Hertsmere Community Safety Partnership

Domestic Homicide Review

“Maria”

Died July 2017

Overview Report (amended)

Original Chair	Jeff Stack
Original Author	Carole McDougall
Chair of updated report	Mary Mason
Date of completion:	August 2023

Contents

1 INTRODUCTION

1.1 This report of a domestic homicide review (DHR) examines responses and support given to Maria, a resident of Hertsmere, prior to her death in July 2017 and to her long-term partner, David who was suffering from prostate cancer and who killed her by stabbing her multiple times in the early morning when she was in bed.

1.2 In addition to agency involvement the review will consider background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. The key purpose of undertaking DHRs is to enable lessons to be learned from homicides where a person, aged 16 or above is killed as a result of violence, abuse or neglect by a person to whom they were related or were an intimate partner. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.3 By taking a holistic approach, the review seeks to identify appropriate solutions to make the future is safer.

1.4 The circumstances leading to the review are that Maria was killed by her long-term partner, David, who was suffering from prostate cancer and had declined conventional treatments.

1.5 David had a history of depression and was diagnosed with severe to moderate depression prior to his trial, when being tested to see if he was fit to plead. There was no known previous history of Domestic Abuse for either party. Maria, who was aged 70 years, lived with David, aged 64 years, in a rented maisonette in Hertsmere. They had been partners for over 30 years, both retired from paid employment. They met while working at a local hospital, David as a porter and Maria as a psychiatric nurse. They started a relationship on Valentine's Day in 1984. Maria had been married in the Philippines and came to the UK in her 20's.

1.6 David was aware that she was married, her husband was in the Philippines, and she had no children. They had no children together and lived a full sociable life. He described the relationship to the Psychiatrist when he was awaiting trial as "It was great. It was an equal relationship, we hardly ever argued and there was never any violence. She was the boss in the house and we both worked. She was in good health and had no mental health problems". This was confirmed by other relatives on both sides of the family who described them as having a close and loving relationship, with no previous violence or abuse.

1.5 David had been diagnosed with prostate cancer in 2015, for which he had decided not to have conventional treatments and instead rely on diet and exercise to treat himself. On the day Maria died, David telephoned Hertfordshire Constabulary to say he had killed Maria. Officers attended, as did paramedics who could find no sign of life. David was arrested on suspicion of murder. On 1 December 2017 David pleaded guilty to manslaughter on the grounds of diminished responsibility, a plea was accepted by the court. He was sentenced to 5 years imprisonment on 19 April 2018.

2 TIMESCALES

2.1 The review began on 30 August 2017 when a DHR panel was convened and concluded 22 May 2018.

2.2 The report was sent to the Home Office in August 2018. The Home Office sent back feedback in July 2019.

2.3 Following this feedback from the Home Office, Hertfordshire County Council commissioned a review of the overview report to address the issues raised. There was some delay in doing this, and this delay was exacerbated by Covid-19 pandemic. The review took place between October 2021 and September 2022. The report was finalised and sent to the Home Office in August 2023.

3 CONFIDENTIALITY

3.1 Until publication of the final report the findings of the DHR are confidential. Information is available only to participating officers and their line managers.

3.2 Pseudonyms are used in the DHR, to protect the identity of the individuals concerned. The following pseudonyms are used:

Maria: Victim

David: Perpetrator

Patricia: Perpetrator's sister 1

Jean: Perpetrator's sister 2

4 TERMS OF REFERENCE

4.1 DHR panel members have agreed the review will focus on events from 1st December 2014, when David was diagnosed with cancer, until 25 July 2017 when N died.

The panel for this further review agreed to obtain full records from the police for both parties and Adult Social Care (ASC).

Additional checks by police forces and Hertfordshire ASC confirmed that neither agency held information prior to this period.

4.2 Terms of reference and key lines of enquiry are as follows[1]:

The purpose of the review is to:

- Establish how effective agencies were in identifying the health and social care needs of both Maria and David and providing support.
- Establish the appropriateness of agency responses to both Maria and David - both historically and within a month of their deaths.
- Establish whether single agency and inter-agency responses to any concerns about domestic abuse were appropriate.
- Identify, based on the evidence available to the review, the need and required actions to improve policy and procedures in Hertfordshire, and more widely.
- 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 domestic abuse is a feature.

The review will exclude consideration of who was culpable for the death as this is a matter for the coroner to determine.

The Home Office commented on the limitations of the purpose of the Review. Given the length of time that has passed and the decision agreed with the Home Office not to re-write the report, it was agreed to note this as a DHR learning point.

[1] Please Appendix for discussion about the terms of reference and key lines of enquiry. It was also noted that the time frame should have been longer and where possible additional data has been added. However, due to GDPR and data retention policies, not all agencies were able to provide data from 2014 and before.

4.3 Key Lines of Enquiry

1. How was information about the health and social care needs of Maria and David received and addressed by each agency and how was this information shared between agencies?

2. What was the impact of David's cancer diagnosis on his mental wellbeing and did this influence Maria and David's relationship?

3. Is there any information in relation to domestic abuse and its impact?

4. Were any carer's/agency assessments completed?

5. Was there an indication or sign of any cultural perceptions or beliefs that were relevant? Did these bring with them any implications on their relationship, and behaviours?

6. What contact did each agency have with Maria and David?

7. What support did they receive and from whom; individually and as a couple?

8. Were there any barriers to seeking support? What were they? How can these be overcome?

9. Were there any indicators or history of domestic abuse? If so, was the immediate and wider impact of domestic abuse on Maria fully considered by agencies involved?

10. Was there any collaboration and coordination between any agencies in working with Maria and David? What was the nature of this collaboration and coordination, and which agencies were involved with whom and how? Did agencies work effectively in any collaboration?

11. How were the issues of intersectionality identified and dealt with by agencies? Did the interventions of agencies demonstrate competent strategies and practice of intersectionality in their responses?

12. What lessons can be learnt in respect of domestic abuse; how should agencies respond?

5 INVOLVEMENT OF FAMILY, FRIENDS, AND WIDER COMMUNITY

5.1 Maria is understood to have 12 siblings only one of which, her brother, lives in the UK. She had a sister in the USA who she was in regular contact with. Her sister spoke to the Police Officer leading on this case. David had 3 sisters; the youngest, who had been suffering from cancer, died in December 2017.

5.2 Through careful and considered discussion and consultation with the SIO and FLO in the case, the panel agreed who amongst family, friends, work colleagues, neighbours, and community members the panel should approach to notify that the review was being conducted and also to invite them to take part.[2]

5.3 As a result the following attempts and contacts were made:

30 November 2017: Email sent to Maria's nephew who was point of contact for the family, including a letter offering the opportunity to be involved in the DHR review. No response received.

4 December 2017: Letters sent to David's sisters offering the opportunity to be involved in the DHR review. No responses received.

[2] See Learning Paper/appendix for further discussion on appropriate and effective inclusion of community, family, and friends in order to centre the victim's voice.

16 April 2017: Letters sent to friends of Maria, but no responses received.

15 June 2018: Letters sent to David's sisters advising the Panel had completed its review and as no response to the 4 December letter, asked if they wanted to review the draft report before publication.

