and Girls (VAWG) charity in London. Mary is a qualified solicitor (non-practising) with experience in both criminal and family law. She has more than 30 years' experience in the women's, voluntary and legal sectors supporting women and children affected by abuse. She has experience in strategic leadership and development; research about domestic abuse; planning, monitoring & evaluation of VAWG programmes. Mary has successfully adopted innovative solutions to ensure effective interventions which achieve results, increasing the quality of life of women and children. She did not have any direct or line management involvement in the case nor knew the victim, perpetrator, or their families.

6. DETAILS OF PARALLEL REVIEWS/PROCESSES

6.1
There are no parallel reviews at this point. As outlined above the criminal proceedings concluded in December 2016 with the conviction of Maggie who was sentenced to life imprisonment. At that time the DHR process resumed as a discrete process.

7. STATEMENT ON EQUALITY AND DIVERSITY

7.1
The Panel considered the 9 protected Characteristics under the Equality Act 2010, (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity). They sought to establish if they were applicable to the circumstances of the case and had any relevance in terms of the provision of services by agencies or had in any way acted as a barrier.

7.2
The following table describes the relevant protected characteristics in this case:

Name	Sex	Age (May 2016)	Ethnicity	Disability	Religion	Marital status	Sexuality

Elaine	F	26	White European	Chronic health condition	N/K	Single	N/K
Maggie	F	52	White European	Chronic health condition and used walking aid.	N/K	Married	N/K

7.3 Disability
Maggie was 52 years old, and she was referred to as 'old & frail' and released from police detention by a nurse due to not having her medication. Between the 1st January 2015 and 1st June 2016 Maggie attended A&E on 15 separate occasions. Thirteen of the attendances related to the management of chronic and ongoing health related concerns.

Between the 1st January 2015 and 1st June 2016 Elaine is recorded as attending A&E on 13 separate occasions. Eleven of her hospital attendances were for the treatment and management of a chronic health related condition.

Whilst Maggie was recorded as using a walking stick on some occasions, she was not recorded by any service as being disabled nor as having any additional care and support needs. Indeed, family members when spoken to, held the view that although Maggie claimed to have suffered a serious back injury, she was mobile and did not need aids for walking although she was recorded as using them on occasion.

7.4 Sex
The 'same sex' and sibling relationship of the victim and perpetrator is reflected upon within the report, this and it is arguable that this did impact upon the responses of some of the agencies and judgement of the risk to Elaine.

This case was uncommon as it involved adult female siblings, and the perpetrator was a woman. The ONS combined data[1] for the three years ending March 2019 to March 2021 showed that there were six female victims of Domestic Homicide whose perpetrator was a female family member.

Whereas both men and women may experience incidents of inter-personal violence and abuse, women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence from a male abuser. They are also more likely to have experienced sustained physical, psychological, or emotional abuse, or violence which results in injury or death.

Women experience higher rates of repeat victimisation and are much more likely to be seriously hurt or killed (Walby & Towers, 2017; Walby & Allen, 2004) than male victims of domestic abuse (ONS, 2019). Elaine was a victim of repeat domestic abuse including coercive control, which

[1]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2022

women are more likely to experience with higher levels of fear. (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).

7.7 Age

The age gap between them of 26 years may well have been significant. Elaine was 26 years old at the time of her death and Maggie was 52 years. This difference of age contributes to the power differential between the two half siblings.

8. DISSEMINATION

8.1
All organisations contributing to this review, will receive copies of this report for learning within their organisation.

8.2
Whilst key issues and learning from the DHR process have already been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement and support, pre-publication drafts of this Overview Report will be shared by the Review Panel, commissioning officers and members of the North Herts CSP. The draft Overview Report will be shared in confidence with family members in order to ensure it reflects their views and any concerns. The associated individual reports from agencies will not be individually published.

9. BACKGROUND: THE FACTS

9.1
In May 2016 Elaine was found dead, by relatives, at her home address in Hertfordshire. She had sustained injuries to the head and face resulting in her death. In December 2016 Maggie was found guilty of the murder of Elaine following a trial at Crown Court. Maggie was sentenced to life imprisonment with a minimum term of 20 years. Maggie was also known by a number of other names. The perpetrator was the half-sister of Elaine. They shared the same father who is now deceased. The age gap between them of 26 years may well have been significant. Elaine was 26 years old at the time of her death and Maggie was 52 years.

9.2
Elaine was part of a large extended family and the youngest child of her father who she was described as being particularly close to. According to family members she was a happy and contented young woman with limited life experience. Her home, work and pleasure activities took place almost entirely within a small radius of her own home and that of many of her relatives. She was warmly regarded within her community both working and helping at a local community centre. The only extended period away from that home area was when she visited her half-sister Maggie in the United States of America (in 2011), who was resident there. As is outlined in the Report this visit, which was ostensibly to work in the USA with the help of Maggie, ended after approximately 11 months with some ill feelings between them. Some family members believed that this breakdown in the relationship amplified the resentment and jealousy that Maggie had for Elaine throughout her life. It is not known if Elaine was ever fully aware of the level of that resentment.

9.3
Maggie has been described by her family members in nearly consistently negative terms. Those who had known her well outlined an anecdotal, but again consistent, pattern of violence since a young age. Her behaviour was focused on her own needs rather than considering others in her family. There was reporting by the family of her having previously assaulted domestic partners in both the UK and the USA. No recording of these historic allegations could be found by the authorities in the respective countries despite research. Police recording of offences in the USA related to non-violent offences. She was described as manipulative, clever and on occasions

threatening. Some family members had concerns about sharing their views in case Maggie sought some form of retribution if she could identify individual family members' contributions to the Review. This was despite her life imprisonment. The Chair and Report Author did seek contact with Maggie via the Prison Service, but there was no response to a personal letter and invite to provide information for the Review.

9.4
Both Elaine and Maggie came to the notice of the services as identified in this report but not in relation to concerns that were primarily recorded as DA, other than by the police. All services attempted to deal with both parties in a supportive manner but there was limited knowledge of their exact history and relationship as half siblings. This was further complicated by adult sibling relationships not being recognised as falling within the definition of DA by some services. The only significant inter agency work that did take place was subsequent to the death of Elaine when housing staff assisted the police investigation of the murder.

9.5
Maggie lived in the United States of America for many years, returning to the UK in June 2015. Elaine had visited the USA in September 2011 returning to the UK in August 2012. During that time, she lived with Maggie. Elaine had told relatives that she had been assaulted by Maggie and as a result had fallen out with her. The family have indicated that Elaine was intimidated by Maggie and felt compelled to let her stay with her upon her return to the UK in 2015. As part of the murder investigation enquiries were made with the USA regarding any police records held for Maggie whilst she had lived there. The response via Interpol was that Maggie had not come to notice for any assaults or DA and/or incidents but she had come to notice for theft, fraud, and drink drive. Information was provided by the family that Maggie had attacked and stabbed her then partner in 1994 in the UK with scissors and had been at one point charged and remanded to prison, but proceedings were discontinued at some unknown time as the victim declined to give evidence and Maggie eventually returned to the USA. There was no record of this alleged historical assault in the UK recorded by police when enquiries were made in 2017 despite extensive research.

9.6
Both Elaine and Maggie had contact with Hertfordshire Constabulary for two incidents involving both of them. The first was an allegation of assault for which Maggie was the alleged victim and Elaine the alleged suspect. The second was a burglary for which Elaine was the victim and Maggie the suspect.

9.7
The two incidents that Hertfordshire Constabulary investigated took place over two days in October 2015. Essentially both parties alleged respective offences of assault at the home address, against each other, and subsequently the burglary at the home address of Elaine for which Maggie was charged. In January 2016 she was charged with offences of dwelling burglary and perverting the course of justice. The perverting the course of justice offence was linked to the burglary and her attempt to frustrate the criminal proceedings. Maggie had bail conditions not to contact Elaine or attend her home address. The case was listed to be heard at Crown Court commencing May 2016, the day Elaine was murdered. Following Maggie's conviction for murder, the burglary and perverting the course of justice charges have been left on file.

9.8
Family Composition

Name	Age (May 2016)	Relationship	Ethnic Origin
Elaine	26	Half-sister	White European

Maggie	52	Half-sister	White European
Robert	N/K	Brother to Maggie; half-brother to Elaine	White European

10. CHRONOLOGY SUMMARY

Date	Event
2015-2016	
Sep 2011-Aug 2012	● Elaine visited the USA and lived with Maggie for almost one year. Elaine returned to the UK after being assaulted by Maggie and as a result was fearful of her.
June 2015	● Maggie returns to the UK and stays with Elaine.
Aug 2015	● Elaine revealed to NHDC a connection with Maggie when she stated that her 'sister' had recently returned from America and was staying with her temporarily. No mention of abuse, physical or otherwise, was made at that time.
Sep 2015	● Maggie initially approached NHDC as she was 'sofa surfing'. In terms of the Council's response, normal operating practice was followed - Maggie was offered housing advice and assistance
Oct 2015	● Assault Occasioning Actual Bodily Harm (ABH) reported to police by Maggie. She alleged she was the victim and Elaine was the suspect. Elaine was arrested for assault on Maggie that same day. Interviewed and released on bail for further enquiries. Both Elaine and Maggie attended the Emergency Dept. (ED) for minor injuries relating to the cross allegations of assault. Their visits did not overlap. No further action was taken against Elaine following further enquiries after she was released on bail. ● Dwelling Burglary reported to police when Elaine returned home. Elaine was the victim and Maggie was the suspect. ● Police completed a Domestic Abuse Stalking and Harassment (DASH) assessment for Elaine as a victim of burglary which included a DA element and was recorded as a domestic incident. ● Maggie was arrested for Dwelling Burglary that same day. Considered not fit for detention. Released on bail for later interview. ● Family members reported Maggie in breach of police bail conditions. Police informed family that Maggie was not in breach of bail conditions. No offences committed. Maggie attended hospital with regard to follow up from the alleged assault. ● Maggie answered bail for Dwelling Burglary. Interviewed and released on bail to separate family address pending further enquiries. ● Police meet Elaine as follow up. Elaine shares fear of Maggie. ● Elaine re-bailed for assault pending additional witness statements. ● Maggie contacted police alleging being asked to buy an iPad for sister so she would drop charges against her.

Date 2015-2016	Event
Nov 2015	● Domestic incident recorded by police. Maggie contacted Elaine in breach of her police bail. Police completed a DASH assessment for Elaine, but Maggie was not arrested. ● No further action against Elaine for assault on Maggie formally recorded. ● Maggie advised NHDC she had fled her home in the United States of America (USA) due to death threats from her husband. She makes a homelessness application. In this she states that her sister Elaine had beaten her up, thrown her out and destroyed her personal belongings. The Council accepted Maggie was homeless, most probably due to DA in the USA.
Dec 2015	● Maggie answered bail for dwelling burglary. Identification procedure took place. Released on police bail for CPS decision to a family relations address.
Jan 2016	● Maggie accessed temporary accommodation. ● Maggie answered bail for dwelling burglary. Interviewed and then charged with dwelling burglary and perverting the course of justice.
Mar 2016	● Maggie accepted for ongoing housing assistance.
Apr 2016	● Maggie entered a not guilty plea for burglary. The case was listed for trial commencing 05/16.
May 2016	● Elaine murdered by Maggie, 11 months after returning to the UK. ● Following day Elaine was found dead in her home address by family after concerns re welfare. Major Crime Investigation followed. ● Maggie arrested for Murder of Elaine a few days later.
Dec 2016	● Maggie sentenced to life imprisonment for offence of murder.

11. OVERVIEW

11.1
Between the 1st January 2015 and 1st June 2016 Elaine accessed services at the ENH NHS Trust on 13 separate occasions. Eleven of her hospital attendances were for the treatment and management of a chronic health related condition and the majority of attendances were in the form of outpatient clinic appointments. The other two attendances for emergency treatment are listed above, one of which relates to the assault allegation.

11.2
Over that period Maggie accessed services at ENH NHS Trust on 15 separate occasions. Thirteen of the attendances related to the management of chronic and ongoing health related concerns. On two occasions she accessed services at the Trust for treatment of injuries which were related to the assault allegations, both of which are listed above

11.3
All four of the agencies who contributed IMRs to the review had some knowledge of allegations of what was in fact DA. The police had the most significant dealings with both Elaine and Maggie and although they did not initially record the allegations from early October 2015 as DA, they were clear in recording and reacting to the later allegations as DA. The initial response in not recording the event as potential DA was based on confusion about the relationship rather than non-recognition of sibling abuse as falling within service and Home Office definitions. The mistake did

not impact on the quality of the investigation nor the outcome and was later rectified on the recording.

11.4
The interactions at the hospital which arose from the allegations of assault were documented but at no point were they formally recorded as DA and therefore referrals were not made in accord with their own existing policy and procedures. As has been reflected on, in the Analysis section below, hospital staff simply did not recognise sibling abuse as DA. It would seem from the health IMR that this was a more general failing historically which is now being addressed as per the recommendations and lessons learned.

11.5
NHDC originally recorded there was an allegation of DA made by Maggie when she alleged historic abuse from her ex-partner in the USA which she gave as her reason for returning to the UK. This did not result in any referral to any other agencies or in consideration of referral in line with their own procedures other than passing the information to NHH as the reason for her housing need. Given there was arguably no imminent threat to Maggie (given she had left the USA) the non-referral was understandable. There should however have been recording of the consideration and of the decision.

11.6
Similarly, when Maggie alleged in November 2015 that she had been abused by Elaine that was not recorded as DA nor shared with other agencies. It was assumed that the allegations were being dealt with by the police but that was not checked.

11.7
NHH were also aware that there was an allegation of some form of abuse or incident involving Elaine and a sister. They were aware of a relationship between the two women and that Elaine had disclosed alleged abuse. Similarly, they made no referral but it was a reasonable assumption on their part that as the police were already at the premises and dealing with the incidents that the matter was already in the hands of the appropriate agencies. It would have been good practice to establish with police colleagues either at the scene or later that the alleged DA was being followed up.

12. KEY ISSUES ANALYSIS OF INVOLVEMENT

12.1
The author has addressed the key lines of enquiry from the terms of reference for each agency as part of the analysis of involvement as outlined below.

12.2
What disclosures Elaine made to agencies and the circumstances behind her contact with them.
The need to ensure supervisory oversight and review of DA cases.

12.3
The effectiveness of inter-agency communication

12.4
<u>Hertfordshire Constabulary</u>
There are two recorded incidents of Elaine being a victim of DA namely, the burglary and the breach of police bail conditions. A DASH risk assessment was completed for both. Given the outcome of the original ABH offence, a DASH assessment should have been completed for Elaine in that incident as well. The level of abuse that Elaine suffered on these occasions arguably gave no indication of the subsequent murder or the later extreme level of violence. Elaine did however make clear her real fear of

Maggie and there was the potential to explore that further to assess the risks and allow increased safety planning and inter-agency communication.

12.5
ENH NHS Trust
The attendance at the Emergency Department (ED) in early October 2015 was the significant event, when both parties alleged that they had been assaulted. Maggie alleged that she had been assaulted by her sister whilst Elaine made a counter allegation that she was assaulted by her sister. Both made disclosures of DA that were not recorded or responded to in accordance with Trust policies existing at that time.

12.6
NHDC
NHDC contact with both women related to their respective housing needs and associated support. Although anecdotal in nature, following the claims by Maggie of DA (by her ex-partner in the USA), the allegations were recorded as DA in November 2015 when she was initially seeking accommodation. After receipt of her letter in March 2016 alleging further abuse, this time by Elaine when seeking housing support, the disclosure was also recorded as DA.

12.7
NHH
NHH contact related to the provision of housing to Maggie after referral from NHDC. The disclosure of the potential abuse and alleged criminal offences to NHH by Elaine was initially by the police attending the incidents in early October 2015 but also by Elaine herself.

12.8
If and how agencies assessed risks to Elaine and the risks represented by Maggie?

12.9
Hertfordshire Constabulary
Elaine was subject of two DASH assessments which were comprehensive but appeared to be graded incorrectly. Professional judgement could have been used to raise the risk assessment level. This could have presented specialist staff and other agencies with opportunities to consider additional safeguarding measures. The risk assessments resulted in no additional safeguarding measures being put in place. Given the outcome of the ABH, Elaine should have been subject of a DASH risk assessment on that occasion. This was a missed opportunity to consider additional safeguarding opportunities including a referral to MARAC and inter-agency sharing of information.

12.10
A DASH risk assessment should have been completed for Maggie as an alleged victim for the ABH. There was confusion as to whether Maggie and Elaine were related but if an assessment had taken place this may have confirmed the relationship. Evidence for all the offences within this Review point to Maggie being the offender. There is no evidence of any risk management of Maggie regarding potential offending. This may have been considered if professional judgement had raised the risk against Elaine. Potential for violence directed at Elaine may have been identified, but from the facts known, it is highly unlikely that murder or serious violence would have been considered a real possibility. There were however missed opportunities as consideration to remand Maggie into custody was not explored, nor was she arrested for the breach of bail in November 2015. Had the risks been graded differently taken together with the breach of police bail and the subsequent burglary charge, remand could have been considered. The police are largely unique in their powers of enforcement and the breach of bail should have been followed up as part of their positive action commitment to DA victims.

12.11
ENH NHS Trust

There was no assessment of the risk to either Elaine or Maggie following their separate admissions to the emergency department in early October as the incident was not recognised as DA. The visits did not overlap, and Elaine was at the time accompanied by police. There was an opportunity to refer to other agencies and the on-site IDVA service if DA had been recognised at this point.

12.12
NHDC
There were two opportunities as outlined above for housing staff to consider the risk and make safeguarding referrals relating to Maggie under the Council's policy and this in turn would have led to the consideration of IDVA referrals which would have been subject to agreement by Maggie and in the case of the HCS referrals, the view of the Designated Safeguarding Officer (DSO) at the time.

12.13
NHH
NHH have reflected on the incident when staff visited Elaine and were made aware of the burglary and alleged assault. They identified Elaine as potentially 'vulnerable' at that point. When NHH have contact with customers who are vulnerable and exceed a threshold that would require statutory support, customers are referred to support agencies. When someone appears vulnerable but does not exceed a threshold of vulnerability that would require statutory intervention, an offer of voluntary engagement of support is made. Elaine met this criterion; she was offered services but declined to engage with these.

12.14
During the visit when police were present and staff visited Elaine, they were made aware of an incident of violence between Elaine and a sister. However, as the police were on site NHH staff considered there was no further role to play at that time.

12.15
NHH did not assess the risk to Elaine as DA. They were reliant on the police actively managing the issues that arose. They could have actively sought confirmation from the police.

12.16
Were the agency responses good practice and proportionate given their knowledge?

12.17
Hertfordshire Constabulary
As above a DASH risk assessment should have been completed initially for Maggie as the victim for the ABH. There was confusion as to whether Maggie and Elaine were related but if an assessment had taken place this may have confirmed the relationship. Evidence for all the offences within this review point to Maggie being the offender. There is no evidence of any risk management of Maggie regarding potential offending. This may have been considered if professional judgement had raised the risk to Elaine. There was a missed opportunity as consideration to remand Maggie into custody was not explored. Had the risk been assessed differently and viewed in conjunction with the breach of police bail, remand could have been considered.

12.18
ENH NHS Trust
There was no direct response to the DA for either Elaine or Maggie following their separate admissions to the ED in early October as the incident was not recognised as DA. The visits did not overlap, and Elaine was at the time accompanied by police.

12.19

NHDC
As above at 12.2 if there had been strict compliance with existing policy then there were two opportunities to at least consider referrals for Maggie in relation to DA.

12.20
NHH
The provision of accommodation to Elaine was in accordance with their policies and there was active consideration of the potential vulnerability of Elaine, but this was not seen in the context of DA nor checked with the police officers dealing.

12.21
Whether relevant agencies discharged their duties appropriately?

12.22
Hertfordshire Constabulary
Officers promptly responded to both the ABH and Burglary offences. They were both professionally investigated in the view of the police IMR writer, and the Author shares that view. Both had an appropriate outcome following investigation, with no further action being taken in respect of the ABH and charges for the burglary and perverting the course of justice for Maggie.

12.23
ENH NHS
In terms of the provision of health services following the allegations of assault hospital staff provided an appropriate and timely service. They did not recognise the DA nature of the allegations and therefore did not consider referral. Trust policy for DA, which was in place at the time of this attendance, defined DA as: 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. Guidance for staff indicated the need to involve the police, IDVA and undertake a risk assessment for the patient, and consider safeguarding referral. In this instance it is acknowledged by the Trust that the guidance was not followed for Maggie or Elaine.

12.24
NHDC
The provision of housing services was supportive of both Elaine and Maggie in their respective circumstances. However, although Maggie made disclosures of DA, referrals were not made.

12.25
NHH
The provision of accommodation and support was appropriate and maintained. NHH only became aware of the allegations of potential abuse at the point the police were already involved and dealing with the issues.

12.26
Lessons to be learnt for the future.

12.27
Hertfordshire Constabulary
All Officers have been re-briefed on DA policy in respect of identifying family members and current policy now reflects the recommendations and lessons learnt identified below.

12.28
Full details of investigation are now included on crime report free text and fully updated before they are recorded as finalised with the DASH assessments included on crime reports.

12.29
Improvements are required in management of crime reports by supervisors and Victim Support Team (VST).

12.30
All allegations of crime must be recorded on the Crime Information System (CIS) in compliance with National Crime Recording Standards (NCRS).

12.31
Any linked crimes will now be linked on CIS.

12.32
Officers have been reminded to use professional judgement when completing DASH risk assessments and a recommendation has been made for these to be reviewed following any further contact with the victim.

12.33
THRIIVES risk assessment will be required on all domestic related incident reports. See 13.7 below.

12.34
Promotion of the use of THRIIVES by all officers and staff in key decision making roles within the Constabulary.

12.35
Improvements are required in management and archiving of DASH assessment books.

12.36
<u>ENH NHS Trust</u>
During the Review of both Elaine and Maggie's ED attendance in October 2015, it was identified that the perception of staff on duty was that the incident was related to a case of sibling rivalry or triggered by a dispute of unknown cause; but not as DA. Additionally it was noted by staff in the department that the police were involved as Elaine was accompanied by the police during her attendance. It was assumed that the alleged assault was being managed by the Constabulary as part of their investigation. The discharge letter for Elaine did ask that the police investigate the assault, but no consideration was made to making a referral to other agencies or the IDVA.

12.37
ED staff felt that there was a high understanding amongst staff in the ED about managing DA within intimate partner relationships. They acknowledged that abuse between adult family members was less likely to be recorded as DA.

12.38
The Trust's local policy relating to DA advises staff that if there is an identified risk that the patient is in imminent danger of harm that the police should be contacted immediately. The procedures include referral to IDVA and Adult Safeguarding. The procedures also include when to make Safeguarding referrals for advice during 'out of office hours' using the 24-hour Herts County Council helpline and duty worker. The Trust policies include the need to undertake DASH risk assessments, and this has been addressed in training programmes for staff. If a referral to an IDVA had been made the IDVA would normally have undertaken the DASH risk assessment. The policy clearly reflects good practice but depended on staff recognising inter sibling violence as DA which did not occur in this case.

12.39
Senior Trust staff therefore identified that increased education needed to be delivered to the

clinical team in the department for staff to look beyond the stereotypical norms of DA and to raise awareness of the definition of DA, specifically sibling relationships. Future safeguarding training in the ED will reiterate that violence between siblings is outlined in local policy as an indication for referral to an IDVA or the adult safeguarding team.

12.40
Trust supervisors highlighted that it would have been unlikely that staff in the department would check with a police officer if a safeguarding referral had been made for a patient in their company. Staff in the ED will be encouraged in future to

12.41
liaise with the accompanying police officer to clarify if a referral or the offer of a referral has been made to all potential victims.

12.42
NHDC
Although anecdotal in nature, following the claims of DA by Maggie in November 2015 and after receipt of her letter in March 2016, there were two opportunities for housing staff to consider safeguarding referrals to Hertfordshire Community Services (HCS) or the police under the Council's policy and this in turn would have led to the consideration of IDVA referrals (although they would have been subject to agreement by Maggie and in the case of the HCS referrals, the advice of the Designated Safeguarding Officer (DSO) at the time).

12.43
The SafeLives-DASH Risk Identification Checklist which is now in use will provide an additional tool for housing staff to assess all cases that might have a DA dimension and ensure they are dealt with appropriately, including possible escalation to a MARAC.

12.44
Following Maggie's allegations concerning her estranged husband and later against Elaine, it was apparent that no specialist support information for DA victims was provided by NHDC's housing staff. Policy has now changed to emphasise the need for support information to potential victims.

12.45
To ensure consistent and timely responses to notifications of DA, NHDC considered a specific policy on its approach to the management of DA, including a comprehensive training programme for all relevant staff.

12.46
NHH
NHH should consider ensuring staff check with police or local authority colleagues what action if any is being taken regarding concerns of domestic abuse or safeguarding, they become aware of and that any action or information is recorded.

12.47
To identify good practice in place

12.48
Hertfordshire Constabulary
The two incidents regarding Elaine and Maggie, that Hertfordshire Constabulary investigated, took place in October 2015. Since then the Constabulary have made substantial investment and improvements in the investigation of DA. The most significant development was the creation of the Domestic Abuse Investigation and Safeguarding Unit (DAISU) in January 2016. This is a specialist unit dealing with domestic abuse reports. Since the introduction of DAISU there have been improvements in policy and procedure which have addressed some of the issues identified in this

report. Hertfordshire Constabulary carried out a review of their processes around DA investigations and professionalised their approach to the safeguarding and investigation of DA. Since 2016 there has been an investment of just over £4m to set up and create a team which brought the safeguarding and investigative functions together to form Domestic Abuse Investigation Safeguarding Unit (DAISU). In addition to this DAISU provides one focal point for partners for DA.

12.49
Since these incidents the Force Control Room (FCR) has introduced 'THRIIVES' risk assessment process for reported incidents.

- Threat
- Harm
- Risk
- Investigation
- Intelligence
- Vulnerability
- Engagement
- Specific need

'THRIIVES' is a dynamic risk assessment and decision-making tool. It is used by FCR staff to identify any potential threat, harm, or risk in order to apply the correct grading and most appropriate response. It is also used to ensure that all staff accurately record their rationale for decisions on the Incident Summary Report (ISR). This must be utilised for all DA related incident reports under current policy.

12.50
ENH NHS Trust
As a result of the DHR Review the ENH NHS Trust in conjunction with Refuge are providing formal and informal education to staff to increase awareness and clinical recognition of the categories of DA and the relationship profile of abusers. Staff are also provided with education on dealing with and escalating concerns surrounding DA through our induction and vital training programs'.

12.51
NHDC
The SafeLives-DASH Risk Assessment Checklist being used will provide an additional tool for housing staff to assess all cases that might have a DA dimension and ensure they are dealt with appropriately, including the potential escalation to a MARAC.

12.52
NHH
NHH have revised their Safeguarding Policy and delivered training to implement the policy. This includes all staff who visit properties to confirm there are no safeguarding and DA issues highlighted. Where NHH staff become aware of safeguarding, including DA cases, colleagues will now follow up with other partner agencies to establish what support is in place.

12.53
Victim Support
Victim Support is currently going through a programme to have IDVA Services accredited to SafeLives Leading Lights standards. SafeLives Leading Lights status is the mark of quality for DA services and is increasingly being recognised by commissioners and funders across the UK. The Leading Lights accreditation programme offers services, partner agencies and commissioners a set of standards for supporting victims of DA.

12.54
Any difficulties agencies encountered when working with Elaine that impact on the case.

12.55
Hertfordshire Constabulary
There were no issues identified in working with Elaine as she maintained contact with police staff and appeared throughout to be willing to support the prosecution of Maggie.

12.56
ENH NHS Trust
No issues identified

12.57
NHDC
No issues identified

12.58
NHH
There was a barrier for Elaine to engage with the usual assessment and check processes following allocation of housing. Additionally, she later declined the offer of support. It is not known why this is.

12.59
It is possible that if Elaine had taken up the offer of support NHH would have been more aware of the concerns Elaine had about Maggie. It may be that Elaine felt she had sufficient support from the police.

12.60
Any difficulties agencies encountered when working with Maggie that impact on the case.

12.61
Hertfordshire Constabulary
The police recorded the initial allegation reported by Maggie but carried out a full investigation and recognised Elaine as a probable victim rather than offender and formally took no further action against Elaine for the alleged assault after making enquiries.

12.62
ENH NHS Trust
No issues identified.

12.63
NHDC
No issues identified.

12.64
NHH
No issues identified.

12.65
The accuracy of records and information imparted.

12.66
Hertfordshire Constabulary
The recording of information was for the most part comprehensive but there was a failure to ensure all the information was fully recorded on all the appropriate forms and systems which meant that all the information was not easily accessible to other officers or supervisors. This

potentially obscured the risks to Elaine. This has been the subject of recommendation and action by the police.

12.67
ENH NHS Trust
The recording is comprehensive and clear that Elaine and Maggie reported allegations but these were not recorded as DA.

12.68
NHDC
The recording of contact with Elaine and Maggie again appears comprehensive and does recognise allegations of DA were being made by Maggie but that did not lead to referrals.

12.69
NHH
Recording was comprehensive and details the allegations, police involvement and the consideration of the possible vulnerability of Elaine and her declining additional support.

12.70
Family and friend's involvement and perspective

12.71
A Family Meeting took place on the 29th of June 2017 and other family members subsequently met with both the DHR Chair and Report Writer present. The Chair had written to a number of family members to outline the DHR process, introduce herself and the Report Writer, and provide information on potential support services with a copy of the TOR for the Review.

12.72
Robert, the brother of Maggie and half-brother to Elaine, gave an extremely detailed picture of the complex relationships across what was and remains a large extended family. Most importantly he reflected the relationship as being complex but with Elaine as the much younger sibling being frightened and intimidated by Maggie. He also saw Elaine as being potentially vulnerable but that she had never been formally assessed as such by any statutory agency.

12.73
His view of Maggie was stark in contrast, in that he saw her as a potentially threatening and sometimes violent individual who had lived in the USA for many years and whilst there had been involved in some incidents of violence/threats of violence. He provided information that Maggie had been charged and remanded to prison for stabbing a previous partner in 1994 with scissors in the UK. Those charges appeared not to have resulted in any conviction due to the victim not supporting criminal proceedings. (Research by police into those alleged offences in the UK and for offences of violence in the USA did not establish any records). Although he held that view of Maggie, he reflected he had not foreseen the murder, or that level of violence. Family members reflected a view that following a work-related injury in the USA and Maggie returning to the UK she was regarded as "old and frail", but not to a level at which she could be regarded as having additional care and support needs.

13. OVERALL ANALYSIS

13.1

Briefing by Standing Together[2] makes the distinction between Interpersonal Violence (IPV) and Adult Family Violence (AFV) making the point that the current definition of domestic abuse combines the violence committed by intimate partners with that between family members. Standing Together report on clear differences in the dynamics and motivations between IPV and AFV and that there continues to be a lack of research into the area of AFV.

13.2
The Police involvement started when Maggie made an allegation of assault against Elaine in early October 2015. She referred to Elaine as her sister. The officers arrested Elaine on suspicion of ABH and Maggie was at this early point regarded as the victim. Whilst in custody Elaine made counter allegations against Maggie. Elaine also stated that although they referred to each other as sisters they were not sisters or half-sisters.

13.3
In her police statement, Maggie stated Elaine was possibly her half-sister on her father's side but it had never been confirmed and his name was not on her birth certificate. As a result of the assault Maggie attended the ED. It is recorded on the hospital admission form that she referred to Elaine as her half-sister. The officer provided a witness statement regarding speaking to Maggie and arresting Elaine. He stated that Maggie referred to Elaine as her sister and that whilst in custody, Elaine had referred to Maggie as her sister. The officer completed handover documentation which initially stated they were sisters but concluded they were not.

13.4
There was clearly confusion around the actual relationship between Elaine and Maggie. Possibly that extended to the two women themselves and certainly to police at one point in time. However as identified in the police IMR the allegation should at least initially have been flagged as potential DA. Police guidance was clear that where there is confusion as to whether the victim and suspect are family members reporting officers should regard them as family members, respond as per Force Policy for a domestic incident and complete a DASH risk assessment. A decision could then subsequently be made to confirm whether it fell within the definition of a domestic incident or not.

13.5
Despite the conclusion stating Elaine and Maggie were not sisters there was sufficient evidence contained within the handover case papers and subsequent suspect interview that they were probably half-sisters. This should have been identified by the officers dealing with Elaine and a DASH risk assessment completed for Maggie. Given the explanation provided by Elaine during the interview, stating she was the victim, a DASH assessment should have been completed for her too. This incident predates DAISU but should have been referred to the then Harm Reduction Unit (HRU) to assess risk for both. This incident would have benefited from the input from experienced HRU staff. There was a missed opportunity from a safeguarding perspective regarding risk assessment for both Elaine and Maggie as they both made disclosures which fell within the definition of DA.

13.6
The police IMR records the free text of the crime report is lacking in detail following Elaine being released on police bail. There is an absence of detail regarding the subsequent investigation and reasons for no further action being taken and this was not identified by the investigating officer's supervisor. However additional research by the police IMR writer showed there was a robust investigation and no issues that would have directly impacted on the risk assessment process. On release Elaine reported a burglary at her home address.

---

[2] https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5efcb376866b33242d04c3cb/1593619318736/AFV+Briefing+Sheet.pdf

13.7
In early October 2015 a witness statement was obtained from Elaine regarding the burglary. The officer taking the statement, correctly identified this was a domestic incident. A DASH risk assessment was completed, and it was graded as 'standard'. The risks identified required further review and assessment by police safeguarding staff. Current police policy, applicable at the time, states officers can raise the level of risk by using their professional judgement. Officers and staff have been reminded since the review that use of their professional judgement can be used in cases to raise risk levels. The burglary crime report did not record that the DASH risk assessment had been completed and there was no reference to DA within the report itself.

13.8
Later that day Maggie was arrested. She was accepted into custody but after being seen by the nurse was deemed not fit for detention as she required medication which she did not have with her. Given the issue was lack of medication it would be reasonable for officers to collect her medication from where she was staying. This crime was subsequently allocated to a detective. She was released on police bail. She was given two bail conditions:

- Not to contact Elaine directly or indirectly.
- Not to attend the home address of Elaine.

13.9
Maggie answered her bail in October 2015 a few days later and was interviewed regarding the allegation of burglary. She denied the offence saying the property was hers. She was released on police bail pending further enquiries.

13.10
In October the detective officer met Elaine to return property to her. She described that despite being scared of Maggie she was adamant that she would give evidence against her and stand up to her. She raised concerns regarding seeing Maggie locally or whilst out shopping but was reassured by the officer and given basic security advice and described the support she could get from the victim support team, but no referral was made. There was also no referral to DA services. Elaine understood that if she had any concerns or questions she could call the officer and support would be provided for her at trial. There was a potential missed opportunity at this stage as the officer could have further reviewed the risk using professional judgement in order to escalate the risk and consider additional safeguarding measures to be put in place.

13.11
In November 2017 whilst on police bail Maggie contacted Elaine via 'facetime'; this was in breach of her bail conditions. It was correctly recorded by the attending officer as a non-crime domestic incident and a DASH risk assessment was completed for Elaine. The DASH risk assessment was included within the crime report and graded as standard. The DASH risk assessment had been completed five weeks after the previous one and if it had been reviewed and forwarded to safeguarding staff the risk against Elaine could have been more accurately assessed. The outcome of this breach was not included on the crime report on CIS, and it had not been linked to the crime for which Maggie was on bail for. This was against force guidelines and appears to be an oversight by both investigating officers and administrative systems in place for the management of crimes. By this point, police were also aware that Maggie had spoken to two family members in an attempt to get Elaine to withdraw charges relating to the burglary. Although family members reported this to the police no action was taken. Therefore, there was again a missed opportunity to review the safeguarding in place around Elaine.

13.12
In December 2017 Maggie answered bail and was interviewed additionally regarding perverting the course of justice following evidence from family and other witnesses. She denied the offences. Maggie was released on police bail pending an identification procedure which took place later in

December 2015 after which she was again bailed for CPS charging advice. No review of the risk assessment was carried out at this point.

13.13
In January 2016 Maggie was charged with dwelling burglary and perverting the course of justice. She subsequently pleaded not guilty, and the trial was listed for May 2016. The Perverting the Course of Justice offence was not recorded as a crime on CIS. The burglary crime number was used for charging purposes. This was not National Crime Recording Standards (NCRS) compliant as both offences should have been recorded as crimes and linked. If the risk assessment had been raised by professional judgement and/or the risk reviewed for Elaine, consideration could have been given to Maggie being remanded in custody after charge as there was also a breach of police bail. This was another missed opportunity to formally review the risk to Elaine; and arguably the most significant.

13.14
As stated previously there was no DASH risk assessment for the ABH in early October 2015. This oversight does not appear to have been identified until November 2015 when the entry relating to the breach of bail was made. The DASH risk assessment completed for the burglary was not recorded on the Domestic Violence Family Front Sheet (DVFFS). The original DASH assessment book completed by the officer was located within the burglary case papers and does not appear to have been submitted to the then HRU. All DASH risk assessments are recorded on the crime report and are reviewed by DAISU. The DASH risk assessment book for the breach of bail could not be located, however the details of the assessment were recorded on the crime report although in the absence of the DASH book the accuracy cannot be verified. If a DASH risk assessment had been made for the ABH and the Burglary these along with professional judgement may have been used to assess risk more accurately, allowing HRU to be in a position to make more informed decisions regarding both Elaine and Maggie as to further action and/or referrals.

13.15
The attendance at the ED at ENH NHS Trust in October 2015 by both parties is a significant event. Here, both parties alleged that they had been assaulted.

13.16
During this admission Maggie informed medical staff that she was asleep and woke up to take her medications when she noted that her sister was in the house ‘going crazy’ and throwing things around before ‘attacking’ her. On medical examination it was noted that her ring finger on her right hand was swollen, and she had a small laceration to the knuckle of her middle finger. A physical examination revealed no other injury to her right arm and a subsequent x-ray revealed a fracture to her right middle finger.

13.17
Maggie also had a physical examination of her back with no obvious bruising or marks evident. It was also documented by the reviewing doctor that Maggie attended the department using a wheeled walking frame. She was discharged from the department in the early hours with a follow up arranged for later in October in the hand fracture clinic. During this attendance there is no evidence that Maggie had been referred to an IDVA. Additionally, staff in the department did not raise any formal safeguarding concern around Maggie.

13.18
Elaine attended the ED in the early hours in October 2015 accompanied by the police. She informed medical and nursing staff in the department that she was assaulted by her half-sister who had punched her three times to the left side of her face and had thrown her against a wall. Elaine reported that she suffered blurred vision immediately after the assault and had developed severe pain to the left side of her head. She was unsure if she had lost consciousness during or

immediately after the assault. In the department she complained that she was feeling nauseous. On medical examination there were no bruises found that could be attributed to the assault.

13.19
Elaine was discharged later that day with standard head injury advice and advised to return to the ED if her symptoms worsened or persisted. A comment was placed by the discharging doctor on Elaine's discharge summary which reads 'for the police to investigate the assault'. There is no evidence that Elaine was referred to an IDVA or that a formal safeguarding referral was made as a result of this attendance. It was the reasonable view of the IMR writer that staff assumed given the police were in attendance that appropriate referrals would be made but this was not queried with police or checked to ensure that was the case. Trust policy at the time stated that guidance for staff would indicate the need to involve the police, IDVA and undertake a risk assessment for the patient, and consider safeguarding referral. In this instance it was acknowledged that the guidance was not followed for Elaine or Maggie.

13.20
It was recorded that an IDVA had conducted DA training and education with staff in the department on several occasions throughout 2015 and 2016. Health staff felt that there was a higher understanding amongst staff in the ED about managing DA in the cases of intimate partner violence and abuse, but less confident when it came to adult familial abuse.