15 June 2018: Email to Maria's nephew who was point of contact for the family, including a letter offering the opportunity to review the draft report before finalising it. No response received.

18 June 2018: Jean and Patricia (David's sisters) phoned to speak to the panel chair having received 15 June letter to say they had not received 4 December letter and would like to see the report which was subsequently sent to them by recorded delivery.

27 June 2018: Teleconference with H, Jeff Stack and Carole McDougall; teleconference with Jean, Jeff Stack and Carole McDougall. The Chair of the second review has been unable to establish the identity of H.

5.4 In addition to writing to Maria's brother and David's surviving sisters advising them that a DHR was being conducted, they were sent a copy of the Home Office DHR information leaflet together with leaflets introducing the advocacy service, Advocacy After Fatal Domestic Abuse (AAFDA). A copy of the Terms of Reference was also provided at this time. The family members were invited to contact the panel chair to discuss how they could contribute to the DHR, which included an opportunity to influence the Terms of Reference. The panel chair did not hear from the family members at that stage.

5.5 The Panel Chair also wrote to 3 of Maria's friends identified through the investigation and DHR process to invite them to contribute to the DHR and did not receive a response.

5.6 Prior to completion of the DHR the panel chair invited family members to meet with panel members and offered to share a draft report. The panel chair did not hear from Maria's brother. Together with the overview writer he spoke with both of David's sisters by telephone, after each had received a copy of the draft report. The feedback they gave has been included within the report. In addition, Police spoke with Maria's sister in the USA. She confirmed that she had been in regular contact with Maria and that Maria was distressed in the days leading up to her death as she was worried about David and his behaviour which she described as 'becoming like a child'.

5.7 At the point of writing the review report, David was still alive and due to be released from prison in July 2022. The panel considered if it would be helpful to the report to approach him for input.

6 METHODOLOGY

6.1 This review is commissioned by Hertfordshire's Domestic Abuse Partnership Board with Hertsmere Community Safety Partnership. A decision to conduct a review was taken in August 2017 and having established that the criteria for a DHR were met, as specified in the Domestic Violence, Crime and Victims Act 2004, an independent panel was convened, and the terms of reference agreed.

6.2 The panel requested chronologies from agencies in contact with Maria and David, listing dates, events, and actions. After considering the chronologies the panel decided that it was not necessary to request individual management reviews (IMRs) as agencies had limited contact with Maria and David.

6.3 Agencies providing chronologies are listed below.

Agency	**Chronology**

Affinity Sutton Housing	√
Hertfordshire Community NHS Trust	√
Hertfordshire Constabulary	√
Red House GP surgery	√
University College Hospital London NHS Foundation Trust	√
West Hertfordshire NHS Hospital Trust	√

6.4 In addition to the chronologies the panel had sight of the following documents: -

- A letter from David's GP, dated 18 January 2018.
- A statement to the police made by a specialist palliative care nurse, employed by Hertfordshire Community NHS Trust, who had contact with David following the diagnosis that he had prostate cancer.
- A statement to the police made by a senior dietician, employed by Hertfordshire Community NHS Trust, who visited David at the request of the palliative care nurse.
- A psychiatric report prepared for David's defence, dated 8 September 2017.
- A psychiatric report prepared for the prosecution, dated 9 November 2017.
- A psychiatric report prepared at the request of the court, dated 21 February 2018.

7 THE REVIEW PANEL MEMBERS

7.1 The DHR panel was established in August 2017 with the following membership: -

AGENCY	JOB TITLE & ROLE	NAME
Affinity Sutton Housing	Head of Operations	Anne Brighton
Clinical Commissioning Groups	Head of Adult Safeguarding	Tracey Cooper
Community Safety Partnerships	Community Safety Manager, Broxbourne	Nicola Pearce
Health and Community Services Hertfordshire County Council	Operations Director	Sue Darker
Hertfordshire Domestic Abuse Partnership - Strategic and Operational Coordination and Guidance	Partnerships Manager, Domestic Abuse	Sarah Taylor
Hertfordshire Community NHS Trust	Named Nurse for Safeguarding	Jane Newcombe
Hertfordshire Constabulary	Detective Chief Inspector Safeguarding, Partnerships and Policy	Tracy Pemberton
Hertfordshire Partnership Foundation NHS Trust	Head of Safer Care and Standards	Nicky Wilmott
University College Hospital London NHS Foundation Trust	Head of Safeguarding	Betsey Lau-Robinson
West Hertfordshire NHS Hospital Trust	Named Nurse for Safeguarding	Dawn Bailey

7.2 The panel maintained ongoing advisory and expert advice from specialist domestic abuse services via 'Refuge' that provide the Hertfordshire countywide IDVA Service. The service was consulted at the initial stages and asked to check records, as per standard local DHR practice. However, the

service confirmed that there had been no involvement with the parties involved in the case and chose not to continue to be involved as active Panel Members. The panel respected that decision and agreed to consult where necessary as the review progressed.

7.3 Following the decision to commission a review of the overview report, the following agencies were also involved. In particular, focus was made to ensure that specialists from the domestic abuse sector were able to input into the report.

7.4 The revised report review panel members were as follows.

AGENCY	JOB TITLE & ROLE	NAME
Refuge	Senior Operations Manager, IDVA Service	Louise Bayston
Hertfordshire Community NHS Trust	Named Nurse for Safeguarding Adults	Naomi Bignell
Clinical Commissioning Groups	Associate Director, Adult Safeguarding	Tracey Cooper
Hertfordshire County Council	Head of Adult Safeguarding	Keith Dodd
Hertfordshire County Council	Development Manager, DA	Katie Fulton
Hertsmere Borough Council	Community Safety Manager	Valerie Kane
Hertfordshire County Council	Contract & Monitoring Officer	Abbie Knowles
Children's Services, Hertfordshire	Head of Quality Assurance & Practice	Tendai Murowe
Clarion Housing	Services Manager, ASB	Grace Robertson
Spectrum CGL	Services Manager	Trudy Sealy
IDVA Service	Services Manager	Carrie Taylor
Hertfordshire Constabulary	Detective Chief Inspector	Graeme Walsingham
Dacorum Borough Council	Group Manager, Communities	Layna Warden
West Hertfordshire NHS Hospital Trust	Named Nurse for Safeguarding Adults	Dawn Bailey
Herts National Probation Service	Deputy Head of Service	Clare Griffiths
Hertfordshire Partnership Foundation NHS Trust	Interim Head of Social Work & Safeguarding	Karen Hastings
West Herts Hospital Trust	Palliative Care	Michelle Sorley
Dacorum Borough Council	Safeguarding Lead Officer	Sue Warren

8 CHAIR OF THE DHR PANEL AND AUTHOR OF THE OVERVIEW REPORT

8.1 The panel was chaired by Mr. Jeff Stack, Chief Executive of Broxbourne Borough Council. Ms. Carole McDougall, a management consultant, was appointed as the overview report writer; neither had previous knowledge of or management responsibility for the case and both are independent of the agencies with which Maria and David had contact.

8.2 Jeff Stack is the Chief Executive of Broxbourne Borough Council, and the Chairman of the Broxbourne Community Safety Partnership. Prior to this he was the Director of Community Services at Broxbourne having joined the Council in 2008.