13.21
It became apparent during the Review process that there was a degree of conflation of adult safeguarding processes, issues of capacity, care needs and DA and a need to keep specific focus on processes around DA referral and support. The Consultant body in the ED have begun the process of educating medical staff on the need to routinely seek permission from the victim to make safeguarding adults and IDVA referrals when encountering patients complaining of injuries resulting from adult family violence and abuse.

13.22
Medical staff highlighted that at the time staff in the department would not check with a police officer if a safeguarding referral had been made for a patient in their company. Staff in the ED have been encouraged in future to liaise with the accompanying police officer to clarify if a referral or the offer of a referral has been made to victims. The importance of this has been raised at team training and this process will be incorporated into future DA training sessions delivered to staff in the Department.

13.23
NHDC - Elaine's interactions with the Council focused on her tenancy, her claim for Housing Benefit, and queries concerning Council Tax. The only contact with Elaine that revealed a connection with Maggie was in August 2015 when she stated that her sister had recently returned from America and was staying with her temporarily. No mention of abuse, physical or otherwise, was made at that time.

13.24
Maggie initially contacted the NHDC over her claim for Housing Benefit for her temporary accommodation. The Review concluded that this interaction followed normal working practices and did not reveal any information relating to alleged abuse or any safeguarding concerns at that point.

13.25
The majority of the NHDC's interactions with Maggie concerned her housing and there was subsequent recording of allegations of abuse.

13.26

Maggie initially approached the NHDC in September 2015 as she was recorded as sofa surfing. She accessed temporary accommodation in early January 2016 and was eventually accepted for ongoing housing assistance in March 2016.

13.27
At her meeting with the NHDC in November 2015, Maggie advised she had fled her home in the United States of America (USA) due to death threats from her husband. NHDC accepted she was homeless, it appears due to the alleged DA.

13.28
Later in November 2015, Maggie reported her sister had destroyed her personal documents and then the next day she stated that her sister had beaten her up, thrown her out and destroyed her personal belongings. Some months later, in her letter received in early March 2016 via NHH, Maggie reported amongst other things, that in October 2015, Elaine broke her finger and punched her in the chest, dragged her out of the flat and took her belongings and dumped them.

13.29
In terms of the homelessness investigation, NHDC considered the relevant legal tests and accepted a duty to provide accommodation for Maggie. During the associated interviews with Maggie (and following subsequent contact) there were no requests from her to provide accommodation away from any areas of risk (NHDC regularly seeks refuge type housing in other parts of the country to keep DA victims safe).

13.30
Although the DA aspect was not central to the homelessness assessment, no further evidence of the abuse from Maggie's former husband or Elaine came to light during the NHDC's investigations. Throughout NHDC's dealings with Maggie, concerns regarding possible DA were not notified to any other agency or service.

13.31
An HCS referral was not considered by housing staff following the disclosures of DA by Maggie. This appears to be largely due to Maggie's circumstances; emergency housing was not being sought away from areas of risk and there was thought to be no involvement from other agencies that specialise in the management of DA cases. However, due to the low threshold when considering safeguarding matters, a Hertfordshire Community Services (HCS) referral should still have been considered (all front line housing staff have since been reminded of the low thresholds when considering HCS and IDVA referrals and this features regularly at team meetings).

13.32
NHDC is a member of Hertfordshire's Multi-Agency Risk Assessment Conference (MARAC) and works with the Independent Domestic Abuse Advisors (IDVAs) on a regular basis. The 'NHDC incident report form for an adult at risk' confirms that staff should also refer DA cases to the IDVA (again normally requiring the subject's agreement). However there is no indication a possible referral to the IDVA service was discussed with Maggie (it appears for the same reasons cited above in relation to a HCS referral). NHDC's Homelessness and Housing Advice Team have been provided with the SafeLives-DASH Risk Identification Checklist since November 2016 which helps assess which DA cases should be escalated to a MARAC.

13.33
Although anecdotal from Maggie, following the claims of DA in November 2015 and after receipt of her letter on 2nd March 2016, it appears there were two opportunities for housing staff to consider safeguarding referrals to HCS or the police under the NHDC's policy and this in turn would have led to the consideration of IDVA referrals (although they may have been subject to the views of Maggie and in the case of the HCS referrals, the view of the DSO at the time).

13.34
The SafeLives-DASH Risk Identification Checklist now provides an additional tool for housing staff to assess all cases that might have a DA dimension and ensure they are dealt with appropriately, including possible escalation to a MARAC and this has been subject of further briefing to all staff.

13.35
Following Maggie's allegations concerning her estranged husband and Elaine, it was apparent that no specialist support information for DA victims was provided to her by the NHDC's housing staff. Policy and training has been supplemented.

13.36
In accordance with NHH's new tenant process, a visit was carried out with Elaine. The purpose of this visit was to ensure the new customer had moved into their accommodation and that there were no outstanding issues. This visit was also used to establish if there are any support needs from NHH or a need for any referrals to other support agencies. In this case there was no identified need to make any referrals. Due to limited furniture in the house and Elaine appearing as 'vulnerable', staff extended the offer of her engaging with NHH's tenancy support team; this support service required voluntary engagement from the customer. Elaine declined this offer and advised that she was fine and did not require any help. There was no evidence of any identified need that would have required any referrals to a statutory agency.

13.37
During the visit when police were present and staff visited Elaine, they were made aware of an incident of violence between Elaine and a sister. However, as Elaine was arrested as the perpetrator and the statutory agency, the police, were on site, staff considered there was no further role for NHH to play at that time.

13.38
When housing Maggie, as per the current process, NHH were sent through a 'Nomination for Temporary Accommodation'. This application highlighted the needs and background of the applicant. This was received from NHDC and advised that Maggie was fleeing DA. Maggie then subsequently engaged in a process with NHDC to gain more permanent housing.

13.39
At the point of housing Elaine there were no circumstances or needs that were made known to NHH. Elaine was housed as a result of a succession from her grandparent. Elaine did not actively engage with NHH. When staff contacted her to carry out a routine tenancy visit Elaine wasn't available. The eventual contact was made as a result of a spontaneous visit. It is believed access was only gained to the property as the police were present. The police were attending to a reported burglary at the property that Elaine alleged was carried out by a sister, who Elaine reported had been staying with her. During this meeting details of an altercation between Elaine and a sister were shared with staff. The police were already involved with the case and Elaine was alleging the burglary had been committed by her sister.

13.40
From an NHH perspective, contact with both parties was as their landlord and therefore remained limited. There were no clear needs or risks that were identified that required referrals to statutory agencies that were not already aware of the allegations. NHH shared information with the police proactively and swiftly following the homicide, but did not check with police what action they were taking in response to the allegations of DA.

14. CONCLUSIONS

14.1

The Panel view was that services were focused on providing an appropriate service to the needs of both Elaine and Maggie but there was a slowness on the part of some agencies to recognise that there was evidence of DA that clearly fell within the Home Office definition and required an appropriate response. The police nor any other agency recorded any reference to the potential for the coercive control of Elaine by Maggie. The criminal offence of coercive control under S76 Serious Crime Act 2015, was operative from the 29th December 2015, shortly after the period of the alleged assault and burglary in October 2015 and when they had ceased to live together. The DASH recording in October and November 2015 documented Elaine's fear of violence and of her being controlled by Maggie. Maggie had assaulted Elaine in the States which led to Elaine returning to the UK. Given their age difference and their familial relationship, grooming of Elaine was a significant risk which, if recognised, would have led to a better understanding of their relationship. That Maggie exercised coercive control over Elaine is evidenced by her level of fear and also the extent of cross allegations of abuse. Helpfully, Respect have developed a toolkit which enables identification of the Perpetrator where there are cross allegations, in the case of male rather than familial DA.

14.2
It appears from the recording that there was some initial confusion about whether the two women were in fact related. That was made more complicated as at times both women had on occasion apparently denied that relationship.

14.3
There was no significant information held by the various services concerning the core family members that identified any indication of abuse, neglect or DA prior to the incidents which were reported to the police as offences of assault and burglary in October 2015. However, subsequent anecdotal information from the family has confirmed that there was a history of threatening and even violent behaviour by Maggie and that Elaine was in fear of her, which included the period when both were in the USA. There is no reason to believe that Elaine used violence against Maggie at any point aside from the reporting by Maggie. Family members reinforced that view.

14.4
It is the view of the Panel, with the exception of the police after their initial assessment and non-recording of a DA incident, that other agencies' perception of the relationship between Elaine and Maggie obscured their view of the incidents as falling clearly within the definition of DA or reduced the recognition of the risk. All services attempted to deal with both parties in an appropriate and empathetic manner. There was a shared Panel view that the ages, full mental capacity, and complex family circumstances probably obscured professional decision making, as well as the fact that both were female. Although, the age difference between the two sisters and the level of known physical abuse, should have alerted them to the possibility of grooming and coercive control. This may well have led to a referral to MARAC/specialist services.

14.5
The only significant inter agency work that did take place was subsequent to the death of Elaine when housing staff assisted the police investigation of the murder. Generally, the Review highlighted the need, to focus and continue DA training across agencies, particularly in relation to sibling relationships; to review DA policies and ensure they are not simply subsumed into general safeguarding advice; to fully record contact with potential victims and offenders and the need to ensure supervisory oversight and review of DA cases.

14.6
The information from the family which was unknown to agencies prior to the murder of Elaine does reflect that Maggie had a history of unpredictable and probably violent behaviour both in the UK and in the USA over a number of years which went largely undocumented and was anecdotal.

14.7

It is now known that over their respective lives, Elaine was fearful of Maggie and controlled by her, allowing her to stay with her even though she had left the States because of Maggie's abuse. Neither family nor professionals were aware of the full extent of that abuse, although the family were aware of Maggie's history of abusive behaviour and of Elaine's fear of Maggie.

14.8
It is the view of the Author and Panel that there were opportunities to intervene in the events immediately prior to the death of Elaine both on the part of the police and also by other agencies. However even if all information had been shared and referrals made by partners, the actions that were taken by the police in terms of the arrest and prosecution of Maggie were unlikely to have been supplemented to any great extent by information from partner agencies. Undoubtedly the police could and should have reviewed the risk assessments around both Elaine and Maggie more frequently in line with their own policies. The most significant missed opportunities were arguably at the point of breach of bail by Maggie and when charged with the offence of perverting the course of justice when a remand in custody application could have been considered. Realistically remand would have been unlikely in the view of the Author, however the police are unique in having extensive enforcement powers and the breach of bail should have been subject of formal investigation and arrest as part of their commitment to positive action in relation to allegations of DA.

14.9
Similarly, health and housing services could and should have recognised events prior to the murder as DA due to disclosure by Maggie.

14.10
The Panel did take the view however that given that there were a number of opportunities to make a referral to an IDVA. A referral to and intervention by an IDVA at any point could have identified further risks, explored Elaine's vulnerability, and appropriately safety-planned with her. They also could have advocated around the breach of bail conditions, which may have led to positive action taken by the police.

14.11
The Panel discussed at length that it was apparent from the Review that some agencies made assumptions that if a leading agency was already involved that any work or support needs would be identified by that agency. It was agreed that in those circumstances and as reflected in current policy some level of professional challenge and curiosity between agencies is both welcome and healthy for the future.

14.12
One of the fundamental questions for this and any other DHR was if there were existing protocols for the exchange of information about DA and if there were inter-agency policies and procedures. There are long established structures and policies across Hertfordshire which have over a number of years been developed and trained jointly. Similarly, there are established MARAC and IDVA structures in place. In the view of the Panel any potential failings in this case relate largely to agencies either not recognising the female sibling abuse in this case as DA, or not recognising that the level of risk could have reached a threshold to enable information exchange and compliance with those policies.

14.13
There was significant information received by the police during the investigation and family that although Elaine was in fear of Maggie, she did maintain some contact over years and particularly over the period subject of the review. Family members reflected a view that following Maggie returning to the UK she was regarded as, "old and frail", following a work-related injury in the USA and that this contributed to her as being regarded as less threatening than previously. Family members had not foreseen the level of violence that Maggie would use against Elaine.

14.14
There is potentially a national issue around the recognition and under recording of Adult Familial Abuse. National research in the most recent Home Office study (2016) on DHRs and the Sharing Together against Domestic Abuse (London Metropolitan University 2016) report, both identified Adult Familial Homicide as less common than Intimate Partner Homicide. This may be the case, but could also represent a level of under-recording given the information from ENH NHS Trust on the frequency of adult sibling assaults which are not consistently recorded or reported as DA.

15. RECOMMENDATIONS

15.1
Hertfordshire Constabulary

Recommendation 1.
Where there is confusion as to whether a victim and suspect are family members, Force Policies for dealing with DA must be complied with, including a DASH risk assessment. A decision will subsequently be made by DAISU to confirm whether it falls within the definition of a domestic incident.

Recommendation 2.
Investigating Officers to be reminded that full details of the investigation will be recorded on the crime report free text screen.

Recommendation 3.
Supervisors to ensure all details of the investigation are included on the crime report free text screen prior to authorising finalisation.

Recommendation 6.
Where a DASH assessment has been completed the ‘DV Risk factor’ will be included on the front screen of a crime report.

Recommendation 7.
All officers and staff will be trained and reminded of the process to raise the level of a risk assessment by using professional judgement.

Recommendation 9.
Any linked crimes will be recorded as linked on CIS

Recommendation 11.

All Incident Reports relating to DA to be subject

of a THRIIVES assessment with the details included within the report.

Recommendation 12.

The THRIIVES framework to be utilised by all staff within Hertfordshire Constabulary in key decision making.

Recommendation 13.

All DASH risk assessment books to be submitted to DAISU for review prior to archiving with Records Management.

15.2

East and North Herts NHS Trust

Recommendation 1.

At the end of each shift in the Emergency Department (ED) or Urgent Care Centre (UCC) the Shift leader, both medical and nursing, to check with their teams if there have been patients in the department who have disclosed DA or DA is suspected to ensure that the appropriate referrals have been made to police, IDVA services or Safeguarding.

Recommendation 2.

Formal DA training for nursing and medical staff working in ED and UCC to be completed and monitored on a planned basis.

Recommendation 3.

Raising awareness of DA in ED and UCC through visibility of the local IDVA (this is subject to Refuge recruiting into the vacant post and maintaining stability in the post).

Recommendation 4.

Matrons and Consultants will use informal teaching opportunities with

staff to raise awareness about DA and to remind staff about the clinical policies and guidelines and definition of DA.

Recommendation 5.

Matrons and Consultants will ensure staff are aware of when they need

to make referrals for DA and Safeguarding, including when they need to make referrals and share information even if the adult does not give consent.

Recommendation 6.

Learning from this DHR will be shared with ED staff and in the wider Trust so that staff have a greater awareness of DA cases and learn from case reviews.

Recommendation 7.

Matrons and Consultants will ensure ED and UCC staff are confident in raising concerns to the police and will check with police which agency will be responsible for what action, including referrals to IDVA or Safeguarding. Staff will need to clarify with police if they are pursuing investigations, whether criminal or safeguarding.

Recommendation 8.

Refuge IDVA services will recruit into the current hospital vacancy and take steps to maintain continuity and stability in the hospital IDVA service.

15.3

North Herts District Council

Recommendation 1.

That NHDC Senior Management Team and its Overview and Scrutiny Committee continues to receive annual reports on Safeguarding and DA training and referrals with a view to considering the effectiveness of its policies and processes.

Recommendation 2.

That the NHDC adopts a procedure on its approach to the management of DA notifications, followed by training on the policy for all relevant officers by the end of March 2018.

Recommendation 3.

All relevant NHDC staff continue to receive refresher training on DA and Adult Safeguarding by the end of March 2018 as part of the existing three year training cycle; it is recommended this includes specific reference to the 'NHDC Safeguarding Children and Vulnerable Adults Policy', the internal reporting process, referrals to HCS and relevant case studies

Recommendation 4.

All relevant NHDC staff receive training on the SafeLives-DASH Risk Identification Checklist, the MARAC and the IDVA service, including the referral processes, by the end of July 2017 and then routinely every three years thereafter.

Recommendation 5.

When members of the public approach NHDC staff and reference is made to DA that written information on the services of specialist support agencies should be provided.

Recommendation 6.

That relevant NHDC staff are reminded of the importance of accurate record keeping with regards to safeguarding and services provided for victims of DA.

15.4
North Herts Homes

Recommendation 1.

NHH should ensure staff check with police or local authority what action, if any, is being taken with regard to concerns of DA or safeguarding that they become aware of and that the information is recorded.

15.5
Additional Recommendations

Recommendation 1

Procedures should be reviewed by the DAEB to clarify that all known or reported breaches of bail conditions of actual or suspected perpetrators that come to the attention of any agency should routinely be forwarded to Police. Expected responses by all agencies should be set out in joint procedures.

Recommendation 2

That the DAEB

Checks that all agencies current DA policies are up to date and that the Champions Network is actively engaged in disseminating information and policy.

That for every DA policy that is introduced, an implementation plan should be rolled out at the point of dissemination identifying what agencies are able to share and what they cannot share and also including information on the role of professional judgement in decision making.

Recommendation 3

That HCC review their commissioning of DA workers for standard and medium risk DA victims throughout Hertfordshire.

Recommendation 4

That the DAEB seeks assurance that DA training and policy fully reflects the significance and frequency of incidences of inter familial abuse across partner agencies.

APPENDIX 1 - LEARNING PAPER

16.1
The delay in finalising this report has given Hertfordshire Local Authority the possibility of establishing how some of the agencies have progressed on the recommendations outlined in the previous section.

16.2
In addition, it is noted that review of this DHR overview report took place alongside the review of 5 other reports from the Hertfordshire area from a similar time frame. Similar themes from these reports are being collated into a learning paper in order to further improve practice in Hertfordshire for victims of domestic abuse.

16.3
Learnings that will be explored can be grouped into two sections:

- Improvements to agency knowledge and practice surrounding domestic abuse
- Improvements to the DHR process

16.4
Learning themes arising from this Review:

1) Familial relationships and professional curiosity
2) DA and AFV
3) Coercive control and how understood and investigated
4) Mental and physical health
5) Economic Abuse
6) Housing and Homelessness
7) Cross allegations of DA and toolkits to assist with this.
8) Community awareness of DA and AFV and how to respond.

In addition wider issues of relevance here are:

16.5
Effective terms of reference: It has been noted across reports that the terms of references have scope to be improved. It is not possible to adjust these terms midway through the DHR process, not least because these have been signed off already by family and friends, and also because too much time has passed to meaningfully manage this[3]. Going forwards, Hertfordshire County Council will be adopting a new SMART approach in order to get the best out of participating agencies' records.

16.6
Centring victim voice: in cases, as here, where the majority of the agency data revolves around the perpetrator, it can be difficult for the victim's voice to come through in the report. Meaningful engagement with friends, family and support networks of the victim is crucial to help fill in this gap. It can also shed light on equality and diversity matters, highlighting, for instance, how religious or cultural expectations impacted the dynamics of the relationship and how the sex of the perpetrator helps to clarify the power and control dynamics between the perpetrator and the victim.

16.7
Risk analysis: since the initial report was written, further research has updated the risk framework that agencies should work with. Notably is Dr Jane Monckton Smith's 2019 research into the homicide timeline for intimate partner violence which highlights the importance of understanding

[3] Data retention policies under GDPR mean that in practice most agencies will no longer have relevant data on file.

both risk clusters and the significant risk factor of separation (or perceived separation) prior to homicide.

16.8
Perpetrator behaviour: It is important for all professionals to be able to pick up on risk factors that may lead to a person causing harm to their partner; we cannot be solely reliant on a victim/survivor to come forward if they are experiencing abuse. Best practice working with perpetrators include community perpetrator programmes

16.9
Multi agency working and best practice:

a) Preparation for introduction of DAPOs and DAPNs and training for agencies

b) Information recording and sharing and its importance

c) Impact of DA Act 2020 - plans to date and how rolled out

d) Chronology of events - who holds this when not referred to MARAC and does MARAC produce this for each case?

e) Use of DASH, assessment of risk

f) MARAC referrals and effective MARAC practice and processes.

16.10
DHR and IMR:

a) The full background of both victim and perpetrator in relation to DA and their criminal records and reporting to the police should be included in all DHRs to ensure that patterns are observed.

b) Journey maps are a useful tool to help identify opportunities for change if services respond well and work together.

c) Use of SMART recommendations

APPENDIX 2 – ABBREVIATIONS

ABH	Actual Bodily Harm
BCHMCU	Bedfordshire, Cambridgeshire and Herts Major Crime Unit
CIS	Crime Information System
CPS	Crown Prosecution Service
DA	Domestic Abuse
DAEB	Domestic Abuse Executive Board
DAISU	Domestic Abuse Investigation and Safeguarding Unit
DAPB	Domestic Abuse Partnership Board
DASH	Domestic Abuse, Stalking and Honour based Abuse
DHR	Domestic Homicide Review
DSO	Designated Safeguarding Officer
DV	Domestic Violence
DVFFS	Domestic Abuse Family Front Sheet
ED	Emergency Dept.
ENH NHS	East and North Herts Hospital NHS (Trust)
FCR	Force Communications Room
HCS	Hertfordshire Community Services (now Adult Care Services)
HRU	Harm Reduction Unit
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
ISR	Incident Summary Record
MARAC	Multi-Agency Risk Assessment Conference
NHCVS	North Herts Community Volunteer Service
NHDC	North Herts District Council
NHH	North Herts Homes
PoHWER	People of Herts want Equal Rights
SIO	Senior Investigating Officer
THRIIVES	Threat, Harm, Risk, Investigation, Intelligence, Vulnerability, Engagement, Risk and Specific need
UCC	Urgent Care Centre
VST	Victim Service Team

Learning from six Domestic Homicide Reviews in Hertfordshire from 2016-2017

Amy, Alice, Elaine, Samuel, Maria, and Sam.

They will be remembered.

Mary Mason June 2023

Contents

1. Introduction

1.1 This paper examines six Domestic Homicide Reviews (DHRs) of deaths that took place in Hertfordshire across four different District and Borough Council areas, including North Hertfordshire, Dacorum, Broxbourne and Hertsmere, in the 15 months between April 2016 and July 2017.

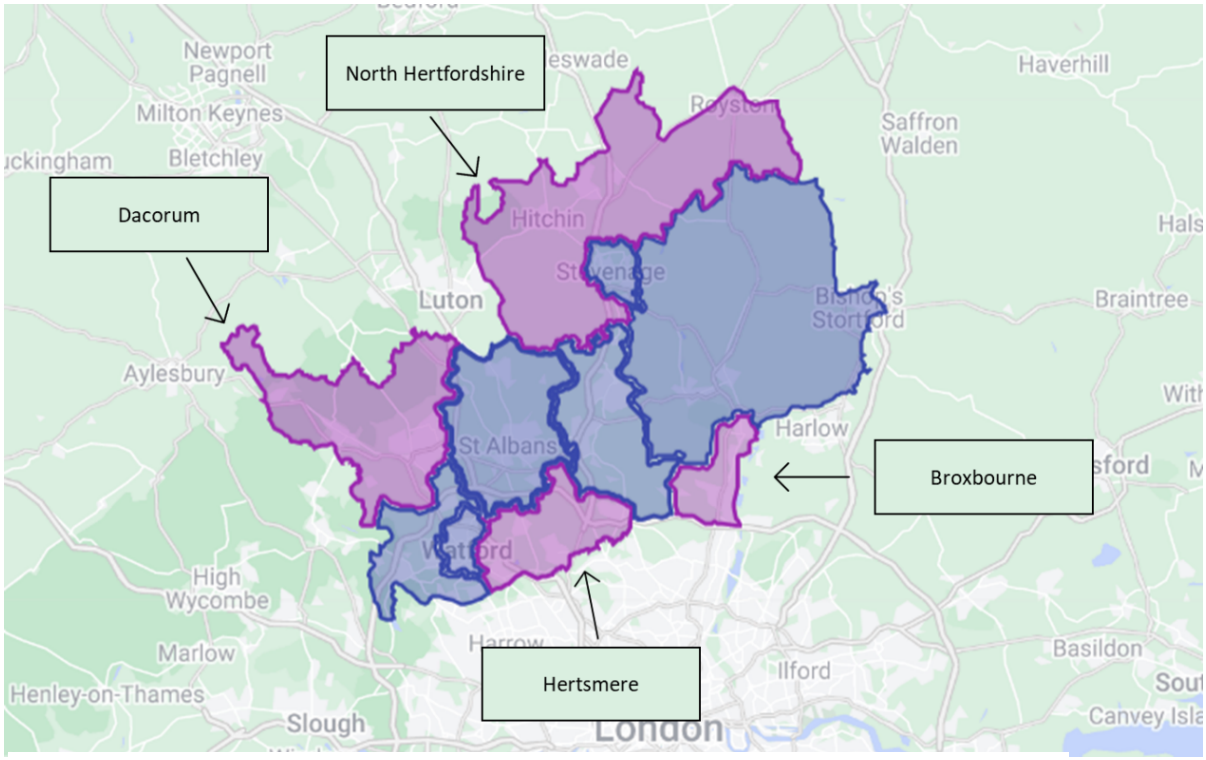


Figure 1 - CSP areas whose DHRs are considered in this paper.

1.2 This review of six DHRs, provides an opportunity to discover patterns of practice and learning across Hertfordshire.

1.3 In 2021-2022, Hertfordshire County Council conducted a review of the needs of domestic abuse victims in the county and how well they were being met.[1] This review was used to form Hertfordshire's latest Domestic Abuse Strategy (2021-2025), which 'aims to ensure we [in Hertfordshire] have a robust response in place to meet the needs of all victims and children as well as working with those using harmful and abusive behaviour by holding them accountable'.[2]

1.4 The Domestic Abuse Act (2021)[3] has brought significant changes in how victims are supported. The Office of the Domestic Abuse Commissioner was established with the remit to ensure good practice is further developed in supporting survivors (including children) and holding perpetrators to account. Legal reforms include Domestic Abuse Protection Notices, Domestic Abuse Protection Orders[4], better protection for survivors in court hearings, recognition of economic abuse and an extension of the Controlling or Coercive behaviour offence to apply post-separation.

1.5 A brief background for each review included in this leaning paper is detailed in Table 1, below.

---

[1] The Domestic Abuse Pathways Project: A review of the support needs of victims and survivors of domestic abuse in Hertfordshire and how they are currently being met

[2] Hertfordshire Domestic Abuse Strategy (2021-2025)

[3] Domestic Abuse Act 2021 (legislation.gov.uk)

[4] Domestic Abuse Protection Notices / Orders factsheet - GOV.UK (www.gov.uk)

Table 1 - High-level overview of cases included in this learning paper

Name of Victim	Name of Perpetrator	CSP	Year of homicide	Brief background	Submitted to Home Office	Returned from Home Office
Amy	Amobi	Broxbourne	2016	Amy was killed by Amobi, in 2016. Amobi then took his own life. Amobi was Amy's ex-partner, carer, and father of their two children aged 9 and 7.	18 November 2019	13 May 2020
Alice	Robert	North Herts	2016	Robert planned the murder of Alice, who was a well-known children's author. Alice's husband had died in a drowning accident. His conviction led to the opening of an enquiry into the death of his wife. He was later convicted of her murder.	1st submission: 15 December 2017	1st return: 31 May 2018
					2nd submission: 18 December 2018	2nd return: 23 October 2019
Elaine	Maggie	North Herts	2016	Elaine was 26 when she died. Her half-sister, Maggie was 52 and was convicted of Elaine's murder. Elaine had reported DA and Maggie made cross allegations.	1st submission: 26 June 2018	1st return: 08 January 2019
					2nd submission: 11 June 2019*	2nd return: 31 January 2020
Samuel	Anwar	North Herts	2017	Samuel, aged 85, died from multiple stabbing by Anwar, his son-in-law. He was convicted of manslaughter in 2018.	1st submission: 09 March 2018	1st return: 17 September 2018
					2nd submission: 23 July 2019	2nd return: 22 January 2020
Maria	David	Hertsmere	2017	David was Maria's partner and was diagnosed with prostate cancer in 2015. He declined conventional treatments. Maria became more fearful of him before she died. He pleaded guilty to manslaughter in 2018.	1st submission August 2018 2nd submission August 2023	29 July 2019
Sam	John	Dacorum	2016	Sam was murdered by her ex-partner John in 2016, who then killed himself. There were multiple reports of domestic abuse, John had been arrested and given bail conditions which he breached.	1st submission: 03 July 2018*	1st return: Unknown
					2nd submission: 17 June 2019*	2nd return: 22 January 2020

**Estimated due to gaps in records*

1.6 Coercive Control [5] became a criminal offence in December 2015[6] just months before the first death in this series. The evolving understanding of coercive control has brought to the forefront the number of Domestic Homicide related suicides, holding perpetrators to account, and developing our understanding of trauma and DA.[7] There was evidence of coercive control by the perpetrators in the cases of Elaine, Sam, and Amy and evidence of planning in all cases.

1.7 None of the deaths of victims were by suicide. Two of the perpetrators (Amobi and John) took their own lives after killing their victim.

2. Background on the need for a learning paper

2.1 All the DHRs considered in this learning paper question were, originally, approved for Home Office submission by the relevant Community Safety Partnerships (CSPs). However, these reviews were later returned to them by the Home Office Quality Assurance Panel (hereby referred to as the 'Home Office Panel'), who requested additional work be done to the Reviews. For each Review, a deadline for resubmitting the report with the relevant changes was set by the Home Office Panel, who would then consider whether the report had been sufficiently improved.

2.2 For some Reviews, this process happened twice, with Reviews being returned to CSPs a second time. For these Reviews, the Home Office Panel either felt that the requested changes had not been made or that there were additional areas of the report requiring improvement.

2.3 In many cases, DHR Chairs retired or ceased operation in the time between submission of their Review to the Home Office Panel and the receipt of the feedback. Further to this, the Herts DHR Team developed an Approved List of DHR Chairs, which went live in September 2020. To be part of this List, and to be appointed as a DHR Chair in Hertfordshire, Prospective Chairs had to demonstrate sufficient specialist knowledge of domestic abuse and experience of DHRs. Unfortunately, two of the Chairs whose Reviews are being considered as part of this paper were not deemed to be appropriately qualified.

2.4 As some reviews were being returned a second time, the Home Office Panel requested that the relevant CSPs attended one of their meetings. This was on the 23rd of October 2019, at which point three reviews had already been returned and two were in the process of being assessed by the Home Office Panel.

2.5 On 22 January 2020, representatives from Hertfordshire County Council's Strategic Partnerships Team, who coordinate all DHRs on behalf of the county's ten CSPs (hereby referred to as the 'Herts DHR Team'), the Chair of the Hertfordshire Domestic Abuse Partnership's Domestic Homicide Review sub-group[8] and the CSP Chairs for North Hertfordshire and Dacorum attended a meeting of the Home Office Panel.

2.6 Prior to this meeting, the Herts DHR Team and DHR sub-group Chair reviewed the three returned DHRs to identify whether there were similarities in the feedback being received by the Home Office Quality Assurance Panel. Several similarities were identified across the Reviews, including:

- A lack of analysis
- Insufficient consideration of possible Equality and Diversity issues

[5] Coercive control - Women's Aid (womensaid.org.uk)

[6] Coercive or controlling behaviour now a crime - GOV.UK (www.gov.uk)

[7] Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021 (publishing.service.gov.uk)

- Too few recommendations
- Victim voice not being amplified.

2.7 The Home Office agreed the Herts DHR Team should collate a learning paper on key themes identified across the three Reviews which would be published alongside the Reviews themselves. It was agreed that this was the most efficient way, both in terms of time and learning, to proceed.

2.8 Further to this meeting on 22 January 2020, three further reports were returned to Hertfordshire CSPs by the Home Office Panel. The first was received on the same day as the meeting (22 January 2020), the second on the following day (23 January 2020) and the third on 13 May 2020.

2.9 At this point, a total of six Reviews had been returned by the Home Office Panel. Both Hertfordshire CSPs and the Herts DHR Team felt it was no longer appropriate for the learning paper to be developed internally and that a new Chair, from Hertfordshire's Approved List, should be commissioned to do the work to ensure sufficient specialist knowledge and independence.

2.10 A letter was drafted and sent to the Home Office on 27 November 2020 with the proposed revised approach. The Home Office responded with their agreement to this approach.

3. Timescales for this learning paper

3.1 The last DHR of this series was completed in August 2018 and the last feedback received from the Home Office in 2020. There have been delays due to two factors:

a) Covid and related health issues
b) In the case of Alice, the conviction of the perpetrator led to an investigation into the death of his first wife. He was subsequently charged and found guilty of her murder. The redrafted DHR includes a review of the case.

3.2 Three panel meetings were held to agree on and review the Learning Paper: on 7 October 2021, 16 June 2022, and 3 December 2022. In addition, Panel meetings were held for the four CSP areas whose six Reviews are being considered in this paper and panel members were asked to review their IMRs and the Overview Report. Comments have been added to the individual Overview Reports.

3.3 The DHRs were upgraded to meet the requirements of the Home Office and the drafts were circulated for comment.

3.4 It was noted that much had changed since the original DHRs. During the Panel meetings, this was discussed, and emerging learning themes were agreed.

3.5 The draft Learning Paper agreed by panel members in August 2023.

3.6 The DHRs and the Learning Paper were agreed by Hertfordshire County Council in August 2023.

4. Scope of this learning paper

4.1 Key themes have been identified across the six cases to identify how agencies focus on the victim's safety and needs within the remit of their work; how perpetrators are held to account and how agencies collaborate and work together. The paper will address three questions:

a) How can agencies make sure they are victim focused, recognise needs as well as risk and ensure strong inter-agency collaboration to keep the victim safe?

b) What is the learning for agencies about their Domestic Abuse practice?

c) How can DHRs become a focus for learning and improved responses to DA with clear opportunities for families and friends to contribute?

4.2 The Home Office required varied additional information to meet their standards for DHRs. They also required the Reviews to be amended to follow the Home Office Guidance for the DHRs.

4.3 There were also concerns about the extent of investigative enquiry by the Chair and Panel, and the lack of specialist VAWG expertise, including from agencies working with Black and Minoritised groups, on the panels.

4.4 The Home Office concerns have been addressed in the revised Overview Reports. Where there are repeated issues across the DHRs or significant information has been missed, they have been reported on in this paper.

4.5 The primary concerns can be divided into two areas, these are outlined on the next three pages.

Area One: Practice Issues

1.1 Domestic abuse expertise
Most panels did not include the necessary Domestic Abuse expertise to fully consider the issues the cases raised. Specialist agencies were not invited to attend in most cases and in one case were invited but declined as they had not worked with the victim. Their overall expertise was not recognised as an essential element to the Review. This led to a failure to recognise where there were patterns and the signs that the abuse was escalating and therefore make targeted recommendations.

1.2 Equality and diversity
The Equality and Diversity sections in DHRs were generally weak. Particularly so for Black and Minoritised victims and for disabled victims and carers. There was little analysis of the Protected Characteristics[9] of victims who were supported by agencies and therefore the barriers to reporting and support needs were not identified, reducing the potential for learning. There was, in addition, no attention paid to intersectionality[10] resulting in a lack of exploration of how survivors/victims could be supported holistically, and their intersecting needs recognised. This played a significant part in misunderstanding the risk victims faced.

1.3 Identification and impact of abuse and trauma
The different forms that abuse takes was not fully explored in the Reviews and the learning for agencies therefore not identified. For example, economic abuse was not identified in any DHRs, but was a likely factor in four cases. The impact of trauma caused by DA was also not explored. This is essential in understanding survivors' behaviour which was misunderstood as an individual failure to engage with support.

1.4 Family and friends
Families and friends who may have had further information about the victim were not always contacted and not as standard practice sent the draft reports. By not including their views and understanding, the victim was not fully at the centre of several of the DHRs.

1.5 Children and Young People
The impact of the DA on the eight children and three adult children was not fully explored. There was little information about how the children were supported while their mother/carer was alive. Even though the children were aware of the abuse and were victims of DA. There is also very little information about what specialist support they were given after their mother and, in some cases also their father, died. The trauma the children have experienced has a potential life-long impact on their mental health.

[9] Domestic Abuse Act 2021 (legislation.gov.uk)

[10] Pragna Patel 'Intersectionality' Appendix 2 below

Area two: Supporting Victims and Holding Perpetrators to Account

2.1 Lack of coordination	
Four of the victims (Elaine, Maria, Sam, and Amy) were known to agencies but there was a lack of coordination so that information known to some agencies was not shared with others. All four were vulnerable. The escalation of risk was not recognised where there was repeat domestic abuse. This included not recognising repeat victimisation by the same perpetrator or by a perpetrator who had offended previously.	
Elaine	In Elaine's case, Maggie was not recognised as the perpetrator firstly due to their familial relationship and then due to cross allegations of physical abuse. Maggie was perceived as vulnerable, and Elaine's vulnerability not fully recognised. There was a significant difference in age (26 years) with Maggie seen as old and frail. DASH was used inconsistently, and her breach of bail conditions not recognised as a potential escalation of risk.
Maria	Maria, as David's long-term partner and carer, became fearful of him after he refused orthodox treatment and became depressed following a cancer diagnosis. Maria called her sister in the States but did not have family in the UK to turn to. Palliative care services attended but did not speak to Maria alone, nor did they ask about David's behaviour or domestic abuse.
Sam	Sam was repeatedly abused by her ex-partner. She was being harassed and stalked by him and reported this to the police many times. He breached his bail conditions but was not arrested for this. Children's Social Care asked her to sign an Agreement that she would not have contact with the perpetrator, and she was perceived to be at fault when she continued to see him.
Amy	Amy was disabled and her ex-partner and father of her two children, had been arrested for domestic abuse with previous partners. Claire's Law was not used, although Amy called the police several times. DASH risk assessments were carried out several times but repeat offences, his domestic abuse history, and her vulnerabilities, did not lead to a referral to MARAC.

2.2 Professional curiosity
The lack of professional curiosity and inter-agency working meant that important signs were missed, or not understood. For example, Amy's situation and the threat that ex-partner had a record of attacking previous partners post separation, she called the police several times when Adobe and he continued to be her carer. Attempts to understand requests and responses from survivors were at times not followed up with stereotypes and assumptions interfering with full professional enquiry. This led to incorrect assessment of risk in a number of these cases. Examples include the police response to reports of breaches of bail conditions and from CSC where there were safeguarding issues.

2.3 Information sharing
There were no formal opportunities for professionals to discuss cases (as occurs within Safeguarding) with Domestic Abuse Professionals. Victim blaming creates barriers to accessing support and increases the victim's distrust of agencies. Ability to discuss cases with trained professionals or DA experts will increase understanding.

2.4 Risk assessment
DASH Risk Assessments[11] were carried out in three of the six cases. One case was waiting for MARAC when the victim was murdered. Risk Assessments showed a lack of awareness that professional judgement can be used in the assessment. In four cases there was sufficient evidence of repeat domestic abuse, level of risk and high support needs to make a referral to MARAC. There was a lack of recognition that repeat victimisation and self-medication with drugs and alcohol frequently reflects the trauma of abuse and are possible signs of the escalation of abuse.

2.5 Referrals
It is unclear how referrals and feedback to and from agencies are made, who holds a case and ensures women's needs as well as risks are addressed. This is particularly for cases which have not reached MARAC.

2.6 multi-agency working
There is no evidence of reciprocal agreements between agencies and multi-agency reports to each other and to MARAC so that: • It is clear who holds responsibility for cases and particularly where the survivor is struggling to engage with support and/or has multiple needs. • Referrals are followed through. For example, CSC requested a school to deliver a support programme for a survivor's children. When the school did not have the knowledge or ability to deliver the programme, alternative arrangements were not made. • There were frequent breaches of bail conditions which were ignored.

5. Confidentiality

5.1 Pseudonyms have been used throughout this paper. Where initials were used in the DHRs, these have been replaced with names which are culturally aligned with the victim and perpetrators original names. Table 1, above (1.5), provides a brief overview of the cases and the pseudonyms used.

5.2 The redrafts of the six DHRs remained confidential and were only available to participating officers/professionals, their line managers, members of the Domestic Homicide Review panel.