8.3 Carole McDougall worked in the Probation Service for 30 years, most recently in Hertfordshire as an Assistant Chief Officer. Since 2007 she has worked independently and completed a variety of projects which have required interviews, scrutiny, and analysis of information, drawing conclusions, making recommendations, formulating action plans, and writing reports. She has been the overview report writer for 4 published DHRs in Hertfordshire.

8.4 Mary Mason chaired the second review. Mary is an independent freelance consultant and has never been employed by nor has she any connection with Hertfordshire County Council or Hertsmere

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.

9 PARALLEL REVIEWS

9.1 There are no other Safeguarding Reviews conducted in parallel to this review. Both local Safeguarding Boards were formally notified of the DHR on 3rd August 2017 and the Joint Safeguarding Board Business Manager consulted to ensure local criteria for conducting SARs and SCRs was fully understood and considered at the Panel's first meeting on 30th August 2017. Likewise, the DHR was considered by the SAR and SCR groups in line with local process.

9.2 The Coroner's Office was also formally notified on 3rd August 2017. As a result of the criminal proceedings being instituted on a charge of Manslaughter, and the subsequent sentencing, the coroner duly completed the Coronial investigation into the death of Maria.

9.3 Post Mortem Findings

Post-mortem findings include that there is no natural disease, that the most significant injury in relation to the cause of Maria's death is a wound in the right side of the upper neck, and that there were multiple defensive type injuries.

10 EQUALITY AND DIVERSITY

10.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

10.2 Of these, the panel recognised that David's depression and Maria's ethnicity in relation to access to support, may have contributed to the circumstances leading to Maria's death. The table below shows the E&D issues highlighted in this report.

Name	Sex	Age	Ethnicity	Disability and long-term medical conditions	Religion	Marital Status	Sexuality
Maria	F	70	Philippines	None	Catholic	Married to an ex-partner in the Philippines Partnered to David	Heterosexual

David	M	64	White British	Cancer Mental Health issues	Not Known	Partnered to Maria	Heterosexual

10.3 Ethnicity

Maria was Filipino and David white British. Maria came to the UK from the Philippines in 1971 when she was approximately 24 years old. She had previously been married and had no children from her first marriage and no children with David.

She came to England when the number of people from the Philippines in the UK was relatively low. In 2001 40,000 Filipino born people lived in the UK and in 2015 132,000.

In Hertfordshire the number of people from Black and Minoritised backgrounds is 20.2% of the population and slightly above the national average of 19.2% for England. In Hertsmere the numbers are slightly above the national average at 24.3% (Herts Insight: Welcome to Herts Insight | Herts Insight (hertfordshire.gov.uk). There is no data on the numbers of Filipino people in Hertfordshire and no specific community groups for East Asian and Southeast Asian people. There is also no organisation offering specific and targeted support to Black and minoritised victims/survivors. The need for dedicated support by and for Black and minoritised victims/survivors is well documented by IMKAAN, (About Policy Space — Imkaan) Women's Resource Centre (https://www.wrc.org.uk) and others. The cultural and faith aspects of migration and integration are different across communities and many women feel more secure if they can access support from people from their own background. Although the couple had friends, there was no one that Maria felt close enough to locally to discuss her fears, she did however call and spoke to her sister in the USA when she became frightened about David's behaviour.

Dedicated support with others sharing her ethnic and cultural identity might have led her to speak about her fears and saved her life.

10.4 As a woman, Maria was far more vulnerable to Domestic Abuse and Domestic Homicide. 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. 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). In addition, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).

10.6 Although there is no evidence of direct discrimination against Maria and/or against Maria and David, there are racialised stereotypes of Southeast and East Asian women which may have led to an assumption that she would care for David without the support she needed. There is in addition no evidence of her requesting this support, which may have been due to her own expectations of her role.

10.7 David was diagnosed with cancer in 2015. He refused chemotherapy and other medication offered to him and relied on an alternative diet to assist him. He also began to take medication which he obtained from the internet. It is not known whether this had an impact on his mental health, but he had a history of depression and possible side effects of depression include aggression.

11 BACKGROUND INFORMATION

11.1 Maria was born in the Philippines, into a family of 13 children. One of her brothers lives in Berkshire, a sister in the USA whilst the other siblings remain in the Philippines. It is understood that Maria had regular contact with her brother in the UK, either in person or by telephone. She also made frequent telephone calls to her sister in the USA, including in the days before she died.

11.2 Maria married in the Philippines, there were no children, and she left her husband and came to live in the UK in 1971. She subsequently became a British Citizen. First, she worked as a dinner lady, then as a hospital health care assistant. She met David in 1983 when they worked at the same hospital, David as a hospital porter, and they commenced a relationship the following year. They moved in together in 1997. During their investigation, Hertfordshire Constabulary were advised by family members that Maria and David appeared to love each other very much and were seldom seen or heard arguing. They were said to have a wide group of friends with whom they enjoyed socialising.

11.3 David was born in Cheshire one of 4 children. He has 2 older sisters, Patricia and Jean, both of whom live in the northwest of England. His younger sister, who had Down's Syndrome, had been suffering from cancer, and died in December 2017. David advised the assessing psychiatrists that he had a happy childhood, although he later reported four previous depressive episodes. He stated that he smoked cannabis and used alcohol excessively in his 20s and 30s but that this stopped when he was 40.

11.4 David ceased working in 2015 after he was diagnosed with prostate cancer. He did not accept the offer of conventional treatment due to his fear of chemotherapy and operations. He decided to try to manage the cancer with diet and exercise. Although there had been some friction between David and his sisters, he was in contact with them in the months prior to Maria's death. Patricia visited the couple late May 2017. She described them cooking her a lovely meal and said that David had driven her to the station. Earlier in 2017 Jean had stayed with Maria and David for a couple of nights. Both sisters said that their brother did not cope well with the cancer diagnosis, and that Maria had said he was prone to mood swings. Patricia confirmed that there was a history of depression within the family. She and Jean were not aware of any domestic abuse and were deeply shocked by events. Since his imprisonment they have written to David, and he has telephoned them.

11.5 In July 2017 David made a telephone call to Hertfordshire Constabulary to say that he had killed Maria. He was very distressed and tearful, and said that he had stabbed Maria and that he was the only other person in the property. He terminated the call, stating he needed to go to the toilet. When the police officers arrived, David opened the door and then slammed it on the officers. He was very agitated, came out and was detained. Maria was found dead in the bedroom. The knife was also found in the bedroom, and several religious statues had been placed around the bed where Maria lay.

11.6 The Hertfordshire Constabulary investigation revealed that a witness, staying in the property above, had heard screaming coming from Maria and David's address. He ran down and knocked on the door and David told him to go away. He checked again later and was told by David that everything was OK. This same neighbour reported having spoken to David and Maria previously. He thought David seemed "a bit fraught". Maria had told him that David was volatile and got angry easily because of his illness. She also had stated that he was behaving in a childish manner and "had gone back to being like a child".

11.7 After David had been arrested Cheshire Police contacted Hertfordshire Constabulary to advise they had heard from David's sister who lives in their area. She had informed them that David had telephoned her at 8.20 am to tell her that he had killed Maria. Cheshire Police asked her why she

had not contacted them as soon as she heard from him, and she said she had not known what to do.