5.3 A decision was made not to refer to family members who had contributed to the original DHRs (see s9 below).

[11] Dash Risk Checklist | Saving lives through early risk identification, intervention and prevention

6. Chair and report writer.

5.3 The Reviews were chaired by Mary Mason. Mary is an independent freelance consultant and has never been employed by nor has she any connection with Hertfordshire County Council or East Herts District Council. Mary was formerly Chief Executive of Solace Women's Aid (2003-2019), a leading Violence Against Women and Girls (VAWG) charity in London. Mary is a qualified solicitor (non-practising) with experience in both criminal and family law. She has more than 30 years' experience in the women's, voluntary and legal sectors supporting women and children affected by abuse. She has experience in strategic leadership and development; research about domestic abuse; planning, monitoring, and evaluation of VAWG programmes. Mary has successfully adopted innovative solutions to ensure effective interventions which achieve results, increasing the quality of life of women and children.

7. Panel members

6.1 Members of the Learning Paper Panel and contributors to this report were:

Agency	Expertise	Contact name	Role
Hertfordshire County Council, Adult Care Services	Domestic Abuse	Katie Fulton	Development Manager
Hertfordshire County Council, Adult Care Services	Domestic Abuse	Danielle Davis	Senior Development Manager
Hertfordshire County Council, Children's Services	Child Protection	Tendai Murowe	Head of Quality Assurance & Practice
East and North Herts & Herts Valleys Clinical Commissioning Groups	Health (including palliative care)	Tracey Cooper	Associate Director Adult Safeguarding

Agency	Expertise	Contact name	Role
Hertfordshire County Council, Adult Care Services, Social Care	Adult Social Care in Herts	Jill Melton	Team Manager: East
Bedfordshire, Northamptonshire, Cambridgeshire, and Hertfordshire Community Rehabilitation Company (BeNCH CRC)	Probation & Community Rehabilitation	Alison Hopkins	Senior Probation Officer
Housing: Broxbourne	Housing: Broxbourne	Katy Leman	Interim Head of Housing
Housing: Hertsmere	Housing: Hertsmere	Emily Dillon	Head of Housing
North Herts District Council	Housing and Community	Jeanette Thompson -	Service Director Legal and Community Monitoring Officer
Police	Operation Encompass	Gemma Kenealy	Detective Sergeant: Police's Domestic Abuse Incident and Safeguarding Unit
Surviving Economic Abuse	Economic Abuse	Nicola Sharp-Jeffs	Chief Executive Officer

Agency	Expertise	Contact name	Role
North Hertfordshire Community Safety Partnership	Local area	Becky Coates	Community Safety Manager
Dacorum Community Safety Partnership	Local area	Sue Warren	Safeguarding Lead Officer
Broxbourne Community Safety Partnership	Local area	Louise Brown	Community Safety Manager
Hertsmere Community Safety Partnership	Local area	Valerie Kane	Community Safety Manager

8. Other contributors to this learning paper

7.1 In addition, the following contributed their expertise to the paper. This was particularly welcomed as there was no relevant expertise in Hertfordshire:

- Kafayat Okanlawon (Consultant and Trustee at IMKAAN)
- Pragna Patel (Consultant and former CEO of Southall Black Sisters)

9. Family, friends, and wider community

8.1 The panel decided not to approach family and friends in five of the six cases. This was because the cases were now at least five years old and had been closed. The main learning was for domestic abuse practice in Herts and much has changed since the deaths occurred. Instead, this paper relies on the interviews with the family and friends in the initial DHRs.

8.2 The exception was in the case of Alice. Robert was found guilty of the murder of his wife after his conviction for the murder of Alice. The Chair spoke with several relatives and friends of Alice to gain better insight into this case and to explore whether there were any barriers to reporting for Alice's family and friends.

10. Brief summary of each case

10.1 Amy, from Broxbourne

Amy was killed by Amobi, in 2016. He was her carer, ex-long-time partner, and father of her two children. He then took his own life. Amobi was of Black Nigerian origin and had worked in Enfield as a barber before moving with Amy to Hertfordshire. Amy was disabled with physical and mental health issues and 32 years old when she died. Although they were no longer in a relationship at the time of their deaths, Amobi continued to be Amy's carer and was at times resident with Amy and their two children. It appears that he was financially dependent on the caring role and had no other source of income. Amobi had a previous record of domestic abuse with two ex-partners after they separated. Their two children were aged nine and seven years when their parents died.

10.2 Alice, from North Hertfordshire

Alice was murdered by her partner, Robert, in April 2016. In February 2017, Robert was convicted of the murder of Alice and other offences connected to her death. Alice and Robert had both been previously widowed. Robert had two children who were teenagers when their father met Alice. Robert's conviction led to the opening of an inquiry into the death of his wife and his children's mother. He was convicted of her murder early in 2022 and sentenced to a whole life order. Later in 2022 this was reduced to a 35-year sentence. The DHR into the death of his wife began later in 2022 and some of information from speaking with relatives and friends for the DHR has, where relevant, been included in the Review.

10.3 Elaine, from North Hertfordshire

Elaine was murdered by her half-sister, Maggie, in May 2016. Elaine was aged 26 years when she died, and Maggie was aged 52 years. The case was extremely uncommon, in that it involved adult siblings with the offender being a woman. Maggie was convicted of Elaine's murder and sentenced to a minimum of twenty years imprisonment. There were previous allegations of domestic abuse and some cross allegations. Maggie returned from the US to the UK in June 2015 and at that point came to live with Elaine. Elaine had visited the US, staying with Maggie, in September 2011 returning to the UK in August 2012. Elaine told relatives that she had been assaulted by Maggie while in the US and as a result fallen out with her and returned to the UK.

10.4 Samuel, from North Hertfordshire

Samuel (aged 85 years) died from multiple stabbing wounds by Anwar, his son-in-law (aged 60 years), in January 2017. Samuel was resident in Syria and staying with Anwar and his wife,

Nour, in North Hertfordshire when he was stabbed and killed. All three were of Syrian origin and Christian. Anwar and Nour have two grown up children. Nour has a schizoaffective disorder and Anwar had mild depression and suicidal ideation. He was convicted of manslaughter in 2018 and sentenced to 8 years imprisonment.

10.5 Maria, from Hertsmere

Maria (aged 70 years) had been in a 30-year relationship with David (aged 64 years) when he killed her in 2017. She had been married in the Philippines and came to the UK after the marriage ended, in her twenties. They had no children and met each other when working in a local hospital. They were both retired from paid employment. David was diagnosed with prostate cancer in 2015, he declined conventional treatments and instead relied on diet and exercise to treat himself. He had a history of depression and no known history of domestic abuse. David pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to five years imprisonment on in 2018.

10.6 Sam, from Dacorum

Sam (aged 37 years) was murdered by her ex-partner John (aged 25 years) in 2016; he then killed himself. Sam was separated from her husband, Richard, who lived with their two children. There had been multiple reports of domestic abuse by John towards Sam; he had been arrested and was subject to bail conditions, which he breached several times. Although Sam and others reported these to the police, no action was taken. A full Coroner's Inquest was held in 2019 at which a jury concluded that Sam's death was an unlawful killing contributed to by the lack of communication between all parties and the lack of visibility within and between authorities regarding the ex-partner's breach of bail. John's death was recorded as suicide.

11. Key themes arising from the cases

10.1 Each DHR was examined and the key themes relating to the types of domestic abuse, the relationships within the family and the community and the response to the Perpetrator were identified. In addition, data was collated to show where there are issues in systems and practice including in the DHR process. The full data set can be found in Appendix 1.

10.2 Key themes identified included the vulnerability of all six victims and how the perpetrators exploited this (three of the perpetrators could also be described as vulnerable) are shown in the table below. Please see Appendix 2 for the full information.

Name	Key Issues with DHR	Vulnerability
Alice	• Economic abuse • Evidence of planning • Family and friends not fully involved in the DHR	Alice was still grieving from the loss of her husband in a drowning accident when Robert met her online. He targeted Alice, choosing her most probably because of her socio-economic status.

Sam	• Breach of bail not investigated. • Lack of multi-agency working • Evidence of victim blaming • Support for children not in place	Sam was using drugs and alcohol when she died, and her mental health was poor. The Perpetrator killed Sam and then took his own life.
Samuel	Lack of exploration of Syrian cultural issues and representation on the panel.	Mental health of perpetrator and family members.
Amy	• Support for disabled women • Lack of exploration of Nigerian cultural issues and representation on the panel. • Repeat offending not recognised and no referral to MARAC. • Possible Economic Abuse	Isolation, disability, and ex-partner as carer. The Perpetrator killed Amy and then took his own life.
Maria	• Lack of support when partner diagnosed with cancer, and she was his carer. • Lack of exploration of mental health history. • Housing support.	Maria was from the Philippines and did not have close friends in the UK. There was also no recognition of potential risk and no dedicated support.
Elaine	• Familial abuse not recognised initially. • Cross allegations of domestic abuse. • Breaches of bail not acted on and DASH not correctly completed. • Possible Economic abuse	Age difference (26 years) between the two sisters was significant. Elaine was vulnerable to her half-sister's demands and abuse.

10.3 The themes were collated around the following subsets and will be further explored below:

a) Supporting Victims: Types and categories of domestic abuse, including familial domestic abuse, children as victims, and recognising where MARAC and specialist support is needed. Understanding of the risks linked with repeat victims, disability, different forms of abuse including the financial/economic abuse, coercive control[12], strangulation, and the traumatic impact of abuse. The importance of avoiding victim blaming which deters reporting and the use of services by the survivor.

[12] Draft controlling or coercive behaviour statutory guidance (accessible) - GOV.UK (www.gov.uk)

b) The importance of recognising the needs of victims alongside risk and using this information to inform actions. Understanding protected characteristics and particularly the intersection between different protected characteristics and their relationship with needs and risk. Always taking account of children, who are victims.

c) Risk and need: working with multiple disadvantages, the importance of recognising the impact of trauma[13] and how mental health and the use of drugs and alcohol can impact on the survivor's ability to engage with support.

d) Holding perpetrators to account: cross allegations of domestic abuse; coercive control, planning, breach of bail, recognising perpetrator behaviour and escalation, perpetrator and suicide, multiple abusers.

e) Carers as victims/survivors and carers as perpetrators: Carers were present in two cases. They were both known to agencies and the records provide us with learning about asking questions and ensuring both the carer and the patient can speak to the nurse/agency alone about how they feel and any fears they have.

f) Systems and Practice: supporting victims and working with perpetrators, a holistic and trauma informed approach, multi-agency work and information sharing, professional curiosity, the impact of victim blaming, referrals to MARAC and how cases are held, cross agency understanding of risk and needs, community awareness of domestic abuse and appropriate support.

g) DHRs: practice, training, and learning

12. Equality and diversity

11.1 The table below, outlines the relevant protected characteristics identified in each Review.

	Victims	**Perpetrators**	**Other**
Sex	Five women One man (perpetrator also male)	One woman (victim also female) Five men	
Race/ethnicity	• One Syrian • One Philippine • Four White British	• One Nigerian • One Syrian • Four White British	
Mental Health diagnosed	Four cases where the victim had mental health issues, including: - Anxiety	Two cases where perpetrator had mental health issues, including depression.	

[13] Judith Herman (2015) Trauma and recovery: The aftermath of violence from Domestic Abuse to Political Terror

	- Depression - PTSD		
Age	Range from 27 years to 85 years	Range from 25 years to 64 years	Large age differences (more than ten years) in three cases: Elaine, Amy, and Samuel.
Children	Two cases aged from 6 upwards	One case aged from 6 upwards	Adult children in two more cases
Disability/health	One case of rheumatoid arthritis	One case of terminal cancer	Two cases where one of the partners were carers
Referrals to MARAC/MAPPA	One referral to MARAC	No referrals to MAPPA	
Previous history of domestic abuse	History of domestic abuse in five cases. In two cases, this was not reported or known to professionals, with abuse only being reporting by family members after homicide.	Three cases where the perpetrator had a history of DA. One was not known to the police.	There were three victims who had reported DA to the police more than once, from the same perpetrator. There were three repeat perpetrators in previous relationships, two of whom were previously known to the police.

11.1.1 Five of the six victims were women and five of the perpetrators were men (83%). One woman was killed by her older half-sister (17%) and one man by his son-in-law (17%).

11.1.2 In three of the six cases, the victim and/or perpetrator was from a Black or minoritised group (50%) there were also two children of dual heritage.

11.1.3 In four cases, the victim experienced mental health issues (66%) including anxiety, depression, and PTSD. In two cases the perpetrator had mental health issues (33%). One victim and one perpetrator (33%) had life impacting issues and had carers.

11.1.4 Victims were between 27 years to 85 years. Unusually, there was a large age difference (over ten years) in three cases (50%).

11.1.5 There were four cases with eight children (including adult children) involved (67%), two cases (33%) where four young children involved.

11.1.6 Equality and Diversity issues and access to the right support is explored further below.

12.2 Equality and diversity analysis and Intersectionality

12.2.1 Sex

Domestic abuse is embedded in all societies, reflecting the dominant power men hold in society. For many this is expressed as holding responsibility for male behaviour, to the extent in some cultures that men cannot be criticised and their behaviour 'is always the woman's fault.'

It is vital that we recognise that being female represents a risk of male violence and homicide and that this is appreciated by all professionals. It is also important to recognise that men are affected by domestic abuse and that the patterns of abuse can be different. Cross allegations of abuse are also common and were seen in the cases of Sam and Elaine. These may be due to a pattern of false reporting by the Perpetrator. The Respect Toolkit helps to identify the main perpetrator, increasing the possibility of reducing risk.[14]

The risk for women should be recognised across services, and the escalation of abuse be seen as a potential risk for domestic homicide. In four cases the victim's fear of the perpetrator increased in the days before the homicide but was either not reported on or not recognised as increasing her risk of homicide.

Women's response to male violence is also poorly understood even though the prevalence of male to female abuse and the lifetime experience of women is very well researched. The Home Office commissioned review of DHRs was published in May 2022. The Home Office reports on data from the Office of National Statistics (ONS), which states that there were 362 homicides between 2018 and 2020, of which 214 (59%) were female victims who were killed by a male partner or ex-partner. By contrast, 33 (9%) were male victims who were killed by a partner or ex-partner and the remaining 115 (32%) were victims killed by a suspect in the family category.

The Femicide Census collates femicides to record the deaths of women killed by men in the UK. By examining the data, including that presented above, 'we can see that these killings are not isolated incidents, and many follow repeated patterns.'

This group of DHRs shows a broadly similar breakdown to that from the ONS: five victims were female, of which four victims (67%) were female and killed by a male partner or ex-partner and one female victim (17%) was killed by a family member. One victim was male (17%) and was killed by a male family member**.**

12.2.2 Black or minoritised victims and perpetrators

Four cases included Black or minoritised victims and perpetrators. There were no black or minoritised experts on any of these panels.
In her paper[15] below Pragna Patel comments:

> *'There are still too many examples of DHRs involving black or minority victims and perpetrators in which there is no input from specialist black and minority organisations either through direct participation as experts on the DHR panel or indirect participation as advisors. This can itself serve to mask issues of race and culture. There is concern that in far too many DHRs, there is little or no*

[14] Respect Toolkit for work with male victims of domestic abuse | Respect
[15] Intersectionality: Pragna Patel Appendix 2

understanding of the needs and experiences of abused black and minority victims resulting in highly flawed reviews and learning.'

'The lack of understanding of religious and cultural influences, can create a number of misplaced assumptions for example, about when and in what way it is appropriate to intervene in family matters which can generate further risks for victims.'

12.2.1 Discrimination and Stereotypes

Black and minority women's needs often go unrecognised and/or are subject to stereotypical and discriminatory assumptions that can have a detrimental impact on their access to protection and justice. Black and minoritised women are often perceived as too aggressive or too passive, depending on their origin or status in the UK.

Notwithstanding the above, it would be highly dangerous to conclude that all black.
and minority women from similar backgrounds will behave in a uniform manner…. the danger lies in the creation of the types of stereotypes described above. This is why a close examination of the wider familial, community and social context and factors such as education, socio-economic status, migration histories and so on are vital to consider when undertaking a DHR.

12.2.2 The lack of an intersectional approach to domestic abuse

Four (67%) of the victim's had intersecting equality issues with mental and physical health, culture, faith, socio-economic status, expectations, and concerns of victims shaping how they experienced domestic abuse. Equality issues and their intersectional impact were not examined in the DHRs nor in professional assessments of need and risk.

In many DHRs, there is little or no understanding of intersectionality as a framework for understanding how a range of protected characteristics and other factors such as socio-economic status (class) or migrant status, combine to create different levels of risks and barriers for a range of victims that can make reporting difficult and curtail timely intervention and access to support. The key issue here is that an intersectional approach requires an understanding of the relationship between various strands of discrimination and how they relate to the victim/perpetrator and their interactions.

For the sake of clarity, intersectionality must be more clearly defined and understood in the work of DHRs. It must be viewed as a framework for understanding how a person, a group of people or a social problem is affected by a number of overlapping and structural forms of discrimination and prejudices, not identities.

An intersectional approach will typically involve undertaking a more thorough and rigorous analysis of the wider social context of both the victims and their abusers . It is necessary to ensure that the barriers facing marginalised groups are understood and addressed whilst also guarding against the stereotyping of victims from minority backgrounds. Each case needs to be approached with an intersectional lens but with reference to its own specific context and power dynamics.

It is also vital to ensure that an intersectional lens is applied throughout the process of the review and weaved into individual agency and collective analysis rather than just limited to a few comments relating to the section on equality and diversity.

12.2.3 Barriers and risks

It is also important to note that the dominant understanding of domestic abuse and gendered harm in policy and practice is based on the intimate partner paradigm which may not be appropriate for some minority women who live in extended family structures and abuse within the environment frequently involves multiple perpetrators. Arguably, the one defining feature of many women of minority backgrounds, especially South Asian women, is the widespread social dimension in which the abuse takes place. It is experienced in wider extended family, kinship, community and business and religious networks that are often interrelated and overlapping. Such close-knit relationships and networks provide not only a context conducive to the perpetration of such abuse but also become powerful barriers to reporting and exiting from abuse. They also contribute to the maintenance of culture of secrecy, silence and victim blaming that is pervasive in many communities. For example, in-law abuse is very common in women's accounts of domestic abuse, forced marriage and honour-based violence and homicide and suicide cases. such culturally specific forms of harm also involve higher degrees of pre-meditation, coercive control, stalking and sexual violence.

12.1.1 Sexual orientation

No victims or perpetrators were known to be LGBT+ in this case group. However, it is important to note that there are several expert groups who offer knowledge and support to panels where a victim or perpetrator is LGBT+. [16]

12.1.2 Disability

While discrimination is unrecognised or stereotyped, the assumptions made can drive women away from support, for example fears that their children will be removed, or that their temporary leave to remain will be affected; or how they can access support if their disability is hidden or when services do not recognise their needs; and how potent intersecting prejudices are.

An understanding of different needs in relation to the risk that victims experience and how this is interpreted by professionals is key to ensuring that all women receive the targeted support they need.

In three of these cases (50%), there were victims with mental/physical health issues from a Black and minoritised group. We know that isolation is a key barrier to victims gaining support. Language, cultural isolation, and a lack of confidence in the system and experience of stereotyping, prejudice and discrimination are all powerful barriers to women gaining meaningful support. Understanding the journey and the needs of survivors requires building trust and ensuring there is support in place.

[16] https://galop.org.uk/

This is most readily accessed where there are specialist organisations able to support survivors and they can see that their culture is respected, and they are believed.

In these cases, one victim was physically disabled but was not referred into MARAC. One of the victims had mental health and drug and alcohol issues almost certainly related to the abuse she experienced. She was on the MARAC referral list when she was murdered. One perpetrator was terminally ill with cancer.

For disabled victims there are significant barriers to support, physical, psychological, and economic barriers as well as prejudice and a lack of understanding of both the increased risk and the interlinked needs of the survivor. The ability to gain support and escape from the perpetrator requires careful planning with professionals giving the right assistance to ensure that services can be accessed as needed. SafeLives[17] Spotlight report shows that disabled women are twice as likely to experience domestic abuse and are also twice as likely to suffer assault and rape. 'Yet our MARAC data shows that nationally only 3.9% of referrals were for disabled victims, significantly lower than the SafeLives recommendation of 16% or higher. Our research also shows low referral rates for disabled people into domestic abuse services.'