11.8 On arrest David was found fit to be detained and remanded to Peterborough Prison. Whilst on remand in prison David was assessed by 2 psychiatrists, one for the Crown Prosecution Service (CPS), the other on behalf of David's defence. During interviews with the psychiatrists David has provided information which is included here due to its relevance to the DHR terms of reference.

11.9 David revealed four periods when he had suffered depression, the first when his mother died in 1975, the second in1980s when he said his father's depression also affected him, and the third was four or five years ago, for which he could not provide a trigger. Finally, he became depressed when he was diagnosed with prostate cancer and felt his condition was worsening. He recalled that he was moody, and that Maria would call him "Mr. Grumpy". He said he had abdominal pain and was having to go to the toilet frequently. His appetite was affected, and he lost a substantial amount of weight. He saw a dietician but said that the diet he was advised to follow seemed to make things worse. His sleep was disturbed, and he was prescribed sleeping tablets which he considered helped to some degree. David said he could not recall being offered counselling and said he did not take up any offer. He said he had not found his GP helpful as sometimes he could not get an appointment with him and had to see a different GP.

11.10 David stated that about 6 weeks before the killing, Maria had asked him how he was feeling, and he had replied that he was in pain. He was beginning to exhibit signs of depression and some paranoia. He felt that Maria had responded negatively to her question about pain and began to worry that she might leave him. Maria was speaking regularly to her sister in Florida for support and David felt that Maria was 'plotting' to go and live there. He stated that this was on his mind all the time.

11.11 Three or four days prior to killing Maria, David said he had strong thoughts of killing himself. He had looked at himself in the mirror and saw that he was wasting away, but when he looked at Maria, he would feel a bit of hope. Following Maria's death, when interviewed by psychiatrists, David described having a fleeting thought of killing Maria at this point.

11.12 During the police investigation, Maria's sister in Florida advised that Maria had spoken to her two days before her death. She had spoken about David "acting crazy" and that he wanted to kill himself. Maria also spoke to her sister about David wanting her to go to America and of her fear that "something will happen to *me* [Maria] tonight".

11.13 David recalled that the day before the killing was not unusual. As far as he can remember he and Maria had not argued about anything, nor was there any friction between them. He slept in the lounge, as a new neighbour had moved into the flat above and was making a lot of noise which could be heard in the bedroom. He had not drunk any alcohol or taken any drugs apart from ½ Zopiclone. He awoke the following morning, went to the toilet, spoke to Maria briefly, and then dozed until 6.55 am. He said he went to the kitchen to get a knife, deciding that he would kill Maria. He had it in his mind that she was going to leave him, and he did not want that to happen.

11.14 The psychiatric assessments completed whilst David was on remand in prison concluded that following the diagnosis of prostate cancer, and because of his physical symptoms, namely pain and weight loss, David developed symptoms of depression and anxiety, which deteriorated after a course of antibiotics, in March 2017, which caused abdominal side effects and significant weight loss. In the weeks prior to the killing, David was said to be feeling depressed and hopeless, his appetite and sleep were disturbed, and he felt convinced that Maria was going to leave him. The assessments concluded that David was suffering from a depressive illness of at least moderate severity, and that his abnormality of mental functioning substantially impaired his ability to form a rational judgement and exercise self-control. As he was not intoxicated, and aggression was absent as part of his personality, it was concluded that the abnormality of mental functioning provided an explanation for his conduct at the time of the killing. The psychiatric assessments stated that the defence to murder or manslaughter, on the grounds of diminished responsibility, was available.

11.15 On 1 December 2017 David pleaded guilty to manslaughter on the grounds of diminished responsibility. This plea was accepted by the Crown Prosecution Service and sentence adjourned.

11.16 On 12 December 2017 David was transferred to a medium secure psychiatric clinic under section 48/49 of the Mental Health Act. The psychiatrist who assessed him at the clinic reported that David had attempted to kill himself in prison and had been placed on constant observations as a result; and an assessment to determine if he had a mental disorder was required. This assessment noted that David had made two more suicide attempts whilst resident at the clinic but concluded that David was not suffering from a diagnosable mental health condition at the time, and that ongoing hospital treatment was not necessary.

11.17 On 19 April 2018 David was sentenced to 5 years imprisonment. In sentencing him the Judge stated that he had considered that David's life expectancy was 2- 5 years, and that "It may be beneficial for you to be detained in a prison where psychological help can be provided to you to address your guilt and thereby reduce risk of self-harm."

12 CHRONOLOGY - SUMMARY

12.1 This section of the report provides a summary of the key contacts and interaction Maria and David had with the agencies, during the period covered by the review. These contacts are largely connected and interconnected, either directly or indirectly, to the health needs of David and as subsequent they are predominantly associated with Health Care and housing providers; all of whom were fully engaged with the DHR throughout.

Please note
We have revised and shortened this section in the review, highlighting important events and have added the original chronology to the appendix.

Date	Event
June - Aug 2015	David was found by his GP to have a raised marker for prostate cancer. He was referred to University College Hospital, London.
Sep-15	David discloses anxiety to GP; prescribed anti-depressant & referred to Improving Access for Psychological Therapies (IAPT). David doesn't make an appointment with IAPT.
20/10/2015	David starts cancer treatment of 'active surveillance' following declining conventional treatment
14/12/2015	David refers himself to the Single Point of Access (SPA) of Hertfordshire Partnership Foundation NHS Trust (HPFT). He reported anxiety having recently been diagnosed with prostate cancer. Following this an initial assessment with the wellbeing team is scheduled for 25 January 2016
08/01/2016	David was seen by his GP when he said his anxiety had lessened and he was no longer taking the antidepressant medication.
11/01/2016	David written to by wellbeing team confirming that he had telephoned and asked to be discharged from their service. They advised him he could re-refer himself.
Various 2016	David receives treatment for various physical health matters, including erectile dysfunction, prostate cancer review, diarrhoea & diverticulitis
Various 2016	Maria also seen by GP and hospital for three matters; no significant outcomes stem from these
March - April 2017	David was seen on several occasions by his or a colleague GP, due to difficulty urinating and with abdominal pain. The GP considered him to be anxious and prescribed Zopiclone to help him sleep. He also referred him to the Specialist Palliative Care Team.