12.1.3 Socioeconomic status and housing

Whilst socioeconomic and housing status are not protected characteristics under the Equality Act (2010), it is relevant to consider here given the bearing this might have had on how victims and perpetrators interacted with professionals and services.

Victims were from different socio-economic groups although three (50%) were living on state benefits: two on disability benefits and one on a pension. Two had significant wealth generated through business. There was some evidence of Economic Abuse in five cases (83%) with only those who were pensioners showing no sign of this form of domestic abuse.

Surviving Economic Abuse[18] was founded in 2017, successfully highlighting economic abuse which is now included in forms of domestic abuse in the Domestic Abuse Act 2021. Their research shows that:

> *'Economic abuse rarely happens in isolation and usually occurs alongside other forms of abuse, including physical, sexual, and psychological abuse. 95% of cases of domestic abuse involve economic abuse'.*

When it occurs alongside other forms of coercive control, then victims are at increased risk of homicide.[19]

---

[17] Spotlight #2: Disabled people and domestic abuse | Safelives

[18] Surviving Economic Abuse: Transforming responses to economic abuse

[19] Websdale, N. (1999). Understanding domestic homicide. Boston, MA: Northeastern University Press.

Insecure housing was a feature in three cases (50%). IMKAAN centre their policy work on racial, economic, and social/housing justice, these three are key barriers to equality for many women. With housing insecurity being increasingly common, the pressure to stay with an abuser increases, including the pressure to return to the perpetrator after leaving a safe space.

The Domestic Abuse Act (2021) addresses this need but for many the availability of affordable alternative accommodation precludes those with insecure incomes or on benefits from having a safe home.[20]

Dedicated support is needed to ensure those impacted in multiple ways can access the right support when they need it.

13. Supporting victims

13.1 The lack of awareness of domestic abuse amongst the community was flagged in Sam's case (where relatives attempted to raise concerns).

13.2 Recognition, prevention, third party reporting and early intervention are all aimed at changing the culture of abuse and keeping women safe. It is important that agencies can intervene early and put in preventative measures to support victims. To achieve this, family, friends, and neighbours need to have the confidence that reporting domestic abuse will be taken seriously. Clear pathways into and from services are needed to ensure that all women are referred into the right services and get the support they need.

13.3 Keeping the survivor at the centre of the work is key to understanding and recognising the barriers to her leaving an abuser. Victim blaming, which was present throughout these cases, magnifies the shame victims frequently feel and creates barriers to support. The use of agreements by Children's Social Care focuses on the survivor's responsibility for the domestic abuse and not on the impact of the perpetrator's behaviour and his responsibility for this.

13.4 Domestic abuse is highly traumatic with Judith Herman (2015) [21] comparing trauma experienced by war veterans with the trauma experienced by DA survivors. PTSD, anxiety, and depression being symptoms of ongoing trauma suffered by many survivors.[22] It is important to emphasise recognition of trauma at an early stage and its signifiers including self-medicating with drugs and alcohol, because specialist support is needed to address this.

13.5 Recognising the different forms of abuse is essential to understanding the position of the survivor and the support she needs. All six victims experienced multiple forms of abuse; a breakdown on which is included in Appendix 1. Economic abuse, coercive control and planning were not recognised in any of the cases, a history of domestic abuse (which was present in three cases) by the perpetrator wasn't recognised as high risk.

[20] Resources library | Solace (solacewomensaid.org)
[21] Judith Herman Trauma and Recovery 2015.

13.6 Stalking and a history of non-fatal strangulation were not seen as significant risk factors and as escalating the risk of homicide. Non-fatal strangulation has now been recognised as a highly significant precursor to IPH or Suicide.

13.7 Familial abuse, in two cases, was not initially recognised by agencies who are more familiar with interpersonal DA. Elaine's case was not initially recognised as DA and in Samuel's case the risk to the family where there was a daughter/partner with a severe mental health diagnosis. Although increasingly recognised as DA within the family, the attached stigma and shame, often preventing reporting, means that support needs to be very carefully handled.

13.8 There were 362 domestic homicides recorded by the police in the three-year period between year ending March 2018 and year ending March 2020. Of the 362 homicides, 115 (32%) were victims killed by a suspect in a family category.

13.9 The Domestic Abuse Act 2021 recognises children as victims of abuse and Local Authorities are beginning to introduce support for this group of survivors. Children's safety and support was not fully addressed in the Overview Reports. In Sam's case, the schools were asked to do work with the children, but they did not have the training or tools to do this.

13.10 Only one case was referred to MARAC, and the victim died before her case reached a MARAC meeting. Professional judgment, withstanding, there was sufficient information in five of the six cases to consider escalation to MARAC. The indicators included:

- A known history of perpetrators domestic abuse in four cases
- Repeated incidents of domestic abuse in three cases
- Repeat perpetrators in three cases.
- Breaches of bail conditions in two cases
- Disability and carer responsibility in two cases
- Economic Abuse (which is often seen as low risk compared to physical abuse) in five cases.
- Coercive control in four cases
- Planning the homicide in four cases
- Support services not able to engage with the victim in four cases.

13.11 The relationship between carers and those being looked after, for example a disabled and/or terminally ill person, is very stressful but does not cause DA. Rather, as described by The Local Government Association:

> *'Risk of abuse, either for the carer or the person they are caring for, increases when the carer is isolated and not getting any practical or emotional support from their family, friends, professionals, or paid care staff. Abuse between the carer and cared for person may be domestic abuse. The definition of domestic abuse extends to paid and unpaid carers if they are also personally connected, such as a family member.'* [23]

13.12 In the cases of Amy and Maria, there was a carer relationship between the perpetrator and the survivor. In one case, the abusive partner was also the carer who appears to have been

[23] Carers and safeguarding: a briefing for people who work with carers | Local Government Association

financially dependent on his carer role. He had a history of domestic abuse, including to Amy, the police had been involved on several occasions but Adult Social Care, the Police and Health Services did not enquire further into the relationship, and it was not fully explored. In Maria's case, she was the carer. Checks were not carried out about how she was coping with the role and what support could be put in place.

13.13 In both cases isolation was also a feature, this limited the support that Amy and Maria got from the community and family and friends, putting them at risk of further abuse and finding it more difficult to name what was happening and describe their fear.

14. Holding perpetrators to account

14.1 There had been multiple calls to the police in three cases and a risk assessment by mental health services in one case. In another case, there were warning signs which might have led to a risk assessment and/or a referral. It was only in the case of Alice that the perpetrator hid his plans and even then, warnings about unusual drowsiness and seeking support from a doctor may have led to tests for drug use.

14.2 The police were aware of the domestic abuse in three cases. In Sam's case, there were multiple reports of breaches of bail conditions, but the perpetrator was not arrested because of these breaches.

14.3 DASH risk assessments were conducted several times in three cases (Elaine, Sam, and Amy). The risk from the perpetrators was measured using DASH but consideration was not given to:

a) Repeat victimisation.
b) Repeat perpetrator with previous partners (Sam and Amy)
c) The level of fear expressed by the victim.
d) The vulnerability of the victim and their ability to cope.
e) Children's presence in the family unit and children as victims

14.4 Claires Law[24] was in force (2014) but not used in any case to make sure the victim was aware of the history of abuse by the perpetrator and enabling support to be put in place. The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. Support should also be put in place to enable the survivor to make informed choices about the relationship.

14.5 Domestic Violence Protection Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs) (Crime and Security Act, 2010) were introduced to protect victims by removing the perpetrator from the family home. The Notice is used by the Police to remove the perpetrator until the case is taken to court for an Order to be made. This might have assisted in two of the cases but were not used. Changes to these were made in the Domestic Abuse Act 2021 with the introduction of Domestic Abuse Protection Notices (DAPN) and Domestic Abuse Protection Orders (DAPOs) which are being brought into force, tightening the processes to increase their effectiveness.

[24] Clare's law to become a national scheme - GOV.UK (www.gov.uk)

14.6 There were two cases of cross allegations of abuse which led to the risk from the perpetrator not being fully recognised. Respect[25] has a toolkit to help recognise the dynamic of cross allegations and the perpetrator of abuse.

14.7 Sam and Amy's children were known to Children's services, but it is not clear in the DHR how they were working with the family and being supported. Sam's ex-husband and father of the children felt that he had not been listened to by social workers as he reported the escalation of abuse of Sam. Social workers asked the school to put in place a programme of support, but the school was unaware of the programme and didn't feel they had the right expertise to run it. In the same case, the victim was asked to sign an agreement that she would not see the perpetrator. Although criticised for seeing him, he was controlling her and so she was unable to prevent him from coming to her house. Housing moved her to a safer flat, but this was very close to the perpetrator's family.

14.8 The level of risk the victims were facing might have been recognised if there had been earlier referrals to MARAC and the escalation of abuse and history of both the victim and perpetrator had been brought together in one case history and shared across agencies.

14.9 Holding perpetrators to account requires their behaviour to be in plain sight by all agencies. It also requires agencies to understand the impact of both physical and psychological trauma on the victim.

14.10 The police have powers to hold perpetrators to account. By not using these powers, including arresting when there is a breach of bail or a breach of an Order, they are failing to use their powers to protect the victim. A bail condition and a restraining or non-molestation order are there as a protection for the victim and to prevent further harm. By failing to arrest for a breach, they are not held seriously and consequently more frequently breached.

14.11 A referral to MARAC means that all agencies are aware of the conditions and Orders in place and can share them with other agencies for example housing and disability services, as needed.

14.12 In this series of cases, five of the perpetrators had vulnerabilities ranging from drug use, mental health issues, long term physical health difficulties and a history of domestic abuse. Working with perpetrators includes first recognising the risk they pose and then making sure they are held to account. Providing support to address their behaviour also increases women's and children's safety. Respect[26] has worked with perpetrators of abuse for over twenty years and have developed several resources and tools to assist in working with perpetrators and in cross allegations of domestic abuse. They 'advance best practice on work with domestic abuse perpetrators, male victims and young people who use violence and abuse.'

[25] https://www.respect.uk.net/

[26] https://www.respect.uk.net/pages/what-we-do

15. Risk and need: a strengths-based approach to working with multiple disadvantage[27]

15.1 All the victims, except perhaps Alice, were vulnerable with additional support needs. The victims were visible to different statutory services apart from Alice, whose only warning was increased sleepiness. Elaine, Sam, Amy, and Maria were very frightened by the perpetrator's behaviour with Elaine, Sam and Amy informing the police and Maria telling her sister and a neighbour.

15.2 The impact of trauma on survivors cannot be underestimated. A generally accepted definition of *trauma* is *'*an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being…Domestic abuse is clearly a form of trauma, made all the more complex due to the fact that it is planned yet unpredictable and takes place in the context of a relationship.'[28]

15.3 AVA reports on a significant overlap between experiences of abuse, substance use issues, and mental health. 'Up to a half of women with dual diagnosis of mental health and substance use issues had have experienced sexual abuse. Between 60-70% of women using mental health services have a lifetime experience of domestic abuse. Women who have experienced domestic and sexual abuse are 3 times more likely to be substance dependent than non-abused women. These figures demonstrate a clear need for a more trauma informed approach to supporting women experiencing domestic abuse and multiple disadvantages.'

15.4 AVA[29] found that cases were often closed and then would need to be re-referred with *'non-engagement ... therefore seen as a refusal of services, not a common symptom of mental health, trauma and complex needs, when sometimes attending appointments can feel overwhelming and frightening'*. Sam's experience of services reflects this description.

15.5 When the impact of domestic and sexual abuse is recognised, and trauma understood professionals begin to look for a different approach. It is within this context that a strength-based approach enables the survivor to see her own self-worth with professionals using a positive rather than a deficit model.

15.6 The work carried out by AVA in close collaboration with the Make Every Adult Matter (MEAM) Coalition, Agenda, and St Mungo's[30] with survivors of abuse and multiple disadvantage reporting that statutory mental health services were the most difficult to access. Women told of missed appointments, leading to cases being closed and needing to be re-referred with *'non-engagement' being seen as a refusal of services, not a common symptom of mental health,*

---

[27] https://avaproject.org.uk/ava-services-2/multiple-disadvantage/

[28] https://safelives.org.uk/practice_blog/trauma-informed-work-key-supporting-women

[29] Supporting Survivors - AVA - Against Violence & Abuse (avaproject.org.uk)

[30] https://avaproject.org.uk/wp-content/uploads/2018/09/Jumping-Through-Hoops_report_FINAL_SINGLE-PAGES.pdf

trauma, and complex needs, when sometimes attending appointments can feel overwhelming and frightening'.

15.7 These sentiments were echoed in AVA's research for the National Commission into women facing domestic and/or sexual violence and multiple disadvantages.

16. Carers as victims (Maria) and carers as perpetrators (Amy)

16.1 In Maria's case there was no known history of domestic abuse by agencies, but Maria was increasingly fearful of David and expressed this to a neighbour and to her sister in the USA. In Amy's case, her ex-partner and father of her children was her also her carer. He had a history of Domestic Abuse, which had escalated at the end of two previous relationships. Amy called the police several times, but her case was not referred to MARAC, even though she was physically disabled, and he was a repeat perpetrator, particularly when the relationship ended. A prior history of abuse is one of the significant indicators of further abuse.

16.2 There was a lack of enquiry in both cases, perhaps due to support workers not being provided with sufficient training and information but also in the case of Amy, the police not recognising the significance of the carer relationship and so not escalating the case to MARAC. In Maria's case, the end-of-life team did not speak to her alone and did not ask about abuse. This was not a fault in their work, but a reflection of professionals not asking because they have not been given the knowledge, skills, and resources to be able to identify domestic abuse nor the training to facilitate safe disclosure. Similarly, David was not asked by his GP although he had returned to the GP several times with depression. The GP might have been sufficiently concerned given David's history of depression and prognosis to refer the case to Adult Social Care.

16.3 Equally, specialist domestic abuse services can be, or at least feel, inaccessible to victims with care and support needs. Added to this, perpetrators who are carers will often deliberately emphasise and reinforce dependency as a way of asserting and maintaining control. Research also shows that people dependent on their abuser for care may be more likely to blame themselves or their care needs for the abuse.

17. Systems and Practice

17.1 Coordination between agencies in individual cases and an understanding of risk management between agencies are essential to supporting the survivor (including children) and holding the perpetrator to account. Multi agency working was missing in many of the cases with agencies who were supporting either the victim or the perpetrator not recognising the abuse/risk or not escalating the case to domestic abuse support services.

17.2 A holistic, trauma-informed approach both in and between agencies which are victim centred is necessary to maintain the victim at the heart of the case and to ensure that targeted support is in place.

17.3 Multi-agency coordination and cooperation was missing from the six cases. The approach is necessary to ensure that the survivor is supported, and the perpetrator held to account. A

coordinated approach to domestic abuse[31] includes the list cited by Standing Together as well as other necessary elements to understanding the perpetrator and providing support to the survivor:

a) Data collection and awareness of what other agencies need to know.
b) Community understanding of domestic abuse.
c) Knowledge/understanding across agencies about perpetrators and situations which might heighten risk.
d) A case lead for each case with MARAC holding information and noting progress against agreed action.
e) Referrals and training in place so all agencies are aware of their role and the role of partner organisations; and
f) Clarity about where to refer survivors for support and for targeted support to be available.

18. DHRs and process

The Overview Reports were returned by the Home Office with several issues raised about the DHR process. The full report can be found in Appendix 2. These can be grouped into three themes.

1. Terms of Reference not tailored to meet the needs of the Review.
2. The panels not including the necessary expertise in reference to DA.
3. Panels not including the necessary expertise in relation to equalities issues and particularly Black and Minoritised organisations and Disability organisations.

These themes are addressed in the Recommendations at Paragraph 20 below.

19. Conclusion

19.1 The combination of issues in this learning paper, reflect similar patterns found nationally in a Home Office paper (March 2022) analysing in detail 50 DHRs between October 2019 and March 2022. There is a need to improve understanding of the dynamics of abuse and the impact of trauma on already vulnerable survivors. To achieve this, frontline staff need clear processes for risk and needs assessments and referrals. They also need to know who is holding a case and the process in place when the survivor is unable to engage with support. They also need clear expectations of how the perpetrator is being held to account, including breaches of orders. This includes how DAPOs and DAPNs will be rolled out.

19.2 At the beginning of this paper, we asked three questions. We have used these questions to discuss our observations based on an analysis of the information received.

Q1. How can agencies make sure they are victim focused, recognise needs as well as risk and ensure strong inter-agency collaboration to keep the victim safe?

[31] Domestic Homicide Reviews — Standing Together

We know that homicide is rare when survivors are being supported by domestic abuse professionals and perpetrators are on domestic abuse programmes or held to account via the Criminal Justice Service.

Across these cases there was a lack of clarity about the pathways for survivors from reporting domestic abuse to independent, safe lives free from abuse. Agencies, working with victims and/or perpetrators were either not aware of the domestic abuse or did not have sufficient knowledge and support themselves to understand and act. Training, while essential, is only a starting point, professionals and communities need support to embed their practice.
Economic abuse victims/survivors should disclose to their bank as early as possible and before reporting to the police about this form of abuse.

A coordinated community awareness response, enabling survivors and their family and friends to raise confidential concerns would give further confidence in reporting. This should include different access points encompassing face to face access as well as the advice phone line and an on-line advice service.

Q2. What is the learning for agencies about their Domestic Abuse Practice?
The DASH, while a useful standard measure of risk, does not reflect the varying needs of the victim. Access to early tailored support requires a pathway which is flexible enough to ensure the varying needs of the victim are met these will vary and include the needs of ethnic minority survivors, of disabled survivors, including those with mental health issues, and those with learning difficulties and understanding the impact of trauma on a survivor's ability to access support including economic resources and housing away from the abuser.

It is unclear who 'holds' a case, especially where no social workers are involved. Where do agencies present background information of the risk from the perpetrator as well as the needs of survivors. How is this information is updated and accessed by agencies, so they are up to date in their analysis and case plans?

Creating a robust safety and support plan for survivors will help to identify the pathways for action and bring clarity to how a case is being held. For high-risk cases this can be held by MARAC but for other cases, especially where there are vulnerable survivors, a decision needs to be made as to how cases are held and tracked.

To embed pathways, training, ongoing support for front-line staff and managers, reciprocal agreements are needed so all agencies are clear about their roles.

Q3. How can DHRs become a focus for learning and improved responses to DA with clear opportunities for families and friends to contribute?

The voice of the victim and those close to them was not fully explored in these DHRs, leaving important questions about what had happened and what professionals might have missed. This insight is invaluable in determining how professionals can learn from what happened.

Families, friends, and communities (i.e. those groups a victim might have belonged to faith groups, work, social and other) should be invited by the Chair to contribute to the DHR throughout.

This includes meeting the panel, assisting with details of facts and feelings and how they perceived any agency responses to the victim and/or perpetrator.

In a DHR, the voice of the victim and their people is essential to:

a) Making as much sense as family and friends can of what happened and contributing to preventing this from happening again. It is their perspective which enables us to hear the victims voice and understand their story from those close to her.
b) Children, so they have a lifetime record of what happened to their parent/carer and understand this was not their fault and that any guilt and shame belongs with the perpetrator.
c) The victim's voice is not filtered by bureaucracy and professional training but is authentic, bringing additional knowledge and insight into their experiences and thereby adding to the knowledge base of domestic homicides.

20. Recommendations

20.1 There are a series of recommendations in the individual DHRs, which have been implemented and much progress has been made in developing services across Hertfordshire.

20.2 This learning paper has identified several areas for development to ensure that victims are supported, and perpetrators held to account.