28/4/2017	Hertfordshire Community NHS Trust (HCT) recorded receipt of a referral from David's GP. The request was for psychological support; Maria was named in the referral also. The same day a member of staff telephoned him and planned for a specialist palliative care nurse to visit him on 5 May 2017.
5/5/2017	HCT palliative care nurse visited David; Maria was also present. David described being anxious as his condition seemed to be deteriorating. He was not due to see the oncologist at UCLH for another 3 months, which concerned him, and the nurse arranged for the appointment to be brought forward. Referrals and support were offered around finances and physical health. The nurse noted that David and Maria chatted freely, they seemed to have a good partnership and were supportive of each other. It is not clear if the nurse spoke separately to Maria or to David.
10/05/2017	UCLH recorded follow up review of David's prostate cancer.
12/05/2017	HCT palliative care nurse visited David; Maria was present again. The nurse noted that David seemed brighter. He said that the oncologist had told him the disease had not spread. He said he was taking paracetamol for pain and Zopiclone to help him sleep. The nurse explained she would be discharging them from her caseload as their situation was settled but they were both free to self-refer if things changed. Again, it is not clear if the nurse spoke to them separately.
Various May 2017	David & Maria call Affinity Sutton Housing requesting move to bungalow (this put in motion), and assistance maintaining garden (this was declined due to ineligibility)
07/06/2017	Affinity Sutton Housing received a letter from Maria and David to say that their neighbour upstairs had moved out and they asked if the flat could be let to someone who was kind and considerate. A staff member contacted them to advise that it would not be possible to dictate who the new neighbour is but if there are any issues, they will resolve them.
13/06/2017	David attended a follow up for prostate cancer at UCLH. It was noted that he was not experiencing pain but some irritative symptoms during urination and ejaculation.
22/06/2017	HCT senior dietician visited David following a referral from the palliative care nurse. Maria was present during the visit. David had been researching to find positive things for his diet and was willing to change anything as he was so worried about his weight. He had been maintaining exercise. At this time David was 9 stone 7 pounds, and the dietician helped him to develop a plan for gaining weight. The dietician noted that David and Maria interacted well and there was nothing to raise her concern. Again, 0000did not speak to either separately?
10/07/2017	David was seen by a GP for a review of diverticulitis. He mentioned some sleeping difficulties and that he was using Zopiclone intermittently. He was not thought to be particularly anxious at this consultation.
18/07/2017	David was seen by a GP when he requested a repeat blood test for his prostate cancer; no anxiety symptoms were noted. He was prescribed Zopiclone as he complained of insomnia.
Jul-17	David killed Maria at their home.

13 OVERVIEW

13.1 Maria and David had lived together in Hertfordshire for 20 years. They had limited contact with agencies and there were no reports of domestic abuse. David had a history of experiencing depression on and off throughout his life.

13.1 Following a diagnosis of prostate cancer in 2015, David had frequent contact with his GP practice. Maria was registered with the same practice and attended on a relatively small number of occasions for physical ailments.

13.2 David's GP referred him to UCLH, to see a cancer specialist. After the initial diagnosis David was offered conventional treatment but decided against it. UCLH staff saw him to monitor his condition.

13.3 David was also referred on several occasions for various kinds of psychological, therapeutic, and practical support during 2015 & 2016. David did not take this up until April 2017, when David's GP referred him for end-of-life care. The palliative care nurse met with David and Maria on two occasions and referred David to a dietician who met David and Maria on one occasion. The palliative care nurse also gave David some other practical support and discharged David from her caseload in May 2017. There was no evidence of DA or disagreement noted between the couple who appeared to be getting on well. However, there is no evidence the nurse or dietician speaking to David & Maria separately.

13.4 Maria and David lived in a flat rented from Affinity Sutton Housing. The tenancy was in Maria's name only. In the months leading up to Maria's death the couple asked about a transfer to a bungalow, and David applied to be included on the tenancy. In May 2017 David asked for help with maintaining the garden; he said he had cancer and was no longer able to do the garden. They were advised that they were not eligible for assistance, providing advice about possible use of any benefits being received.

13.5 A few days before her death, Maria had expressed to David's sister that David was 'acting crazy' and he wanted to kill himself. David himself expressed thoughts of wanting to end his life to the psychologist following arrest, and he also expressed concerns about his and Maria's relationship in the six or so weeks prior to her death. She also spoke to her sister about her concerns about David's behaviour and told her she felt unsafe.

14 ANALYSIS

14.1 The panel has considered, from the evidence available, the questions raised in the DHR Terms of Reference and Key Lines of Enquiry.

- *How effective agencies were in identifying the health and social care needs of both Maria and David and providing support,*
- *Were there any barriers to seeking support? What were they? How can these be overcome? and*
- *What was the impact of David's cancer diagnosis on his mental wellbeing and did this influence Maria and David's relationship?*

14.2 Maria did not have any significant health needs.

14.3 In 2015 David was referred to UCLH by his GP after which a diagnosis of prostate cancer was confirmed. David was offered conventional treatment, but he decided against this. He was then monitored through appointments with an oncologist at UCLH.

14.4 The GP noted in September 2015 that David had developed some anxiety symptoms whilst he awaited the prostate diagnosis. The GP prescribed an antidepressant and referred him for psychological therapies with IAPT. David decided that he did not want to pursue the therapy.

14.5 Three months later David referred himself to HPFT and they responded promptly by allocating his case to the Wellbeing team. He was spoken to by telephone when it was noted that he was anxious due to the cancer diagnosis. He was given some contact details for the Wellbeing team, and mental health helpline; and an appointment was made for him to have an assessment by telephone the

next month, January 2016. He subsequently decided not to go ahead with this and reported to the GP that he was feeling less anxious and had stopped taking the antidepressant.

14.6 Had David progressed the contact with either IAPT or the Wellbeing team there *may* have been opportunities for Maria to engage with the services offered.

14.7 When David saw the GP for a review in April 2017, he said he had been using a friend's sleeping tablets, Zopiclone, to help him sleep. The GP noted he seemed anxious and prescribed him Zopiclone. He also made a referral to the palliative care team.

14.9 The palliative care team made prompt contact with David and a nurse made two visits to David and Maria to assess needs and give assistance and advice following David's terminal diagnosis. The nurse evidently provided support to David. At that stage she considered her intervention was no longer needed but she told David and Maria that they could self-refer at any time if things changed or if they felt they needed support or advice they could contact the duty nurse.

14.10 One of the Key Lines of Enquiry in the DHR is to ask if a carer's/agency assessment was completed. The palliative care nurse and dietician made their own assessments to provide advice, principally to David. At that stage a carer's assessment would not have been expected for Maria because David was still mobile and relatively active. Had the assessment been needed a referral to Adult Social Care could have been made. It is not clear whether any consideration was made of the intense pressure Maria would have been under and whether any support was offered to her individually or whether she was counselled about dealing with the stress she faced.

14.11 David was reviewed by a GP on 10 and 18 July 2017. At the earlier appointment he mentioned using Zopiclone intermittently, to help him sleep. No anxiety symptoms were recorded.

14.12 Although David's GP noted that the British National Formulary, produced by the British Medical Association, records that Zopiclone has been associated with an increase in hostility and aggression, we have not been able to find a reference for this and information provided by BNF on Zopiclone side effects does not mention hostility or aggression although they list hallucinations, depression and delusions as rare but serious side effects of Zopiclone. However, Sanofi-Aventis New Zealand Ltd. reports aggression as a side effect of Zopiclone. The GP also noted that although David seemed a little bit anxious during consultations, there were no signs of aggression or volatile behaviour. Although Maria had told neighbours that David was behaving in a childish manner and was volatile, becoming angry easily due to his illness. She also told her sister of her fear of David in the days before her death. David killed Maria by repeatedly stabbing her, exhibiting highly aggressive behaviour.

14.13 Maria and David were residents of a flat rented from Affinity Sutton Housing for 20 years. There were no concerns in respect of the tenancy, which was in Maria's name.

14.14 During the DHR timeframe, there were 19 contacts with the housing provider which were associated with general repairs and maintenance (leaking taps/sticking door), support to maintain the garden and a request for transfer. Fourteen of these contacts were over a four-week period May/June 2017 and centred on the need to move due to health and neighbour issues.