20.3 The recommendations are divided into key themes identified in this paper:

1. **Risk assessments** to identify the perpetrator and take account of their history of domestic abuse and the needs of the survivor.
2. **Create pathways** for support to survivors, including carrying out a needs assessment with the survivor to identify their needs and agreeing a support plan. Ensure all survivors are helped to move across the pathway at a speed which meets their needs.
3. **Develop a children's** pathway for support, ensuring their needs are met at school and by Children's Social Care. Ensure that counselling and support services are in place for children. Where there is a homicide, a plan to support them emotionally and psychologically is essential.
4. **Consider MARAC** referrals and who gets support. Can repeat and/or additionally vulnerable survivors be referred into MARAC? When and how should an emergency MARAC be called?
5. **Support front line staff with:**
    a) Training on all forms of domestic abuse, (including economic abuse), trauma, and its impact with the assurance that learning is embedded across agencies and services.
    b) Create opportunities for front-line staff to discuss cases with domestic abuse experts.

c) Support front line staff to be professionally curious and to work with other agencies as appropriate; and

d) Help staff to understand and question victim blaming and how it increases risk.

6. **Map** what different agencies need to know, e.g., arrest, release from detention, whether the survivor is engaging with support.
7. **Information sharing** and agreed protocols (including reciprocal agreements) between agencies based on safeguarding to ensure decisions are evidence based and use professional judgement.
8. **A central data base** of information to be held by one agency (MARAC) and updated regularly for all agencies to check on developments of cases.
9. **Records of Breaches of Bail and response, and DAPA and DAPN** to be held by Police and a regular report provided to the Community Safety Partnership.
10. **Training and support on DA** for health and palliative care professionals to include where the patient is being cared for or is a carer.
11. **Review DHR practice** to ensure there is DA and other relevant expertise on all panels, including representatives, where relevant from Black and minoritised groups and disability groups. That all panel members are trained and that the Chair and Report writer have a relevant domestic abuse background and can show how they can lead a professionally curious panel.

Appendix 1

Breakdown of issues present in each case and across the six DHRs.

	Amy	Alice	Samuel	Elaine	Sam	Maria	Total
Victims							
Victim's Voice	x	x	x	x	x	x	6
Previous Trauma	x			x	x	x	4
Children	x	x	x		x		4
Barriers to victims' disclosure	x	x	x	x	x	x	6
Drugs and side effects		x				x	2
Mental and physical health & multiple needs		x	x	x	x		4
Housing & homelessness	x			x	x		3
Multiple DA Coercive Control Historic/ Physical DA Economic Psychological/ Emotional Stalking	4 Economic Physical Emotional and Coercive Control	3 Coercive Control Psychological Economic	4 Coercive Control Physical Economic Emotional	4 Physical Coercive Control Economic Psychological	4 Physical Coercive Control Stalking Psychological	1 Emotional	
Perpetrators							
Evidence of Planning	x	x		x	x	x	5
Familial DH			x	x			2
Palliative/end of life care				x		x	2
Isolation	x			x	x	x	4
Cross allegations of DA and toolkit		x		x			2
Perpetrator suicide	x				x		2
Breach of Orders				x	x		2

Systems and practice							
Multi agency working and information sharing	x	x	x	x	x		5
Professional curiosity	x	x	x	x	x	x	5
Community awareness of DA and AFV and how to respond		x		x		x	3
DHRs							
SMART ToR	x			x	x	x	4
DHRs/IMRs and best practise & planning and research		x	x	x	x		4
E&D	x			x		x	3
Risk analysis & planning	x	x	x	x	x	x	6
I/V family and friends		x					1
Isolation	x	x		x	x	x	5

Appendix 2

Issues raised by the Home Office in each case.

Victim's name	Issue raised by Home Office relating to the DHR process and report
Alice	a) Insufficient independent analysis b) Could have included a review of accessibility of local services c) Current training examined to ensure that the needs of all victims are considered. d) The Report did not explore possible learning fully. e) The Panel's view was that the terms of reference were brief and broadly expressed and not tailored to the particulars of the case f) Examples of relevant issues that could be considered for each review are given in the statutory guidance. g) Recommended templates not used h) Involvement of family, friends, and the wider community. Unclear, why only three individuals were invited to contribute to the review. i) No reference in the report on whether consideration was given to interviewing the perpetrator as part of the review.
Amy	a) Use SMART methodology for ToR b) Equality Diversity – consider all protected characteristics as set out in the Equality Act. c) Use references when quoting from research d) Panel Membership – detailed information needed. e) No representation from the charitable sector with domestic abuse expertise. f) Show Chair and Report writer's experience of DA g) Consider using pseudonyms and ensure the family are consulted. h) Remove details of children's ages and any other recognisable information. i) Follow the guidance template structure j) Several issues should have been further investigated including incidents of economic abuse. Considering this it would be good to explore in more detail the use of economic abuse in DA relationships. k) Highlight the lack of professional curiosity l) Acknowledge the good practice by the outreach worker in March 2015.
Maria	a) Domestic Abuse specialists not on panel b) Report lacked the voice of the victim and of links with the victim's friends, and community. c) The report doesn't probe enough into the detail of the couple's past. It was felt that the timescale from 2014-2017 wasn't long enough. d) Barriers to support e.g., disability could have been explored further. e) Lessons not explored e.g., working more closely with cancer charities f) Improve anonymity and remove the exact date of death in the report. g) Use pseudonyms
Samuel	a) Little analysis and so no findings, no lessons learned and no recommendations. b) This report did not fully explore possible learning. c) A more probing review with more detailed terms of reference that have been

	tailored to the particulars of the case would help identify appropriate learning. d) Panel recommended an expanded review panel with representation from voluntary sector specialists in mental health and domestic abuse and a community member with in-depth knowledge of Syrian culture. e) The Panel also noted that there is limited detail in the report about family engagement in the review.
Sam	a) Anonymity for children b) IOPC – incorrect information c) Explore the impact of trauma from the domestic abuse on the victim's life skills. This analysis may contextualise her inability to engage with services. d) You may wish to review the language used with regards to the perpetrator's alcohol consumption being the catalyst for him to have 'just snapped'. It could be construed that this is minimising the domestic abuse behaviour. e) We would recommend the report challenges the use of a written agreement as referred to in paragraph 09.15. Social work experts on the QA Panel stated that this intervention is not advised with victims of coercive control as it puts added pressure on the victim and sets them up to fail. f) To add weight to the report, it could further explore the role of housing in relation to their ability to use risk mapping when offering properties and why the victim was evicted from her previous home. This could include links to the Domestic Abuse Housing Alliance and Greenwich Council who have developed a domestic abuse check list for housing to support work with domestic abuse victims. g) Further clarification of the statement on page 41 in regards overnight visitors would be helpful as it is possible to have overnight guests in temporary accommodation. h) It would be useful to review the recommendations for housing as not all housing will have CCTV and sharing multiple databases would have significant logistical challenges. i) The review highlights a complete system failure with breaches of bail not being followed through and patterns of behaviour not being picked up. The need for better multi-agency working at a local level through sharing information is paramount. This could highlight the effective practice published on MARAC processes. j) It would be helpful to add a recommendation in relation to the school that highlights working on issues of domestic abuse with the police through Operation Encompass.
Elaine	The Panel felt that the DHR panel may have benefited from Domestic Abuse specialists as all members were from statutory agencies. • The Panel felt that the report lacked the voice of the victim or any sense of who the victim was and would encourage the Panel and Chair to try and make links with the victim's friends, religious leaders, community groups or employers to try and bring out more detail in the report, a sense of who the victim was and what the victims experience was.

	• The report doesn't probe enough into the detail of the couple's past. It was felt that the timescale from 2014-2017 wasn't long enough. More probing could also have been done around protected characteristic and disability possibly being a barrier. This could have been explored further. • The panel feels that there are opportunities to learn lessons from this tragic incident and we would encourage you to think about what those lessons could be and produce an action plan which could support this review more thoroughly, for example, working more closely with cancer charities around the experiences of this couple and to ensure sufficient support is in place for people going through similar circumstances. • Please note 11.13 there is a typo. Similarly, paragraph 9.1 states there were no parallel reviews but there would have been an inquest into the death so we would encourage the DHR chair to have a discussion with the coroner. • Paragraph 11.2 states that the victim came to live in the UK in 1971 but this contradicts paragraph 10.1 which states she came to live and work in the UK in the early 1980s. • A conversation with the housing association the couple resided with could be useful, to find out if there was any support being offered to them. • To improve anonymity please remove the exact date of death in the report. Although pseudonyms are used in the executive summary, initials are used in the main report (despite paragraph 3.2 stating that pseudonyms are used).

Appendix 3

Intersectionality

Pragna Patel

I set out below key concerns regarding the way in which issues of diversity and equality are handled in DHRs. The first section sets out general themes and concerns arising from the cases provided. Section Two focuses on specific flaws and limitations of analysis on equality and diversity issues that I have identified in the Hertfordshire DHRs where either the victims or perpetrators are from black and minority backgrounds. Section three makes some recommendations for the way forward.

Section 1

Key themes and concerns

21 Poor understanding of equality and diversity issues

In many DHRs, all too often little or no attention is paid to the issues of equality and diversity which remains very poorly analysed if at all. This renders the lessons learnt ineffective since recommendations for improving risk assessments and prevention where black and minority communities are concerned are non-existent. This is a recurrent theme that runs through many DHRs. DHR panels often fail to pay close attention to how issues of race or ethnicity, religion, culture, and socio-economic status shapes how domestic abuse is experienced in minority communities. For example, there is usually no exploration of how specific cultural and religious values create powerful constraints in respect of exiting abuse for victims and provide justification and excuses for perpetrators that leave them less accountable. At best equality and diversity issues are reduced to 'tick box exercises' in which diverse identities are simply noted but no attempt is made to undertake a contextual analysis of the wider background intersecting factors concerning the victim and perpetrator or the risks and barriers that are generated. For example, there is no attempt to understand how race, religion and culture shapes the gendered or familial forms of harms that are experienced within relationships, families, and communities and how they are addressed.

22 The lack of an intersectional approach to domestic abuse

In many DHRs, there is little or no understanding of intersectionality as a framework for understanding how a range of protected characteristics and other factors such as socio-economic status or migrant status, combine to create different levels of risks and barriers for a range of victims that can make reporting difficult and curtail timely intervention and access to support. The key issue here is that intersectionality is usually taken to mean adding up overlapping identities. This is a very flawed understanding of how intersectionality should be applied because it leads to a check list approach to equality and diversity that simply translates into noting the race, religious, sex or ethnic background of perpetrators and victims. There is

no attempt made to understand the relationship between various strands of discrimination that create conducive contexts to abuse and violence.

For the sake of clarity, intersectionality must be more clearly defined and understood in the work of DHRs. It must be viewed as a framework for understanding how a person, a group of people or a social problem is affected by several overlapping and structural forms of discrimination and prejudices, not identities. An intersectional approach is one that recognizes that the concrete social locations of people are constructed along multiple (if shifting and contingent) axes of difference, such as gender, class, race and ethnicity, sexuality, caste, ability and so on. It relates to how people are disadvantaged by such multiple sources and structures of oppression, inequality and discrimination and takes account of how people's experiences are multidimensional. Significantly, Intersectionality recognizes that each inequality marker (e.g., "female" and "black") do not exist independently of each other. They are interconnected and each informs and shapes the other, often creating a complex convergence of oppression that is more heightened than that created by a single strand of discrimination and oppression.

Integrating an intersectional approach within the DHR framework is vital if we are to learn whether specific risks to a particular victim were properly identified and assessed by the relevant agencies and whether the safeguarding responses were adequate and what if any lessons can be learnt for improvement. The Equality Act is a good starting point because it sets out the various discrimination strands as forms of protected characteristics that DHRs need to consider when approaching the question of intersectionality. It must be noted however, that the list of protected characteristics is not exhaustive and there may be other critical matters that need to be taken account such as migrant or socio-economic status.

An intersectional approach will typically involve undertaking a more thorough and rigorous analysis of the wider social context of both the victims and their abusers to ascertain the range of intersecting and overlapping power structures that form complex barriers to disclosure and protection. It is necessary to ensure that the barriers facing marginalised groups are understood and addressed whilst also guarding against the stereotyping of victims from minority backgrounds. Each case needs to be approached with an intersectional lens but with reference to its own specific context and power dynamics.

It is also vital not to ensure that an intersectional lens is applied throughout the process of the review and weaved into individual agency and collective analysis rather than just limited to a few comments relating to the section on equality and diversity.

23 Barriers and risks

Where black and minority victims are concerned, it is necessary to be alert to the specific forms of harm and the diverse range of barriers faced since without this it is not possible to assess the different levels of intensity and risks created or develop effective interventions and safeguarding measures. The extent and forms of physical, sexual, financial, and psychological abuse and coercive control and its specific impact on women, including their responses to it,

cannot be gaged without exploring how factors such as sex, ethnicity, class, religion, age, and culture overlap with abuse in contexts of profoundly unequal power.

For example, some minoritised women are more likely to stay in abusive relationships for longer than their counterparts in the wider society due to several interlinked barriers. Understanding the range of multiple and overlapping barriers both internal to the person and community in which they live (e.g. Cultural and religious constraints, patriarchal concepts of shame' and 'honour', family dynamics, mental health and trauma, stigma and ostracisation, financial status, low self-esteem etc) and those that are external (lack of English language, lack of access to housing and welfare support, lack of access to legal aid, insecure migrant status, isolation, racism etc) combine to create different degrees of discrimination, marginalisation and powerlessness. In my experience, most black and minority victims experience of abuse are not properly understood or analysed within DHRs and yet all these factors need to be critically examined as part of the contextual analysis that should be attempted.

It is also important to note that the dominant understanding of domestic abuse and gendered harm in policy and practice is based on the intimate partner paradigm which may not be appropriate for some minority women who live in extended family structures and as a consequence, are often subject to abuse by multiple perpetrators. Arguably, the one defining feature of many women of minority backgrounds, especially South Asian women, is the widespread social dimension in which the abuse takes place. It is experienced in wider extended family, kinship, community and business and religious networks that are often interrelated and overlapping. Such close-knit relationships and networks provide not only a context conducive to the perpetration of such abuse but also become powerful barriers to reporting and exiting from abuse. They also contribute to the maintenance of culture of secrecy, silence and victim blaming that is pervasive in many communities. For example, in-law abuse is very common in women's accounts of domestic abuse, forced marriage and honour-based violence and homicide and suicide cases. such culturally specific forms of harm also involve higher degrees of pre-meditation, coercive control, stalking and sexual violence.

24 Discrimination and Stereotypes

Black and minority women's needs often go unrecognised and/or are subject to stereotypical and discriminatory assumptions that can have a detrimental impact on their access to protection and justice. Often there is a failure on the part of state agencies to identify the dynamics of power and control that underpin experiences of abuse in BME communities. Women are often either perceived as too passive or too aggressive. For example, migrant women with immigration insecurities or those from African-Caribbean communities are particularly vulnerable to 'over-policing'. The myth of African and Caribbean women as

fulfilling masculine roles in their own communities is pervasive. Notions of such women as 'strong', 'aggressive' or 'independent' and 'self-reliant' often work to their disadvantage when they find themselves subject to abuse. They are often deemed to have 'no culture' or constraints that would impact on their ability to exit from abuse. Despite evidence that suggests that women from such backgrounds face high levels of domestic abuse, their accounts of abuse or coercion and control are often deemed to be incapable of belief. Any act of retaliation to abuse on their part is often treated as an act of aggression and as a consequence many are treated as perpetrators of abuse and so disproportionately criminalised.

On the other hand, women from South Asian and other culturally distinctive minority backgrounds are more likely to experience minimal intervention or 'under -policing'. This arises due to a reluctance on the part of statutory agencies to intervene in what are viewed as the internal or private affairs of minority communities that are deemed to be guided by their own cultural and religious values. Agencies have been known to turn to community leaderships for guidance and dispute resolution when women report abuse. Yet what is little understood is that such leaderships are more concerned about preserving so called family values and in limiting state interference in family matters. Such a culturally relativist approach on the part of state agencies is often based on a fear of not wanting to offend religious or cultural sensitivities but it usually results in women being delivered back into the hands of abusive perpetrators and family members.

Additionally, where inter-racial relationships are involved, it is also necessary to understand the racialised power dynamics that can underpin such relationships since they may raise specific issues that impact on barriers experienced by victims and impunity enjoyed by perpetrators. There are several aspects to bear in mind when examining inter-racial contexts: Firstly, families of the perpetrator or victim may disapprove of the inter-racial relationship or marriage, making it difficult for victims to turn to them for support when deciding whether to exit from an abusive marriage or relationship. Secondly, inter-racial relationships can create additional barriers for minority women when reporting abuse to state authorities in circumstances where the perpetrator is white. It is not uncommon for public bodies to discriminate in favour of male white perpetrators and to disbelieve black or minority female victims who may even be detained and criminalised if counter-allegations are made. The privileging of the male white voice over that of a black or minority women is a classic example of intersectional discrimination which needs to be explored together with other factors such as age, education, migrant status, and wealth.

Notwithstanding the above, it would be highly dangerous to conclude that all black and minority women from similar backgrounds will behave in a uniform manner, always and in all places. The danger lies in the creation of the types of stereotypes described above. This is why a close examination of the wider familial, community and social context and factors such as

education, socio-economic status, migration histories and so on are vital to consider when undertaking a DHR.

25 Failure to consult and enlist specialist support.

There are still too many examples of DHRs involving black or minority victims and perpetrators in which there is no input from specialist black and minority organisations either through direct participation as experts on the DHR panel or indirect participation as advisors. This can itself serve to mask issues of race and culture. There is concern that in far too many DHRs, there is little or no understanding of the needs and experiences of abused black and minority victims resulting in highly flawed reviews and learning. Specialist organisations are more likely to be aware of what are often complex family and community power dynamics and wider institutional discrimination and cultures of indifference that are at play. The lack of understanding of religious and cultural influences, can create several misplaced assumptions for example, about when and in what way it is appropriate to intervene in minority family matters which can generate further risks for victims. Specialist services are more likely to be alert to key risk indicators and barriers that state agencies fail to identify or assess and more likely to make appropriate recommendations for prevention, support, and protection. Such services have been shown to be effective in providing victims with the immediate and long-term advice, advocacy, emotional and practical support they need to overcome the considerable and multiple barriers that make exit from abuse difficult and even dangerous. This is why their contribution to the DHRs is so central in cases involving black and minority victims.

Section 2.

Comments on individual DHR cases

In all the cases listed below, there is a glaring absence of any contextual analysis of race, culture and other multiple equality and diversity issues that are likely to have created risks and vulnerabilities for the victims or opportunities for abuse and control by perpetrators. This omission also means that key areas for improvement as well as recommendations on early identification of risks to prevent the escalation of violence are likely to have been missed. The learning from the DHRs would therefore have been rendered limited at best and meaningless at worst.

Amy (description from the Learning Paper)

Amy was killed by Amobi, in 2016. He was her carer, ex-long-time partner, and father of her two children. He then took his own life. Amobi was of Black Nigerian origin and had worked in Enfield as a barber before moving with Amy to Hertfordshire. Amy was disabled with physical and mental health issues and 32 years old when she died. Although they were no longer in a relationship at the time of their deaths, Amobi continued to be Amy's carer and was at times resident with Amy and their two children. It appears that he was dependent on the caring role and had no other source of income. Amobi had a previous record of domestic

abuse with two ex-partners after they separated. Their two children were aged nine and seven years when their parents died.

Issues:

The case raises the intersection of a number of issues that appear to have been ignored when assessing risks and barriers faced by Amy.

- Amy was disabled with physical and mental health issues with two young children. This appears to have made her entirely dependent on Amobi to meet her needs and general support.
- The extent of Ami's disability, her dependency on Amobi to meet her care needs and indirectly that of her children needed to be properly explored. The intersection of these issues with Amy's own caring responsibilities for her children may have severely limited her options for exit.
- Both Amy and Amobi appear to have been highly dependent on each other - Amy needed a carer and Amobi financially relied on this caring role as he had no other source of income and therefore nowhere to go. All of this needed to be properly examined to ascertain the extent to which they felt locked in with each other without any hope of exit and to what extent the dependency dynamic on both their parts contributed to their volatile relationship. Such an exploration would also have allowed for greater scrutiny on the possibility of economic abuse of Amy by Amobi.
- There appears to have been a complete lack of exploration of Amobi's Nigerian cultural and religious background to ascertain how this may have influenced his perception of his role as a partner, father, and carer. An exploration of cultural attitudes to issues such as gender roles and masculinity in the context of marriage, relationship and the family needed to be examined to ascertain the underlying dynamics. Female subjugation in Nigerian communities is often justified and normalised in the name of tradition and culture. Studies in Nigeria for example, also show that disabled women are at higher risk of gender violence. Has this attitude also filtered through into Nigerian communities in the UK? An analysis of Amobi's specific religious and cultural beliefs and its intersection with issues of disability and socio-economic dependency may have provided greater insight into Amobi's abusive and controlling behaviour that would also have helped to identify the levels of risks that Amy faced. Such an analysis is also necessary to raise awareness and prevent violence against women in Nigerian communities and more generally and to de-normalise violence and misogynist attitudes towards women.
- Amobi had a record of abuse and coercive control against two ex-partners post separation which suggests that Amy was also at high risk of post separation abuse and violence, even though she continued to live with him due to her dependency on him. Here the intersection of culture with disability and separation needed to be properly scrutinised to ascertain the barriers that this created for Amy.