14.15 During this time David asked about moving to a bungalow. When he was advised any requests would need to be made by Maria as he was not the tenant, Maria gave permission for him to speak on her behalf. Affinity accepted the request for a transfer and allocated an additional 30 housing points, towards this. Maria and David subsequently sent a letter, which they both signed, requesting that when a new neighbour was allocated to the flat above, that the tenant could be kind and considerate. Affinity acknowledged this and advised they could not dictate who the neighbour would be but offered to resolve any issues if they arose.

14.16 David asked for help with maintaining the garden; he said he had cancer and was no longer able to do the garden. In line with their policy Affinity advised that they were not eligible for assistance but did not appear to carry out a welfare check to see how they were managing following David's

diagnosis. This is particularly relevant given Maria's background and possible lack of knowledge of systems in the UK and what support she might be able to expect.

14.17 David was admitted to West Hertfordshire Hospital on one occasion in July 2016 as he had been suffering from diarrhoea. His health needs were met as he was referred urgently to the gastroenterology team and subsequently scanned, chest, abdomen, and pelvis due to weight loss; and no sinister pathology was found. He was diagnosed with diverticulitis and dietary treatment was suggested. No social care concerns were noted.

14.18 Following a referral from the GP, Maria had a specialist appointment at West Hertfordshire Hospital in December 2016, for investigation of thyroid goitre. This was found not to be sinister and follow up was not required.

14.19 As identified in preceding paragraphs the presenting concern was David's health after he had been diagnosed with prostate cancer. The DHR panel found that agencies responded appropriately to help David manage his physical symptoms.

14.20 The GP particularly acknowledged that there were emotional, psychological, and spiritual implications for Maria – but there is no record of support in place for Maria and no evidence of an assessment of her support needs and a support plan being put in place. The GP encouraged David towards IAPT at an early stage. When David's symptoms worsened the GP referred David and Maria to the palliative care team. The nurse and dietician provided practical advice and support but did not speak to them separately to check if they were coping individually and together.

14.21 Organisations that help cancer sufferers and their families are clear that a cancer diagnosis can make relationships stronger or cause extra strain. Talking about cancer is challenging and even couples who typically communicate well may have trouble talking about cancer because it involves intense emotions. Discussing a cancer diagnosis also involves topics that couples may not wish to discuss. This includes sexual problems, physical limitations, financial worries, and the possibility of death.

14.22 Although the agencies in contact with David and Maria were not aware of any obvious tension, information has come to light, as part of the police investigation into Maria's death, which suggests there was. This has re-enforced the need for agencies in contact with cancer sufferers and those receiving palliative care to acknowledge the problems they and their carers/partners could face together and provide opportunities for support and guidance both separately and together, and where needed, safeguarding.

14.23 There is evidence of inter-agency practice in promoting David's health and his well-being: that:

a) The GP made referrals to UCLH and WHHT; the hospitals in turn informed the GP about outcomes, as a result of which David received diagnosis and advice about treatment.
b) The GP encouraged David to take up psychological therapies through IAPT. David made a self-referral to the HPFT Wellbeing team, and when he decided not to pursue this, the team informed the GP. The GP made a referral to the Palliative Care Team for support for David and Maria, and following two meetings with them both, the nurse provided feedback on the outcome to the GP. The nurse made a referral to the dietician who also provided feedback.

14.24 David had initiated support around his mental health and wellbeing on at least two occasions, but then did not follow up these referrals. Had David progressed the contact with either IAPT or the Wellbeing team he may have had oversight from Mental Health professionals who could have picked up on his increased anxiety in July 2017. It is not known why these offers were not taken up by David.

14.25 None of the agencies had identified any indicators of potential domestic abuse. Additionally, from the information seen, none of the agencies missed any significant risk factors that would have suggested domestic abuse was occurring although there were no individual meetings with Maria, and she had no opportunity to raise any of her concerns about David or to learn about the changes which might take place to his mental as well as physical health.

14.26 Multiple health professionals involved in the case noted that they observed no concerns regarding the couple's relationship. However, there is no record of Maria being asked separately about any concerns she had or any changed behaviour. This may have led to a disclosure about his mood changes or helped Maria to understand that the increased tension was something she could ask for help with.

15 CONCLUSIONS

15.1 Maria and David had been together for over 30 years and according to friends and family interviewed for the investigation into Maria's death, they appeared to be a loving couple. There had been no known disclosures of domestic abuse.

15.2 Maria and David had limited contact with agencies, and most of what there was resulted from David's ill health which was diagnosed October 2015.

15.3 Following this diagnosis David was offered support through IAPT and HPFT's Wellbeing team but chose not to progress this. When the symptoms had worsened in April 2017 the GP recognised that Maria and David would benefit from emotional and psychological help and made a referral to the Palliative Care Team. The nurse saw them together twice in May 2017, and the dietician saw them once in June 2017, only a few weeks before Maria was killed. Neither observed any concerns about the relationship between Maria and David, or David's behaviour towards Maria. However, there is no record of her meeting separately with them. The nurse left the door open to both Maria and David to contact her if they had any concerns but neither Maria nor David made further contact.

15.4 When David was diagnosed with prostate cancer, he was understandably anxious. Although not evident to agencies at the time, information which has come to light subsequently confirms that David was depressed and there was tension between David and Maria in the last few weeks of her life. David has stated that Maria had suggested she may leave him. Two days before she was killed Maria had told her sister that David was "acting crazy". When Maria spoke about visiting her sister in Florida, David was convinced she was preparing to leave him, and this belief at least in part precipitated the violent act.

15.5 After David had been told of his terminal diagnosis his behaviour appears to have changed. He was referred to the palliative care team by his GP. The palliative care team prepares and assists those who have received a terminal diagnosis. It is recognised that a terminal diagnosis can significantly increase the tension and stress between the patient and carer. This increased tension was recognised by both David and Maria. They had been told they could reach the Team for support but neither did so. This may be because they were unaware that the increased tensions between them were usual in the circumstances. The need for individual and separate assessments for both partners and a discussion about changes which might take place and when to reach out for support might have helped them to individually reach out for support from professionals.

15.5 David was taking zopiclone to help him sleep and it is not known whether he or Maria were aware of possible serious side effects.

15.6 David became more and more depressed and anxious about his physical condition over time. He experienced some suicidal ideation and admitted to fleeting thoughts of killing Maria. He also had concerns that Maria would leave him. In addition, Maria spoke to both a neighbour and her sister in America, about her concerns about David's behaviour. In *In Control: Dangerous Relationships and How They End in Murder (2021)* Dr Jayne Monckton Smith refers to the patterns of behaviour of perpetrators in Domestic Homicide. The separation, or perception of a separation, of partners is a significant motivator for many men who kill their partners.

APPENDIX 1 – FULL CHRONOLOGY

16.1 **12/01/2015** Maria attended the GP when high blood pressure was noted; there was no significant outcome recorded.

16.2 **June – August 2015** David was found by his GP to have a raised marker for prostate cancer. He was referred to University College Hospital, London (UCHL) where he had a magnetic resonance imaging (MRI), bone scan and biopsy.

16.3 **15/08/2015** Maria was seen by her GP, with thyroid swelling; there was no significant outcome following a blood test.

16.4 **04 & 21/09/2015** David was seen by his GP when he had developed some anxiety symptoms resulting from the news about the raised marker for prostate cancer. The GP prescribed an anti-depressant and referred him to the Improving Access for Psychological Therapies (IAPT) team. David declined to make an appointment with IAPT.

16.5 **20/10/2015** David was seen by his GP after UCHL had confirmed the prostate cancer diagnosis. The plan was for active surveillance of his condition as he did not want conventional treatment.

16.6 **24/10/2015** David contacted Affinity Sutton Housing to report that a repair was needed at the property shared with Maria; and the repair was completed.

16.7 **14/12/2015** David referred himself to the Single Point of Access (SPA) of Hertfordshire Partnership Foundation NHS Trust (HPFT). He reported anxiety having recently been diagnosed with prostate cancer. 3 days later the SPA sent a letter to David, copied to his GP, informing him that his case had been forwarded on to the local Wellbeing team. On the same day an administrator from the Wellbeing team telephoned David and arranged for a practitioner to telephone him on 25 January 2016, to complete an initial assessment.

16.8 **08/01/2016** David was seen by his GP when he said his anxiety had lessened and he was no longer taking the antidepressant medication.

16.9 **11/01/2016** HPFT Wellbeing team wrote to David, copied to his GP, to confirm that he had telephoned and asked to be discharged from their service. They advised him he could re-refer himself.

16.10 **12/01/2016** UCLH recorded that patient David required treatment.

16.11 **January – April 2016** Maria was seen by her GP on 2 occasions, in respect of blood pressure and a cough, and David was seen once for a viral illness; there was no significant outcome recorded.

16.12 **18/05/2016** David saw his GP and reported erectile dysfunction; the GP recorded that David's tumour markers for prostate cancer had risen and that David was under review at UCHL.

16.13 **19/07/2016** David was seen by his GP, suffering from diarrhoea.

16.14 **21/07/2016** David was admitted to West Hertfordshire Hospital Trust (WHHT) having suffered from diarrhoea for 3-4 days. He told hospital staff he is on a special diet and eating a lot of fibre, due to the cancer diagnosis. David was observed and had blood tests and electrocardiography (ECG) He was discharged as the diarrhoea had stopped.

16.15 **25/09/2016** Following further referrals to WHHT from the GP, in respect of problems with his bowel, David was diagnosed with diverticulitis; suggested treatment was dietary.

16.16 **26/09/2016** Maria was seen by her GP in respect of a thyroid nodule; a referral was made to WHHT and she had a consultation with an endocrinologist on 02/12/2016. There were no sinister lesions and follow up was not required.

16.17 **18/10/2016** David attended UCLH for a review of his prostate cancer.

16.18 **01/03/2017** Maria was seen at the GP surgery for a blood pressure check; no significant outcome was recorded.

16.19 **March and April 2017** David was seen on several occasions by his or a colleague GP, due to difficulty urinating and with abdominal pain. The GP considered him to be anxious and prescribed Zopiclone to help him sleep. He also referred him to the Specialist Palliative Care Team.

16.20 **28/04/2017** Hertfordshire Community NHS Trust (HCT) recorded receipt of a referral from David's GP. The request was for emotional, psychological and spiritual support for the patient and his family and carer; Maria was named in the referral. The same day a member of staff telephoned him and planned for a specialist palliative care nurse to visit him on 5 May 2017.

16.21 **05/05/2017** HCT palliative care nurse visited David; Maria was also present. David described being anxious as his condition seemed to be deteriorating. He had gone to see the GP because he was in pain and was prescribed antibiotics for a urinary infection. He said these made him feel unwell and he had lost weight. He was not due to see the oncologist at UCLH for another 3 months, which concerned him, and the nurse arranged for the appointment to be brought forward. He had told her he did not need transport and could make his own way there with a friend.

16.22 Following this meeting the nurse referred David to a community dietician due to him suffering weight loss and suffering from diverticulitis. She also ordered a pressure cushion for him, to aid his comfort. In addition, she supported a financial referral for personal independence payments (PIP). The nurse noted that David and Maria chatted freely, they seemed to have a good partnership and were supportive of each other.

16.23 **10/05/2017** UCLH recorded follow up review of David's prostate cancer.

16.24 **12/05/2017** HCT palliative care nurse visited David; Maria was present again. The nurse noted that David seemed brighter. He said that the oncologist had told him the disease had not spread and is still contained in the prostate. He said he was taking paracetamol for pain and Zopiclone to help him sleep. He did not refer to any other medication. The nurse explained she would be discharging them from her caseload as their situation was settled but they were both free to self-refer if things changed.

16.25 **22/05/2017** David telephoned Affinity Sutton Housing and asked to speak with a neighbourhood housing officer (NHO)**.** He was advised this would not be possible as he is not the tenant. The following day Maria telephoned Affinity Housing and gave permission for staff to speak with David. She said she wanted to move to a bungalow and followed this up in writing.

16.26 **26/05/2017** David called into Affinity Sutton Housing offices. He advised he has been living at the property since 1997 and asked to be added to the household. On the same day Maria telephoned and gave permission for the member of staff to talk to David. He asked for help with maintaining the

garden but was advised he is ineligible. 4 days later a member of the housing options team sent a letter to Maria asking for proof of address for David. He responded by e-mail the following day.

16.27 **01/06/2017** Affinity Sutton Housing wrote to Maria to advise she has been added to the transfer list.

16.28 **07/06/2017** Affinity Sutton Housing received a letter from Maria and David to say that their neighbour upstairs had moved out and they asked if the flat could be let to someone who was kind and considerate. A staff member contacted them to advise that it would not be possible to dictate who the new neighbour is but if there are any issues they will resolve.

16.29 **13/06/2017** David attended a follow up for prostate cancer at UCLH. It was noted that he was not experiencing pain but some irritative symptoms during urination and ejaculation, and that considering that his prostate specific antigen (PSA) fluctuates significantly, he may be suffering on a regular basis from prostatic inflammation.

16.30 **22/06/2017** HCT senior dietician visited David following a referral from the palliative care nurse. Maria was present during the visit. David had been researching to find positive things for his diet and was willing to change anything as he was so worried about his weight. He had been maintaining exercise including practising Tai chi in the garden. At this time David was 9 stone 7 pounds, and the dietician helped him to develop a plan for gaining weight. The dietician noted that David and Maria interacted well and there was nothing to raise her concern.

16.31 **10/07/2017** David was seen by a GP for a review of diverticulitis. He mentioned some sleeping difficulties and that he was using Zopiclone intermittently. He was not thought to be particularly anxious at this consultation.

16.32 **18/07/2017** David was seen by a GP when he requested a repeat blood test for his prostate cancer; no anxiety symptoms were noted. He was prescribed Zopiclone as he complained of insomnia.

16.33 **July 2017** David killed Maria at their home.

APPENDIX 2 - LEARNING PAPER THEMES ARISING FROM THIS REVIEW:

17.1 The delay in finalising this report has given Hertfordshire Local Authority the possibility of establishing how some of the agencies have updated their practice since the original report was written.

17.3 In addition, it is noted that the 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 that is attached to this report. The aim of the paper is to further improve practice in Hertfordshire for victims of domestic abuse. Themes that have been taken (and expanded further) from this DHR are as follows:

17.4 **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.

17.5 **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.

17.6 **Equality and Diversity**: The potential for isolation of victims from Black and Minoritised backgrounds is high especially where there are no close family members and where they might be fearful of or unaware of support they may be able to obtain from agencies.

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

17.7 **Perpetrator behaviour:** as seen above, primarily the perpetrator was interacting with professionals. In cases such as these, it is important for 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.

17.8 **Palliative Care:** Where treatment for a potentially terminal illness is refused both parties need continual support and information about what might happen and how to access support. This includes dealing with the changes which are taking place and the possibility of increased stress and tension especially for those in the same household. A referral should always be made to ASC.

APPENDIX 3 – ABBREVIATIONS

ASC	Adult Social Care
AAFDA	Advocacy After Fatal Domestic Abuse
CPS	Crown Prosecution Service
ECG	Electrocardiography
HCT	Hertfordshire Community NHS Trust
HDAPB	Hertfordshire Domestic Abuse Partnership Board
HPFT	Hertfordshire Partnership Foundation University NHS Trust

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

IAPT	Improved Access to Psychological Therapies
IMR	Individual Management Review
NHO	Neighbourhood Housing Officer, Affinity Sutton Housing
PIP	Personal Independence Payment
PSA	Prostate Specific Antigen
SPA	Single Point of Access (HPFT)
UCHL	University College Hospital London
WHHT	West Hertfordshire Hospital NHS Trust

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.

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

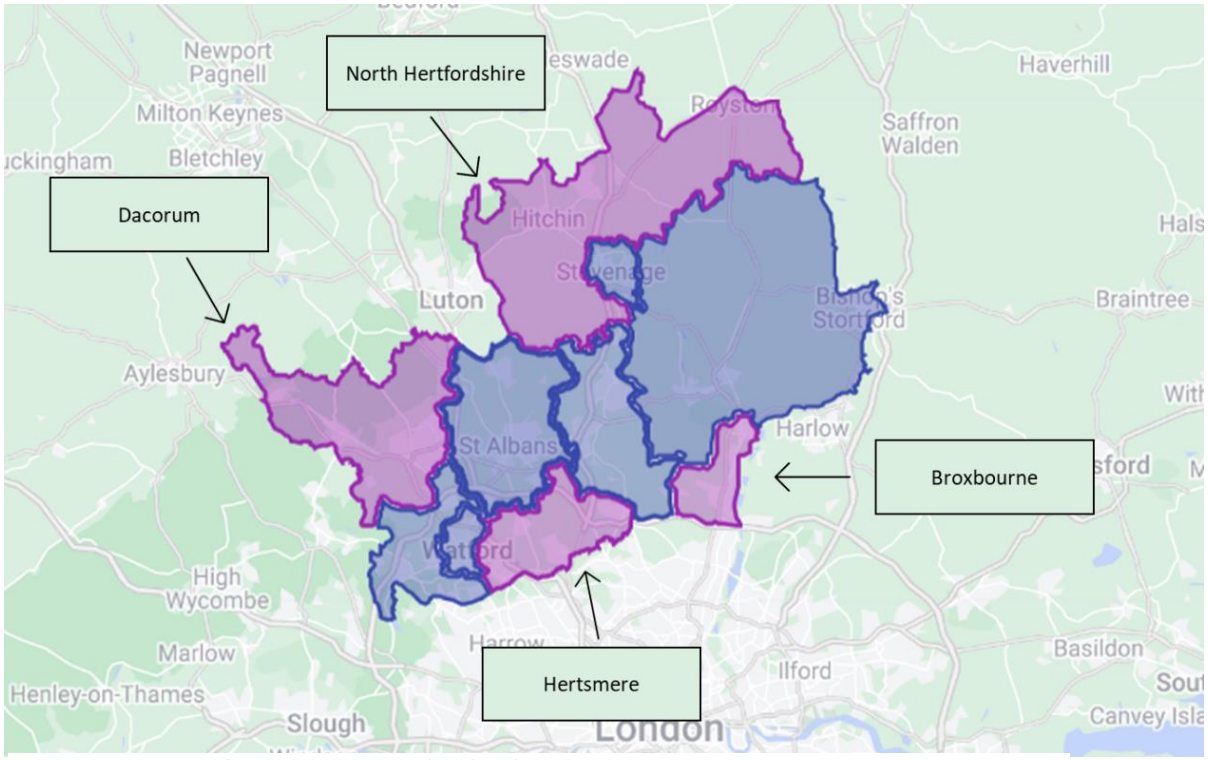

Figure 1 - CSP areas whose DHRs are considered in this paper.

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.[4] 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'.[5]

1.4 The Domestic Abuse Act (2021)[6] 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[7], 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.

[4] 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

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

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

[7] 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	29 July 2019

					2nd submission August 2023	
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* 2nd submission: 17 June 2019*	1st return: Unknown 2nd return: 22 January 2020

**Estimated due to gaps in records*

1.6 Coercive Control [8] became a criminal offence in December 2015[9] 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.[10] 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[11] 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
- Too few recommendations

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

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

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

- 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[12] 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[13] 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

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

[13] Pragna Patel 'Intersectionality' Appendix 2 below

	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.

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[14] 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.

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

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).

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

Agency	Expertise	Contact name	Role
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
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

Agency	Expertise	Contact name	Role
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
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

Agency	Expertise	Contact name	Role
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

10.1Amy, 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[15], strangulation, and the traumatic impact of abuse. The importance of avoiding victim blaming which deters reporting and the use of services by the survivor.

[15] 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[16] 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	

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

Mental Health diagnosed	Four cases where the victim had mental health issues, including: - Anxiety - Depression - PTSD	Two cases where perpetrator had mental health issues, including depression.	
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.[17]

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.'

[17] Respect Toolkit for work with male victims of domestic abuse | Respect

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[18] 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 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.

[18] Intersectionality: Pragna Patel Appendix 2

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+. [19]

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.

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[20] 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

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

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

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[21] 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.[22]

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.[23]

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,

[21] Surviving Economic Abuse: Transforming responses to economic abuse
[22] Websdale, N. (1999). Understanding domestic homicide. Boston, MA: Northeastern University Press.
[23] Resources library | Solace (solacewomensaid.org)

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) [24] 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.[25] 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.

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

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.

[24] Judith Herman Trauma and Recovery 2015.

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.'* [26]

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 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.

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

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[27] 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.

14.6 There were two cases of cross allegations of abuse which led to the risk from the perpetrator not being fully recognised. Respect[28] 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.

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

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

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[29] 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.'

15. Risk and need: a strengths-based approach to working with multiple disadvantage[30]

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

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

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

more complex due to the fact that it is planned yet unpredictable and takes place in the context of a relationship.'[31]

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[32] 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[33] 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, 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,

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

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

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

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[34] 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

[34] Domestic Homicide Reviews — Standing Together

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?

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 & planni		x	x	x	x		4

ng and research							
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).

Appendix – Home Office Feedback Letter

Home Office

Interpersonal Abuse Unit 2 Marsham Street London

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

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

						 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.		