- No expertise was sought to provide insight on cultural and religious attitudes and practices or wider community dynamics within the Nigerian diaspora to inform the panel in the review process. This was a missed opportunity to consider making recommendations on changing attitudes and raising awareness about gender-based abuse and attitudes to women amongst men within the Nigerian diaspora or develop pathways of support for all victims including disabled victims and those in need of alternative accommodation and support when faced with destitution and homelessness.

Samuel (description from the Learning Paper)

Samuel (aged 85 years) died from multiple stabbing wounds by Anwar, his son-in-law (aged 60 years), in January 2017. Samuel was resident in Syria and staying with Anwar and his wife, Nour, in North Hertfordshire when he was stabbed and killed. All three were of Syrian origin and were Christian. Anwar and Nour have two grown up children. Nour has a schizoaffective disorder and Anwar had mild depression and suicidal ideation. He was convicted of manslaughter in 2018 and sentenced to 8 years imprisonment.

Issues:

- There appears to have been no exploration of the Syrian cultural and religious contexts and how this impacted on family dynamics.
- The standout issue appears to be the intersection between culture, religion, and mental illness. The interplay of these factors needed detailed scrutiny because it is likely this is likely to have also shaped perceptions of mental illness within the family and influenced the management of not only of Nour's mental illness but also Anwar's depression and suicidal thoughts and how they were managed. Such an examination would have also led to the identification of the pressures, vulnerabilities, and barriers to seeking support faced by all the parties involved. For instance, it is acknowledged that there is considerable stigma attached to mental illness in various Arab cultures. Those with mental illness face considerable social discrimination due to such widespread stigma resulting in low self-esteem and social isolation. These attitudes may have inhibited the parties from seeking timely support and possibly contributed to a sense of isolation that they may have faced.
- There appears to have been no exploration of the wider family dynamics and the intersection of culture, wealth, socio-economic status, and education and how these may also have impacted on the relationship between Anwar and Samuel.
- There appears to have been no attempt to seek advice on Syrian and middle eastern cultures or ensure that such expertise was represented on the DHR panel. Without such input, insight into the family's background and dynamics between the parties is bound to have been limited. It is difficult to understand how those conducting the review could have come to any informed views and recommendations without more exploration and analysis of the family's socio-economic and cultural background.

Maria (description from the Learning Paper)

Maria (aged 70 years) had been in a 30-year relationship with David (aged 64 years) when he killed her in 2017. She had been married in the Philippines and came to the UK after the marriage ended, in her twenties. They had no children and met each other when working in a local hospital. They were both retired from paid employment. David was diagnosed with prostate cancer in 2015, he declined conventional treatments and instead relied on diet and exercise to treat himself. He had a history of depression and no known history of domestic abuse. David pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to five years imprisonment on in 2018.

Issues:

- The power dynamics that often play out in inter-racial relationships where the perpetrator is a white male, and the victim is from an ethnic minority deserve proper examination. For example, did Maria have a voice in the decision made by David to decline conventional treatment for his cancer? Did she feel able to disclose the difficulties she faced in her relationship when it became stressful for her? To what extent did her own Filipino cultural and religious background and attitudes to marriage influence her decision to take care of David? Without such scrutiny it would have been difficult to ascertain the power dynamics involved in this relationship and how it intersected with David's physical illness and the extent to which it may have impacted on Maria's isolation and her engagement with state authorities.
- By rejecting conventional treatments for his cancer, Maria's husband is likely to have made excessive demands of Maria and had unrealistic expectations of her. This in turn is likely to have altered the balance of power in the relationship. it is possible that excessive demands and expectations may have created additional pressures for Maria and forced her husband into greater dependency on her. In these circumstances, the intersection of race, gender, ill health, and power needed to be carefully examined to understand how and why Maria was isolated and rendered vulnerable.
- Maria did not have close friends in the UK which suggests that she was probably isolated and may even have had her own mental health problems arising from the isolation which she may not have felt able to disclose.
- The DHR does not appear to have sought advice or expertise input about the reality of the lives of Filipino women in the UK, especially those who have entered inter-racial marriages or relationships with white British men. Consequently, potential risk indicators for Maria may have been missed and with it, recommendations to do with the need for outreach work with all minority women, especially those who are less visible. The need for dedicated support that also includes counselling and practical help to address issues of isolation appears not to have been addressed. There are several organisations working on the rights of migrant Filipino women who may have been able to provide guidance and input into the DHR.

Section 3

The way forward

- The challenge for statutory and non-statutory services is to adequately address within the DHR process, the many barriers and challenges faced by black and minority victims in reporting and exiting from domestic and other forms of gender-based abuse and violence. Much more needs to be done to explore their lived realities and meet their need for protection and support.
- Chairs need to understand the concept of intersectionality and how to apply an intersectional approach to the work of DHRs so that it is embedded throughout the different stages of the DHR process. It is necessary to make explicit to the panel members at the outset that the review will be guided by such an intersectional approach when examining what went wrong and what lessons need to be learnt.
- All chairs should receive robust training on how to guide panel members to apply an intersectional approach and undertake a contextual analysis of the case in hand. Panel members writing IMRs must be directed to approach their own individual reviews using an intersectional lens which means that an intersectional analysis must be weaved throughout their IMRs rather than be treated as an 'add on' that is confined to the section on equality and diversity only. There is a need to ensure that there is a more meaningful engagement with issues of equality and diversity.
- All panel members should undergo mandatory in-depth training on needs of black and minority women and girls and the specific contexts in which they experience domestic abuse. Such training needs to cover issues of intersectionality and the specific internal and external barriers faced in seeking protection and in seeking accountability from perpetrators and the state.
- Where possible, advice and input from specialist BME services in the locality or experts must be sought. Their contribution can help guide the intersectional approach and provide insight into family and community dynamics and constraints and barriers faced in seeking support from state agencies. Enlisting the engagement of specialist experts is also vital in thinking through recommendations, particularly those aimed at hard-to-reach groups and raising awareness and changing attitudes that generate harm to women and other powerless subgroups within communities. Where a relevant specialist organisation in the locality area is not available, the Chair should still seek advice and guidance from another service or expert. This has occurred in some cases, but it needs to be institutionalised as best practice.
- It is important to involve appropriate specialist organisations with a track record of working on VAWG from a rights-based perspective in minority communities. Not all community organisations including women's organisations approach gender-based violence from the point of view of gender equality. All too often, when a BME specialist organisation cannot be found in a particular locality, there is a tendency to revert to any community or religious organisations for advice, but this is a dangerous move

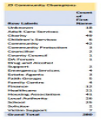
since they may be more interested in maintaining religious and cultural values that generate the risks and barriers that victims face.

- Great caution is also urged in seeking input from family members to gain a better understanding of minority backgrounds and contexts. However well-intentioned, family members, relatives and community members are not necessarily able to provide an objective analysis of their cultural and religious backgrounds since many are invested in the same value systems and structures and are often intentionally and unintentionally complicit in the constraints that are placed on victim seeking to report abuse. Very rarely do accounts from members of a family or community provide a gendered analysis of culture or critically reflect on how power is allocated within marriage, family and community which impacts on men and women differently in respect of the perpetration and response to abuse. They are highly unlikely to provide an insightful account of harmful practices or explain how the lives of domestic abuse victims are shaped by the changing cultural and religious custom and practice that keep them in subjugated and powerless positions within the family and normalise abuse. A proper distinction needs to be made between obtaining background information (often supplied by families and friends) and seeking expert input (which should come from experts in the field).

HERTFORDSHIRE domestic abuse PARTNERSHIP

Domestic Homicide Reviews in Hertfordshire: SMART Recommendation and Action Plan Alice, Amy, Elaine, Maria, Sam, Samuel

Recommendation (SMART goal)	Scope of recommendation (i.e. local or regional)	Action to take/ Similar actions from DHR CF	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Risk assessments to identify the perpetrator and take account of their history of domestic abuse and the needs of the survivor.	Local	**Recommendation six from the case of CF:** Survivor led safety planning should be represented in all agencies involved with the family. Refuge, the children's, adults' and community safety partnerships in Hertfordshire are recommended to develop a consistent template to be used for all survivor led safety planning and to include, if appropriate, family, friends and the local community.	Strategic Partnership Team, Risk management sub-group	The risk management sub-group was consulted to see if there are any areas of the risk assessment that need improving and a consistent template to be developed considering national benchmarking and good practice. This recommendation will be included in their current audit. There was a T&F group formed for the case of CF that will discuss each agencies risk assessments and collate information. Hertfordshire Police start using DARA (Domestic Abuse Risk Assessment) on 1st July 2023 which is a new way of identifying risk on the frontline of policing.	September 2023 August 2023 July 2023	It has been discussed how challenging it would be to come up with a template now, however, this is this is part of the work that is being done on the One Stop Shops project. Each organization that will be part of the One Stop Shops will agree to a template (risk assessment and referral form) that will be used and accepted by all participating organizations. Family and friends are involved to the extent that victim-survivors are always encouraged to have a 'code word' with a friend or family member in case they need them to call the police on their behalf. In terms of the community element of this recommendation, the J9 initiative in Hertfordshire is the 'help on the high street'

						approach. Every agency/individual trained through this will have access to a resource/information pack and receive a J9 Pin badge and window/door sticker to display in a prominent/public place (such as a shop doorway) as part of this. There is ongoing work within the general population to raise awareness of what the logo means. Currently there are over 400 champions across the network. The attached overview shows the number of champions in each area withing Hertfordshire as well as the sector. Please note that 'Community' covers a vast range including shops, cafés, hairdressers.  
Create pathways for support to survivors, including carrying out a needs assessment with the survivor to identify their needs and agreeing	Local	Same as above.	Strategic Partnership Team	In addition to the above, the Strategic Partnership Team completed the Community Mapping report that looked at all available domestic abuse organizations in each double	June 2024	Same as above.

a support plan. Ensure all survivors are helped to move across the pathway at a speed which meets their needs.				district and is in process of designing the One Stop Shops, taking into population data, that will bring together all the DA services and streamline pathways.		
Develop a children's pathway for support, ensuring their needs are met at school and by Children's Social Care. Ensure that counselling and support services are in place for children. Where there is a homicide, a plan to support them emotionally and psychologically is essential.	Local	**1, Recommendation three from the case of CF:** The Hertfordshire Safeguarding Children's Partnership should reassure itself that young people aged 16 and over who experience domestic abuse as a victim/survivor are appropriately assessed and supported. Children aged under 18, who are victims/survivors of domestic abuse, should be referred to Children's Social Care and police.	Hertfordshire Safeguarding Children's partnership and Quality Innovation and Commissioning sub-group	Referral pathways are already used at CSC: 16-18 cohort: young adult who are victims in their own relationships. 18 and under who are recognised as victims of DA. This recommendation will be taken to the QIC sub-group to see what is currently being done and whether we have the appropriate services for these victims.	June 2023 September 2023	**Recommendation 3 from the case of CF:** Herts Police send automatic referrals to Children's Social Care if they attend an incident where DA is identified. It is mandatory for officers to obtain details for a child referral for any children within or linked to the household/adults involved. However, there is no obligation on those involved to provide the details of any children, nor in many cases is there a legal obligation to allow police to physically check on any children. Officers try to accomplish this through consent and building a rapport with those involved. There is a tab on the police system called Athena where the Voice of the child should be reported based on the AWARE principle: A - APPEARANCE W - WORDS A - ACTIVITY R- RELATIONSHIPS AND DYNAMICS E- ENVIRONMENT

						 A guiding principle to listen to the child's voice Young people aged 16 and above can make their own decision regarding what support they need, even if the parents do not want DA support. There are a number of organizations that offer DA related support to children under the age of 18, such as Future Living and Beacon. There is no obligation for the parents to be also involved in any DA related support/ therapy.
Consider MARAC referrals and who gets support. Can repeat and/or additionally vulnerable survivors be referred into MARAC? When and how should an emergency MARAC be called?	Local	MARAC team and every organization signed up to MARAC to follow existing MARAC Operating Protocol.	Strategic Partnership Team	Currently people can be referred into MARAC based on high risk, MARAC repeat, 4 in 12 and professional judgment. There is no process for emergencies that are referred between the 2 weekly district meetings. The Operating	Ongoing.	Ongoing based on the MARAC Operating Protocol.

				Protocol for MARAC states that: "Where a victim is assessed as meeting the MARAC threshold and the risk of harm is so imminent; then statutory agencies will have a duty of care to act at once rather than wait for the next scheduled MARAC. In these exceptional circumstances, the agency dealing with the victim should contact the Police via the emergency 999 contact number. The Police will gather information, assess the threat and risk, and take the appropriate action in line with the National Decision-Making Model." This recommendation will be included in the MARAC audit recommendations.		
Support front line staff with: A, Training on all forms of domestic abuse, (including economic abuse), trauma, and its impact with the assurance that learning is embedded across agencies and services;	Local	**Recommendation 2 from the case of CF:** The strategic safeguarding, well-being and community safety boards and partnerships are recommended to develop a 'trauma informed' learning and development strategy to ensure that adverse childhood experiences are well understood when assessing survivors, victims and perpetrators.	Children's Social Care, Strategic Partnership Team, Hertfordshire Partnership University NHS Foundation Trust	Karen Dorney to share information with SPT about what is already ongoing within Children's services regarding the Trauma informed strategy that was launched with a dedicated team to look at children and families. 2, Sarah Taylor to look into involving the Joint Boards		Updates from Sarah Taylor: Next Joint L&D subgroup is scheduled for 10 July – current activity and foci for this meeting is the single board and joint L&D action and work plans; so timely for reflection and discussion point to include. workforce training strategy: Safeguarding Adults Training-

B, Create opportunities for front-line staff to discuss cases with domestic abuse experts; C, Support front line staff to be professionally curious and to work with other agencies as appropriate; and D, Help staff to understand and question victim blaming and how it increases risk.				L&D Sub group that has a Safeguarding children, Safeguarding adult and DA&VAWG board joint priorities and work plan. 3, Catherine Johnson to share information on HPFT's work around co-creating their new 5 year strategy as one of the elements is for a Recovery and Trauma formed approach. 4, SPT to collate information from everyone.		Levels and Outcomes (hertfordshire.gov.uk) 'Champion the Adverse Childhood Experience and trauma informed practice learning across the partnerships' was an objective included within the Joint L&D subgroups Work Plan 2020-2021. 21 live webinar sessions were delivered to more than 2,600 individuals across the children and adult sectors along with eight in-depth sessions on trauma informed practice. The Council have recently launched an All-age Trauma Strategy: Hertfordshire all-age, all-partner trauma strategy | Hertfordshire County Council. The strategy is accompanied by a self-evaluation tool which is being promoted and rolled out for adoption across all Herts-based organisations and services. The tool sets out 10 minimum criteria to embed and develop. The strategy has 6 recommendations and underpinned by a governance structure to follow that will encompass adult and children sectors and be supported by working groups and events.

						Currently L&D opportunities are being developed to accompany the strategy – supported by the Joint L&D subgroup. In scope for 2023/24 programme is development and delivery of a trauma informed practice e-learn package for all children social care staff.
Map what different agencies need to know, e.g., arrest, release from detention, whether the survivor is engaging with support.	Local	The Strategic Partnership Team to develop a shared referral form and to take this to the Quality, Innovation and Commissioning Sub-Group to sign off.	Strategic Partnership Team	As part of the ongoing work regarding one stop shops, there will be a shared referral forms developed taking into account all the organization that will be part of the one stop shops and the information they might need to provide an effective service to victims and survivors of domestic abuse.	June 2024	Completed, shared referral form finalised for One Stop Shops.
Information sharing and agreed protocols (including reciprocal agreements) between agencies on the basis of safeguarding are needed to ensure decisions are being made based on evidence as well as professional judgement.	Local		Strategic Partnership Team	There are protocols for information sharing between agencies as well as for MARAC cases. Consent is an issue here: when victims do not want to engage with other services, ie CGL or do not want to report to the police but want support from IDVA. If the case is not high risk and does not meet MARAC criteria, victims' consent is needed for information sharing.	June 2024	Completed.

A central data base of information to be held by one agency (MARAC) and updated regularly for all agencies to check on developments of cases.	Local	Central database to be implemented by MARAC to hold information that is regularly updated. For the Strategic Partnership Team to develop a system that includes information on all risk levels.	Strategic Partnership Team	MARAC updates can be checked on MODUS but not all cases go to MARAC so this would not work for all risk levels. The Hertfordshire Domestic Abuse Partnership is developing a 'one stop shop' where multiple agencies will work together to support the victim. Information sharing and a central data base will be part of the discussions during the development.	Already in place. June 2024	Completed. Ongoing.
Records of Breaches of Bail and response, and DAPA and DAPN to be held by Police and a regular report provided to the Community Safety Partnership.	Local	For the Domestic Abuse Investigation and Safeguarding Unit (DAISU) at Hertfordshire Police to hold information on breaches of bail. For the Multi-Agency Tasking and Coordination (MATAC) to try an engage DA perpetrators in support.	Multi-Agency Tasking and Coordination (MATAC)	The information on breaches of bail and breaches of injunctions are held by the Domestic Abuse Investigation and Safeguarding Unit (DAISU) at Hertfordshire Police. In addition, the Multi-Agency Tasking and Coordination (MATAC) is being implemented in Hertfordshire to ensure that agencies work in partnership to try to engage serial domestic abuse perpetrators in support, take action where required, and protect vulnerable and intimidated victims and survivors.	Already in place. September 2023	Completed. Ongoing.

				Hertfordshire Police will be responsible for identifying and researching the perpetrators for discussion by partners. This will include application of the Recency, Frequency, Gravity (RFG) scoring matrix to identify those serial perpetrators who cause the most harm and pose the most risk to future victims.		
Review DHR practice to ensure there is DA and other relevant expertise on all panels. That all panel members are trained and that the Chair and Report writer have a relevant domestic abuse background and can show how they can lead a professionally curious panel.	Local	For all approved Chairs in Hertfordshire to have DA expertise. For a DA expert to be invited to the panel at each DHR.	Strategic Partnership Team	All approved chairs for DHRs in Hertfordshire do now have experience of DA. Their experience and background have been assessed to ensure they are suitable to chair a DHR. Procedures now in place to ensure a DA expert and other relevant experts are included in panel meetings. Currently working on a new protocol. Panel member training was delivered in May 2023 and a recording of this will be	Already in place. Already in place as either Refuge or Safer Places are invited to a DHR as DA experts. Completed.	Completed. Completed. Completed.

				available for new panel members.		

Home Office

Interpersonal Abuse
Unit 2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848

www.homeoffice.gov.uk

Beth Goodall
Development Manager
Domestic Abuse
Strategic Partnerships Team
Adult Care Services
Hertfordshire County Council
Farnham House, Six Hills Way,
Stevenage,
SG1 2FQ

14th February 2024

Dear Beth,

Thank you for submitting the Domestic Homicide Review (DHR) reports for (Alice, Amy, Elaine, Maria, Sam and Samuel) for Hertfordshire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The reports were considered by the QA Panel in January 2024. I apologise for the delay in responding to you.

The QA Panel and Home Office have reviewed all the reports and the learning paper and are content that these can now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final versions of the report with all finalised attachments and appendices and the weblink to the site where the reports will be published. Please ensure this letter is published alongside the reports.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel