REPORT INTO THE DEATH OF J

Report produced by Welwyn Hatfield Community Safety Partnership
Approved for Publication – August 2016

CONTENTS **PAGES**

FOREWORD

This is the report of the Domestic Homicide Review that followed the tragic death of J, a resident of Hertfordshire who was killed as a result of domestic abuse by her husband in June 2014. (The name J is a pseudonym agreed for the purposes of this document in which all names have been replaced by letters to protect the identities of those involved.)

Our deepest condolences are sent to the family of J, and our grateful thanks for their helpful participation in the review.

Any domestic homicide is one too many. The key purpose in undertaking Domestic Homicide Reviews (DHR) is to enable lessons to be learned where a person is killed as a result of domestic abuse. When I was asked to chair the Independent Panel that was set up to conduct this review, I made clear that I wanted it to be conducted in the spirit of learning, not blame, so that we minimise the chances of such tragedies happening again in the future. The review encountered many examples of dedicated professionals working tirelessly in the community to tackle the challenge of domestic abuse. I am grateful for the co-operation, commitment and openness of these staff, and their senior colleagues who were represented on the Panel, all of whom were committed to examining their practice and making improvements.

We should not lose sight of the fact that the responsibility for this tragedy lies with the person who committed the murder. The review concluded that based on the information available to the agencies at the time, it could not have been predicted that J would have been killed by her husband.

However the review has looked in detail at what happened, how different agencies were involved and, most importantly, what needs to change. The report makes some recommendations specific to individual agencies, but also some general recommendations for all involved in tackling the challenge of domestic abuse. Particular themes relate to the need to improve the way in which risks are assessed, support to families is co-ordinated, information and training are shared and disseminated and capacity is matched to workload. The Panel took care to make these recommendations pragmatic and easy to implement, and I hope the Welwyn and Hatfield Community Safety Partnership, who take responsibility for overseeing the delivery of this Action Plan, will be able to make rapid progress.

Finally, I am aware that some of these themes are not new, and have also emerged from previous Domestic Homicide Reviews, and from a recent Hertfordshire wide review carried out by CAADA (Co-ordinated Action Against Domestic Abuse), now renamed Safelives. There is clearly a need for some focused leadership, across all public sector agencies in Hertfordshire, to ensure that work to improve the way domestic abuse is tackled is given the priority it deserves.

James Blake
Independent Chair, Domestic Homicide Review Panel
July 2016

EXECUTIVE SUMMARY

1 Key Facts

- J was murdered in June 2014.
- Her husband, B, pleaded guilty to the murder in December 2014, and was sentenced to life imprisonment, to serve a minimum of 13 ½ years.
- The couple had 3 children aged between 3 and 13 years.
- Prior to J's death there had been 7 reports to police about domestic abuse, one in 2004 when the family lived in London, the others between August 2012 and April 2014.
- Two of the incidents resulted in charges. The first, in 2004, which did not proceed before the courts when J withdrew her complaint, and the second, in April 2014, when B was charged with assault; he was remanded on bail from the courts, pending trial, at the time he killed J.

2 The review process

2.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) and this provision came into force on 13 April 2011. The legal duty under the act lies with the Community Safety Partnership to conduct a review in the area where the victim was resident, in this case Welwyn Hatfield. Until recently the county's Domestic Violence Strategic Programme Board facilitated the DHR process. However the multi-agency governance structure for tackling domestic abuse within Hertfordshire has now changed and the Hertfordshire Domestic Abuse Partnership facilitates the DHR process through a dedicated DHR Sub-Group.

2.2 Following J's death a Domestic Homicide Review has been undertaken by an independent Domestic Homicide Review Panel, on behalf of Welwyn Hatfield Community Safety Partnership. This review was commenced on 2 July 2014 and completed in July 2016. In approving the review the Home Office Quality Assurance Panel stated that there were some issues which would benefit from further consideration and clarification and these have now been addressed.

2.3 The following agencies participated in the review by providing information about their contact with J, B and family. In addition three schools provided information for the review. The National Probation Service, Hertfordshire County Council Health and Community Services and Hertfordshire County Council Community Safety Unit participated in the review as members of the DHR panel.

- East Of England Ambulance Service
- Hertfordshire Community NHS Trust
- Hertfordshire Constabulary
- Hertfordshire County Council Children's Services
- Hertsmere Borough Council
- Herts Valleys and East & North Hertfordshire Clinical Commissioning Groups
- NHS England Central Midlands
- Places for People
- Victim Support

- Welwyn Hatfield Community Housing Trust
- Welwyn Hatfield Borough Council

2.4 The panel was chaired by Mr James Blake, Chief Executive of St Albans Council and 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 J and B had contact.

2.5 Family members who agreed to participate in the review have made a significant contribution to its findings and a copy of the final report has been shared with them. A friend of J and another who was also a friend to B were helpful in contributing to the findings of the review. The Welwyn Hatfield Community Safety Partnership which commissioned the Domestic Homicide Review made a decision to publish the Executive Summary of the final report. Copies of the report have been provided to the agencies involved.

2.6 Agencies known to have provided a service to J and/or B were asked to give chronological accounts of their contact prior to J's death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Where the chronology indicated that more significant contact had taken place the agency was asked to provide an individual management review, each of which covers the following:

- A chronology of interaction with the victim, perpetrator and/or their family; and analysis of involvement;
- whether internal procedures were followed; and
- Examples of good practice, lessons learned and recommendations from the agency's point of view.

2.7 The accounts of involvement with the victim and perpetrator cover different periods of time prior to J's death and some of the accounts have more significance than others.

2.8 The key purpose of the review is to understand what happened, what lessons have been learned and most importantly, what has to change to reduce the risk of such tragedies in the future. The Terms of Reference agreed by the review panel, were to:

2.8.1 Establish how effective agencies (which includes organisations and community groups) were in identifying the victim's health and social care needs and providing support, taking into account any relevant cultural issues.

2.8.2 Establish the appropriateness of agency responses to the victim and perpetrator - both historically and within a month of the victim's death

2.8.3 Establish whether single agency and inter-agency responses to any concerns about domestic abuse were appropriate.

2.8.4 Identify, on the basis of the evidence available to the review, whether the death was predictable and preventable, with the purpose of improving policy and procedures in Hertfordshire and more widely.

2.8.5 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 and children where domestic abuse is a feature.

2.9 In conducting the review the following Key Lines of Enquiry have been considered:-

- **Information:** How was information about the victim's health and social care needs received, assessed and addressed by each agency and how was this information shared between agencies?

- **Assessments and diagnosis**: What was the impact of the perpetrator's mental health on the victim's physical and mental health? Were there any recent changes in the physical or mental health of either the victim or perpetrator that may have affected their behaviour? Was there any evidence to suggest there to be any physical conditions or behaviours that had an impact on the victim's or perpetrator's mental health?

- Is there any information in relation to domestic abuse? Were any agency assessments completed? Were there opportunities for referral or signposting to, and within, agencies? Were there any additional needs? Were the appropriate referrals and service provision put in place?

- **Contact and support from agencies:** What contact did each agency have with the victim and perpetrator? What support did they receive and from whom? Were there any indicators or history of domestic abuse?

- **Any additional information considered relevant:** If any additional information becomes available that informs the review this should be discussed and agreed by the independent chair and the review panel. The chair of the Domestic Abuse Strategic Partnership Board (DASPB) will be advised of the change.

2.10 The review focused on events from January 2010, which was close to the time when J and B registered for social housing in the area, until J's death in June 2014.

3 Findings of the review

3.1 The findings have been drawn from a review of each of the IMRs provided by agencies in contact with J, together with information which was provided during the police investigation into J's murder. J's family, as well as two friends and her employer, have also contributed to the findings.

3.2 From police records it is clear that J was the victim of physical abuse from B whilst they were living in London. B was charged with assaulting J in 2004 but the case was not proceeded with as J withdrew her complaint. This is not unusual, research showing that many women withdraw statements for a variety of reasons which include - the abuser has said he is sorry and the victim wants to give him another chance; the victim does not want her children's father to have a criminal record; she may have been threatened, and/or feel frightened about what the abuser or his family might do if she proceeds with her statement; and she does not want to have to give evidence in court.

3.3 After the family moved to Hatfield the police received 6 domestic abuse calls. The first was in August 2012 when officers attended and assessed the risk as standard using the recognised Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) assessment tool. The police IMR said it was not clear that information about the previous incident in 2004 had been researched and that if it had it may have set "alarm bells ringing". It was noted that the children were in the house when this incident occurred and although they did not witness it, a referral was made to Children's Services in line with established procedures. As this was not assessed as a high risk case, where the notification to Children's Services must be done within 48 hours, the expectation is for a referral to be made within 5 days, and this timescale was met.

3.4 The subsequent calls were received by police in September and November 2012, February and June 2013, and April 2014. Police officers attended on each occasion and spoke to both parties. In September 2012 B was arrested and subsequently issued with a caution, and J was informed about this in line with the Victim's Charter. At the third incident in November 2012 J had reported over the telephone that she had been struck but when officers attended she did not confirm this. The officers did, however, correctly record that a domestic incident had occurred in line with policy. The fourth incident was reported by B who said he had been hit by J; following this J was cautioned. J reported over the telephone that the fifth incident in June 2013 was a physical assault but when the police attended she advised it was a verbal altercation rather than physical, again in this case the officers correctly recorded in line with policy that a domestic incident had occurred. The sixth incident was in April 2014 which resulted in B being charged with assault and criminal damage.

3.5 Each call out for domestic abuse led to police officers completing a DASH assessment, the lowest score being 1, the highest, when J was cautioned, being 8; the scores resulted in the incidents being classified as standard with the exception being the incident where J hit B which was assessed as medium risk. There were two occasions when the Harm Reduction Unit challenged decisions made by officers attending the domestic abuse incidents. First, after the incident in November 2012 they challenged the decision to close the case, but it was closed, because both parties maintained

J had been struck accidentally. Second, after the incident where J had struck B the DASH risk assessment was standard; the Harm Reduction Unit reviewed this and changed it to medium the reason given being that there were children at the address and there had been previous incidents. It is not clear why this was different from previous assessments or those undertaken subsequently, as risk factors appeared similar.

3.6 After each of the six incidents a referral was made to Children's Services because there were children in the family.

3.7 There were three other incidents picked up by police. First, in November 2012 they received a silent call which they treated appropriately as high risk because of the previous incidents. Although J confirmed over the telephone there were no concerns the police IMR suggested that given the previous domestic abuse incidents a home visit should have been made to check everything was in order.

3.8 Second, in May 2014 the police took a telephone call from the victim and perpetrator's son, C, saying he had been assaulted by an unknown male. This does not seem to have been a serious allegation and when police checked with J she would not provide a statement. Third, and on the same evening, B contacted the police to say the children had been left alone and it is difficult not to assume these events were somehow connected. B told the police he did not want to go to the home because of his bail conditions. J was later visited by officers and confirmed the children had not been left alone. The police IMR recorded that this incident gave the impression B was conscious of and adhering to his bail conditions. However during the murder investigation police became aware that he had been visiting the address and staying there contrary to bail conditions. The police IMR concluded that had a risk assessment been carried out after B's arrest and release, these issues may have been highlighted and possibly a police specialist domestic abuse officer appointed to the case.

3.9 J's aunt, D, said the family were aware that B was in contact with J and the children at their home in May 2014 but were not aware, until after J's death, of the criminal proceedings or any conditions restricting B's contact with J. D said they had been told after J's death, (possibly by neighbours) that the police had been called to the home after, what they thought was an injunction had been imposed, (it was bail conditions rather than an injunction); she thought this was about two weeks before J's death. D said they could not understand why the police did not act to remove him. The police have been able to confirm the only visit they made to the home during this period was following the allegation, made by B that J had left the children on their own; B was not at the home.

3.10 After the sixth domestic abuse incident in April 2014, B was charged and appeared in magistrates' court in May 2014 when bail conditions were imposed which prevented him attending the home and having contact with J. The police IMR noted that the case report to the Crown Prosecution Service referred to assaults in 2004 and 2012 for which B was cautioned; it did not mention the incidents in 2013 and therefore B's bad character history was not considered by the magistrates in addressing bail. J was not informed of the charges, bail conditions or court date as per the Victim's Charter until she contacted the police the next day to find out what had happened. The police IMR suggested that the fact she had to do this herself was the first step in

alienating her from the process. Also, following B's release a risk assessment should have been completed by the police, and consideration given to J having access to a mobile telephone as hers had been damaged during the offence.

3.11 During the period after B was charged with assault and criminal damage J tried to retract her statement but later said she wanted to proceed. The police IMR questioned why the witness care officer had not made more effort to make contact with J, to keep her informed of the case and support her through the process. The IMR also suggested there were two reasons why consideration should have been given to a referral to the Multi Agency Risk Assessment Conference (MARAC). Although the case did not meet the "Visible High Risk" criteria contained within Co-ordinated Action Against Domestic Abuse (CAADA) (now renamed Safelives) Guidance, the criteria for "Potential Escalation" was met and "Professional Judgement", which is the other CAADA criteria, should have been used because the incidents were, according to the IMR, "quite nasty" and in the presence of children; and if research had been carried out on the assault in 2004, some sensitive questioning may have identified a history of abuse unknown to any agency and which, not unusually for victims, J had not wanted to disclose. It is common practice, in line with CAADA's guidance to consider "Potential Escalation" as being three or more call outs in a 12 month period. In J's case there were five call outs between August 2012 and June 2013 which suggests the escalation criteria would have been met.

3.12 As a result of this case Hertfordshire Constabulary reviewed their use of the escalation criteria and estimated that if they continued to use the 3 in 12 as a basis for referral to MARAC this would result in 13.7% of cases being referred, whereas CAADA (now renamed Safelives) estimate 5% of cases should be referred. A decision was taken at strategic level, and after consultation with partner organisations, to refer cases where there had been four call outs in a 12 month period, which it was anticipated would lead to 6% of cases being referred to MARAC, and allow for resources to be provided where most needed. This case would have met the escalation criteria under the old and new arrangements.

3.13 The police IMR noted the workload of the Harm Reduction Unit and Witness Care team; there has been an increase in reported domestic abuse incidents further increased by the Domestic Abuse Disclosure Scheme and Domestic Violence Protection Orders.

3.14 After each of the reports of domestic abuse received by Hertfordshire Police they have a record that they informed Children's Services because there were children living at the address where the incidents took place. For the first report, of August 2012, Children's Services had no record in either of their recording systems, of receiving a referral; therefore, they have a record of dealing with five not six referrals. Each was received by the multi-agency Targeted Advice Service (TAS) whose role is to gather more information and make decisions regarding any further action needed.

3.15 The first incident of which Children's Services became aware was that which took place on 26 September 2012. There was a three week delay dealing with the case following referral. The records show that the incident did not meet the threshold for referral to Children's Social Care and the management decision was for TAS to make contact with the family to find out more

information, but this was not done. The delays and the fact TAS did not follow up as originally intended were due to capacity issues within the team. The case was reviewed two months after the referral was received and a decision taken it should be closed to TAS because there had been no more incidents.

3.16 Following referral to Children's Services for the incident in November 2012, this was not picked up by TAS until late January 2013; it is understood this was because of capacity issues, as in September. A manager decided that contact should be made with the parents to discuss the situation but before this was acted on, the next and third incident occurred and the result of this was a referral to Specialist and Safeguarding Services, (S&SS) for assessment, leading to closure of the case to TAS.

3.17 Children's Services received a third referral, relating to an incident in February 2013, but it was not picked up for nearly one month because it had not been recorded as a priority. TAS referred it on to S&SS for assessment, and a home visit was arranged within eight working days of the referral being received by Children's Social Care. Children's Services records show that all three children were seen alone, and spoken to, and their bedrooms seen. The case note further indicates that J spoke to social workers alone at the start of the visit and that B then joined the conversation. The Children's Services IMR noted that although J had disclosed at the meeting in March 2013 that there had been previous domestic abuse incidents these were not tracked and therefore Children's Services were not aware of the domestic abuse incidents prior to late September 2012.

3.18 The Initial Assessment concluded that use of the Common Assessment Framework (CAF) was appropriate to support the family including Children's Centre, schools and health visitor; and GP registration, because at that stage the family did not have a GP in the area. The decision was changed early April 2013 when it was decided that as there was only one agency (schools) involved the CAF, which requires more than one agency working together, was not appropriate. Instead schools would be asked to monitor. It is not clear why Children's Services concluded there was only one agency involved given what had previously been recorded about the health visitor and Children's Centre. Also Children's Services were aware of health visitor involvement as a social worker had spoken to a health visitor about the case during this period. The family were sent a copy of the assessment and a social worker made a home visit to discuss the outcome of the assessment. However, it was recorded that only B and two of the children were present at the home visit, and therefore the case was closed without there being a discussion with J.

3.19 When Children's Services received another referral in June 2013 they commenced a further Initial Assessment, and then a Core Assessment. The case was allocated to the same social worker as before which was good practice, and to inform the assessments she made two home visits to all the family; the children were seen alone, and the parents were seen separate from the children, although it is not clear if this was separate from each other, which would have been essential given the nature of the incident reported. In addition the social worker made an unannounced visit when she saw B, and she tried to visit to see J, but did not get a response. Enquiries were made of other agencies and no safeguarding concerns were raised. The risk to the children was assessed as low based on what the children and parents had said; an additional factor was that the parents were not in the home at similar

times, due to work patterns. A decision was taken to close the case and that the health visitor and schools should monitor. Health visitor services were not advised of this decision. C's school had a record of receiving feedback in July 2013, and although E's school (E being the second family child) do not, they were already monitoring E because of communication from Children's Services earlier in 2013.

3.20 Children's Services record having received a referral about the incident in April 2014, on the same day. In May 2014 a TAS manager decided contact was to be made with J to find out more about what had happened, and that there should be a report back to her. In May 2014 the TAS worker had lengthy, separate telephone calls to J and B. It was during the call to J that she told the worker that a counsellor at her Church had told her to drop the charges against B because it would not be good for the children if B went to jail. J said she was not looking to reconcile with B; she felt safe and felt able to keep the children safe. J said she did not need the support of an Independent Domestic Violence Advocate (IDVA) and the worker gave her details about Sunflower support services (a local domestic abuse support service). Although J told the worker she had been in touch with the Housing Association about having B's name removed from the tenancy, there is no evidence this had happened and Places for People (the landlord) confirmed they would not have taken this action without consultation with both parties.

The TAS worker also spoke to B. He made allegations against J and was blaming her for the recent incident. He had involved his eldest son by asking him to talk to his mother, and admitted he had smashed J's mobile telephone. He told the worker he and J need couple counselling and he wanted to keep the family together.

After speaking to the parents, the worker contacted E's school who said they had no concerns about him. She recorded that she was awaiting information from C's school. C's school has no record of an enquiry but had they been asked would have stated they had no concerns. TAS recorded that the parents were no longer living together and J felt able to protect the children. The Children's Services IMR questions if this assessment was sound given it was based on telephone calls and the children were not seen. However, this was not a formal assessment, and the TAS worker spoke to the social worker who had previously been in contact with the family who agreed the case should be closed. Although research shows, as contained within Hertfordshire Safeguarding Children Board guidance, that in the period following separation, victims of domestic abuse are most at risk, the Children's Services IMR confirms it is not normal practice to keep cases open once parents have separated especially in cases where the domestic abuse has been risk rated as low/standard or medium.

3.21 The IMR for health visitor services reflected that there had been considerable organisational change and staffing shortages and these will have impacted on the service delivered in this case. Health Visitor 3 (HV3) described how the demographics for the area covered by the team caring for J and her family has changed dramatically in recent years; this coupled with the increase in student numbers had placed additional stress on the team. On occasions there was delay in health visitors making contact with J after notifications about domestic abuse and some of the recording was not as full as it should have been. Nevertheless, health visitors had many contacts with J initially for developmental checks for her youngest child, and then to provide support and

advice when they became aware she was the victim of domestic abuse. HV3 in particular sought to assist J and made several telephone calls and opportunistic home visits in her efforts to keep J engaged.

3.22 The Health Visitor IMR noted that as the domestic abuse incidents escalated HV3 should have sought advice from her line manager or Safeguarding Children supervisor; this would have most likely lead to a full DASH risk assessment, referral to MARAC and IDVA, and case discussion with TAS or Children's Social Care. The IMR stated that the service would benefit from having a practitioner in each locality who can develop knowledge and skills in domestic abuse, a champion role. The IMR also noted that wider use of a risk assessment tool by health visitors and clearer guidance on what cases to take to safeguarding supervision (within the organisation) would have been beneficial in this case. The IMR also questioned whether J's demeanour and behaviour had distorted HV3's assessment of risk; she had not fully considered the impact of J and B's cultural and religious beliefs and the effect on them if they were to separate. This could have had far reaching effects especially as B had said he was acting as a pastor and therefore in a position of authority. B denied to HV3 that he had hit his wife until she challenged this and his response may have suggested he considered this behaviour acceptable. The IMR noted that the family had been appropriately located in the targeted caseload, rather than receiving a universal service, but this had not been identified in the recording system with appropriate icons, which meant another practitioner picking up the case would not have quickly assessed that there were risks associated with domestic abuse in this case. The IMR reported that the records did not articulate the voice of the child so that it was difficult to see how the children were developing.

3.23 The IMR raised a number of specific learning points about the home visit in October 2012 when HV3 spoke with B which included:

- Although HV3 had not felt threatened by B, another member of staff may have felt differently and therefore events should have led to HV3 reporting this to a manager, and had it been, future visits could be undertaken in line with the lone worker policy.
- As B appeared angry that J had been talking to HV3, HV3 should have sought further advice from her Safeguarding Children Team or Children's social care to risk assess and suggest a plan of action.
- HV3 should have recorded evidence of how the domestic abuse was affecting the health of J and her children.
- HV3 should have sought advice from the Local Authority Designated Officer (LADO) for safeguarding with reference to B's pastoral role.

3.24 During the period covered by the review J and B were in contact with several other agencies.

3.25 Victim Support dealt with two referrals from the police, September 2012 and April 2014. The DHR questioned whether there should have been contact after each incident. The police and Victim Support were able to clarify that, where the victim indicated to the police, at the time of the incident, that she or he did not want contact with Victim Support, this was not offered; this was in line with policy. At the first referral the operating procedures specified that two calls should be made to the victim (when safe and appropriate to do so) within 48 hours and over two different time spans (before/after 16.00); the first call

met this requirement as it was within the first four hours but the second did not as it was made four days later. The contact requirements have now been changed so that at least two attempts at contact must be made within the first 72 hours of which one must be within 48 hours of the referral being received. When Victim Support received the second referral in April 2014 the contact requirements were met.

3.26 Although it is not clear whether this option was offered, because the recording was not clear, the victim care officer in this case did not complete a Risk Identification Checklist when she spoke to J in October 2012. At the time it was common practice to enter into discussion with victims and offer advice even if the victim declined to complete the Checklist. Since then the process has tightened so that if a victim declines to complete the Checklist they are given relevant telephone numbers including Women's Aid and the National Centre for Domestic Violence as well as the number for the Victim Care Unit (now part of the Hertfordshire Beacon service). No further engagement is made without the Checklist being completed because it is not possible to assess the risk level without it, and therefore any advice given could be dangerous.

3.27 The Victim Support IMR expressed concern that the victim care officer suggested Relate to J in October 2012, as couples counselling is not appropriate for a victim of domestic abuse. It was noted this particular victim contact officer had not received training specific to domestic abuse and at the time, but not now, it would have been acceptable for her to talk to victims of domestic abuse, whilst waiting for training, if she felt confident in doing so.

3.28 The IMR provided by National Health Service (NHS) England in respect of the General Practitioner (GP) services showed that J, B and the children had limited contact with a GP. J had only routine visits linked to pregnancies and family planning. B saw a GP in Hatfield in November 2013 when he reported being depressed. The GP spoke to him at length and a referral for counselling was agreed and actioned. B did not take up the counselling when it was offered. The NHS IMR reported that it could be questioned why the GP did not follow this up; however, that B had some responsibility in indicating if he needed further help.

3.29 C was seen alone in January 2014 when he had a rash. Both parents were consulted independently, no concerns were noted and there was no further action.

3.30 GP records show that they received requests for information from Children's Services in 2013 but these requests did not provide any context to the referral.

3.31 The NHS IMR stated that GP's would have had access to SystemOne which is the computerised record keeping system used by the Community NHS Trust and GP's, and in this case included information from health visitors and school nurse and indicated there was trouble in J's marriage and that she was the victim of domestic abuse. The IMR suggested there were two occasions when a "think family" approach may have changed GP decision making. The first, when B attended with stress and anxiety, the IMR questioned whether the GP could have checked on J's records to see what she was experiencing, and this may have indicated that B's stress was part of a wider issue. The second, if the GP had accessed J or B's records when seeing C the GP may

have been informed of a different perspective of the family and made different decisions. The recommendation from the IMR is that whilst acknowledging this may not have changed the outcome for J there is need to indicate a "think family" approach into GP practice**;** and that the learning from this IMR is shared with GP's and built into a training package.

3.32 Places for People were the landlords of J and B following their move to Hatfield. They had a number of routine contacts linked to property repairs and rent. They also received three letters from B in respect of his tenancy, the most recent in June 2013 asking to be removed from the tenancy. Places for People did not act on this and would not have done without consent from both parties as it was a joint tenancy. Places for People have stated in the IMR that they did not consider that the letters from B indicated domestic abuse, and that having reviewed their domestic abuse policy they can see that there were no events or triggers to indicate that domestic abuse was taking place. They had not received any reports from neighbours about noise or arguments and when the staff had contact with both parties there was no indication of domestic abuse. Places for People are reviewing their policy on requests from tenants to move from joint to sole tenancy, to ensure there are no safeguarding concerns or reports of domestic abuse or violence which may be a factor in the request.

3.33 The Welwyn Hatfield Community Housing Trust is part of a consortium of five local authority areas in Hertfordshire known as "Herts Choice Homes" which includes Hertsmere Borough Council. J and B registered with Hertsmere Borough Council for housing and the needs register for this and the other four areas, which includes Welwyn Hatfield, is administered through the consortium's shared web site and back office system. The family were housed, from Hertsmere Borough Council's Register, to Welwyn Hatfield area. The Welwyn Hatfield Community Housing Trust, which acts on behalf of Welwyn Hatfield Borough Council in assessing housing needs and homelessness, had two contacts with B when he approached them for advice, on both occasions citing relationship breakdown. The assessment, advice and onward referral were in line with current legislation and the Trust's policies and protocols. The Housing Trust IMR concluded, however, that a referral should have been made to its own safeguarding team as a result of some of the information disclosed to the Trust; this would have presented an opportunity to work with other agencies to effectively manage the issues raised. The IMR concluded that the case indicated a need to provide further guidance to staff and to test awareness, particularly with front line employees who have frequent contact with tenants, housing applicants and members of the public.

3.34 During the course of the review, information was requested from the schools attended by C and E. They were asked to and did provide information to Children's Services for Section 17 (child in need) enquiries which led them to monitor the children's progress. Although initially they were not aware of domestic abuse E's school were made aware in April 2013 and C's school in July 2013. The schools did not express any welfare concerns about the children.

4 Conclusions and Recommendations

4.1 There was a history of B abusing J which dated back at least to 2004 when B was arrested by the Metropolitan Police for assault. As well as the reports of

physical abuse, there were many examples of B being abusive towards J without physical violence. J spoke about these and they were experienced by agency workers and family. B withheld money and other assistance, and took items from the home, even when this affected the children adversely, criticised her in front of others including the children, punished her by breaking her mobile telephone, and reacted jealously when she formed friendships. He saw himself as the head of the household, did not expect to treat J as an equal and was frustrated when she answered him back. He also misinterpreted teachings in the Bible, to justify his views. There is evidence he involved the eldest child in witnessing arguments and criticising his mother to the extent that J and her mother were concerned that the boy's behaviour was beginning to mirror his father's.

4.2 The DHR panel considered whether B and J's cultural background may have led B to believe that it was appropriate to seek to control J, including with violence, and in turn she may have been more accepting of his behaviour because of cultural influences. However the view of J's family was that cultural influences were not relevant, and that J was a victim like any other. The panel concluded that overall the agencies were culturally sensitive in their management of the case.

4.3 The DHR panel concluded that based on the information available to the agencies at the time, it could not have been predicted that B would kill J. Family members who were interviewed also concurred with this view. Although the agencies were aware of physical assaults they had been assessed as standard or low risk, with the exception of the incident when J was cautioned for assaulting B. Agencies that had contact with J after B was arrested and charged with her assault in April 2014 understood that B was prevented from contacting J or visiting the home, which were protective measures aimed at preventing further abuse. However, the period after separation is known to present the most risk to a victim and the DHR questioned whether the agencies gave this sufficient consideration. Had B not continued to have contact with J her murder may have been preventable, but rather than assume J had welcomed this contact the DHR has considered that she may have felt she had no choice perhaps because of financial considerations and that she needed help with child care.

4.4 It was clear to the DHR panel that many staff were involved at different stages in working with and supporting the family. The review has identified specific instances of individual staff going the extra mile to try and help. The DHR has however highlighted several practice issues which fall under the following headings, and which have given rise to recommendations aimed at securing improvements; Risk Assessment, Provision of Support to the Victim and family, Sharing Information, Support to Agencies, Engagement with the Faith Community, and Workload. In addition to the DHR recommendations, agencies have identified their own recommendations.

4.5 **Risk Assessment**

4.5.1 There were three agencies contributing to risk assessment. Police, focusing on the victim, used DASH and on all occasions where J was the victim the risk assessment was standard. When B was the victim the assessment was medium with a score of 8 and the difference seems to have been because B said he was frightened, isolated, fearing further injury and that there was conflict over the children. The DHR reflected on why J did not also identify

these risk factors, leading to concerns by the Panel that there was an acceptance by officers of J's tendency to minimise incidents, without sufficiently probing questions. J's positive demeanour may have affected the police and other agencies' assessment of risk, with an assumption she was more resilient than she was. Although each DASH assessment is subject to scrutiny by the Harm Reduction Unit, when they take into consideration information from previous assessments, it did not lead them to consider that domestic abuse was escalating in J's case.

4.5.2 There were six reports of domestic abuse to the police, five of which were in a ten month period between August 2012 and June 2013. Although each was assessed as standard or medium risk, the DHR concluded that the frequency should have led the police to apply the escalation criteria and make a referral to MARAC. The DHR also concluded that Children's Services and Health Visitors did not give enough credence, in their assessment of the family, to the fact domestic abuse was escalating and these agencies were also in a position to make a referral to MARAC. This would also have helped to ensure an overview of all agencies' response.

4.5.3 Children's Services conducted two initial and one core assessment, the primary focus being the children and the effects on them of the domestic abuse. They accessed information from other agencies and the feedback in respect of the children was that there were no concerns. The DHR acknowledged that Children's Service's assessment of the case as low risk to the children was accurate based on the information they had. However the panel concluded, in line with the Children's Services IMR, that more could have been done to access all available information, to probe beneath the surface and to avoid over optimistic conclusions. This is particularly the case in relation to understanding the wider family context and the stresses the parents were under and potential risk to J from domestic abuse. In addition, although in March 2013 the parents were said to realise the seriousness of domestic abuse and were willing to engage, using a Common Assessment Framework, this was not progressed as Children's Services wrongly assumed only one agency (schools) was involved whereas closer scrutiny would have revealed health visitor involvement. This was a missed opportunity to work with the parents on what they presented as significant problems. Also Children's Services closed the case twice (April and August 2013) without discussing their reasons for this with J, which was not acceptable given she was the victim of the abuse which had precipitated the referral. At the last contact in May 2014, when a social worker concurred with the TAS worker that the case could be closed, the DHR concluded that this decision should have been questioned more closely because feedback was from parents only, over the telephone, and the children had not been spoken to for nine months. Checks were made with schools but the youngest child did not attend school.

4.5.4 The health visitors had the opportunity to undertake a new birth assessment and a maternal mood assessment because of there being a new baby in the family; at that stage domestic abuse was not apparent and there were no specific concerns noted. Subsequently, alongside TAS the health visitors were informed of the domestic abuse by the police. This should have triggered rising concerns within the family and together with feedback from J and HV3's experience of B during a home visit should have led to a discussion with the organisation's Safeguarding Children Team; so that a wider more comprehensive risk assessment could be completed.

Recommendations

R1 All agencies who use DASH should ensure it is applied consistently, and using professional curiosity, to take into account previous assessments, background information and context already known about those being interviewed in relation to the abuse.

R2 To help ensure consistency and quality, all agencies should consider introducing a formal process of random management checks in relation to the assessment and escalation of risk to different household members in domestic abuse cases. This should be backed up by a rolling programme of Internal Audit review.

R3 All agencies should ensure cases are referred to MARAC where the referral criteria are met.

R4 Children's Services must ensure that before making a key decision in a case which involves domestic abuse, they discuss this with the parties concerned and in particular the victim of the abuse.

4.6 Provision of Support to the Victim and Family

4.6.1 The DHR anticipated that the Common Assessment Framework could have proved a helpful preventative measure for the family as it was known by Children's Services and Health Visitors that J and B were working long and incompatible hours which led to child care problems, and that they had financial pressures. The contacts with Children's Services were for the purpose of conducting assessments, during which information, advice and guidance were also provided. Health visitors, and HV3 in particular, tried to provide on-going support to J but this proved difficult to sustain because of J's availability. J was given information by the police, victim support, social worker and health visitor about support services available for victims of domestic abuse, but it was not clear what this was or that it was consistent. Neither was it clear that either J or B were offered advice and support in respect of finance and child care, the problems they identified as contributing to relationship difficulties.

4.6.2 J was frequently advised (as was B) about the effects of domestic abuse on the children, by social workers and health visitors, but there is little evidence of its impact on her being discussed, and what steps she might take, should she choose to, for her own safety.

4.6.3 J appears not to have accessed any services and the DHR questioned whether the agencies could have been more pro-active in helping her to take advantage of these. This is particularly important as the evidence suggests that many victims of Domestic Abuse can feel fearful of being seen to access support. Some may also, through force of circumstances, or because of the controlling nature of the perpetrator, be in denial about the need to access support. Although she did say she was getting help from the church, it is not known what the nature of this help was or if it was of value to J. According to her mother J did discuss her situation with some family members but in respect of her mother it seems she stopped talking about the problems because she knew her mother disapproved of B.

4.6.4 B referred himself to the GP when he was suffering from depression; appropriately he was offered counselling but did not progress this. B also sought assistance with accommodation from Welwyn Hatfield Community Housing Trust (the Trust) when he was separated from J. Although the information he was given was accurate in terms of his legal rights to the joint tenancy and that he was not in priority need as homeless, the DHR questioned whether the Trust should have given more thought to the consequences of this advice, when he had volunteered the relationship had broken down and that police and "social services" had been involved. In effect the advice could have been an encouragement to return to a far from satisfactory situation and the DHR concluded that before providing this advice the Trust should have made a safeguarding referral within their team.

4.6.5 The police responded promptly to the domestic abuse call outs to J and B. J appeared reluctant to proceed to prosecution and the DHR concluded that she should have received more support in this respect from the police and witness care services. This was particularly so when B was charged in April 2014 and J seemed unsure if she would or would not withdraw her statement.

Recommendations

R5 The Hertfordshire Domestic Abuse Partnership should provide a standard set of information accessible to victims of domestic abuse. This might take the form of a simple leaflet, made available to all agencies.

R6 All agencies should consider how they will conduct safety planning with known victims of domestic abuse.

R7 The Hertfordshire Domestic Abuse Partnership should seek assurance from agencies that they have in place a strategy which they will follow if victims do not respond or refer themselves for services. (E.g. retracting evidence, not turning up for appointments, not going to Sunflower, etc.)

R8 Hertfordshire Constabulary should ensure information and support is provided to victims of domestic abuse and their families during the Criminal Justice process.

R9 Local Housing Authorities, their agents and partner Registered Providers, should review their approach to managing tenancies, assessing housing needs and homelessness a) to ensure safeguarding referrals are made if there are any indicators of domestic abuse, b) that advice given to a tenant takes account of the consequences to a victim or perpetrator of domestic abuse living in or returning to an existing tenancy and c) to ensure appropriate advice and information on support services is made available to both victims and perpetrators of domestic abuse.

4.7 Sharing Information

4.7.1 In line with safeguarding procedures police passed on information to Children's Services and Health Visitors after each domestic abuse incident. Children's Services contacted other agencies for information as part of section 17 enquiries but they did not tell the agencies why they were doing this and did not feedback the outcome which was in line with their policy on information sharing. Where they sought the assistance of schools in monitoring the children's welfare they did advise that there had been

enquiries with regard to domestic abuse. Health Visitor 3 had concerns about the family but did not discuss this with her own Safeguarding Children Team or with Children's Services; a discussion with the Safeguarding Children Team would have triggered a referral to the Local Authority Designated Officer (LADO) in respect of concerns that B had a position of trust as a pastor in the community. The GP had limited contact with the family and had not been informed of domestic abuse. However this information was recorded by health visitors on the recording system which was available to GP's, and had it been accessed would have given a more complete picture of the family's situation when B and C separately presented to the GP. The other agency which might have shared information was Welwyn Hatfield Community Housing Trust which confirmed that they were aware of the domestic abuse because when B sought help in December 2013 he stated that there had been some pushing and shoving between him and J and that he had spat at his wife. The IMR concluded that as B had sought help from them following relationship breakdown they should have considered this indicative of problems within the family and made a safeguarding referral to their own safeguarding team.

4.7.2 The DHR concluded that information sharing was limited, one–way, and because of this and the fact there was no referral to MARAC, agencies tended to look at the case from their own perspective only, so there was not a holistic, 'whole family' comprehensive approach to risk assessment and risk management.

Hertfordshire Children's Services have now introduced a Multi-Agency Safeguarding Hub (MASH), which is a partnership of agencies that have a duty to safeguard children and have agreed to share information, in order to improve decision making. One of the aims of MASH is to ensure that early help is offered to families before more serious situations develop and the DHR panel welcomes this as something that could have benefitted J and her family.

While not strictly within the terms of reference for this review, the DHR panel noted, from conversations with the family, that they felt support to the bereaved family members after the murder of J (in relation to housing, social care, nationality status etc.) has at times been fragmented, with changes of personnel. This can add to the stress and difficulties for those family members left behind.

Recommendations

R10 All agencies should ensure that they take a probing, inquisitive approach to access, interpret, question and share available information for the purposes of risk assessment and risk management in domestic abuse cases, in line with established local and national legislation and guidance. Where in doubt, the balance should be in favour of sharing, not withholding, information within this context.

R11 All relevant agencies should consider the potential impact of the wider family context – "Think Family" – when carrying out assessments in relation to individuals within the family unit.

R12 In the case of an unexpected parental death Hertfordshire Domestic Abuse Partnership should consider mirroring the Bereavement Planning meeting and

review process in use for the Rapid Response to Child Death, to include identification of a single lead agency.

4.7 Support to Agencies

4.8.1 A number of the individual reviews carried out by agencies as part of this DHR have identified the need for clearer information and training for staff involved in dealing with Domestic Abuse cases. The DHR panel supported these conclusions. While there will be a need for individual specialised training within each agency, the DHR panel also considered the potential benefits for some information and training to be carried out jointly.

Recommendations

R13 All agencies should develop and deliver training to front line staff which picks up the points highlighted by this review, such as the skills needed to take a curious, questioning, and whole family approach to domestic abuse. Hertfordshire Domestic Abuse Partnership should consider the potential for training to be jointly developed and delivered.

R14 The Hertfordshire Domestic Abuse Partnership should develop a flowchart, to be disseminated to all staff in all agencies, which sets out the process by which domestic abuse reports, referrals and assessments are carried out, from initial contacts, DASH assessments, and through to more detailed agency assessments. This could form part of the joint training suggested in the previous recommendation.

4.8 Engagement with the Faith Community

4.9.1 The DHR has no independent evidence to support that J was discouraged from making statements about the physical abuse by representatives from the church she attended, but she did state very clearly to a TAS worker that she had been discouraged by her counsellor at the church. In any event the review concluded that with or without this advice J would have felt under pressure to stay in the relationship because her own beliefs were that it was important to maintain the family unit, and it appears B wanted this and enlisted the help of a pastor in his efforts to keep the relationship. The DHR concluded that there would be benefits, in terms of promoting understanding and encouraging use of services for victims, in making contact with churches known to have been attended by J and B. There is targeted training available for faith groups.

Recommendations

R15 The Welwyn Hatfield Community Safety Partnership should engage with local faith groups, in particular independent churches, to promote and make available domestic abuse awareness training.

R16 Chairs of the Hertfordshire Domestic Abuse Partnership Executive together with the Chairs of Adult and Children's Safeguarding Boards should consider how best to engage faith groups and independent churches in its work.

4.9 Workload

4.10.1 During the course of the DHR each of the agencies in contact with J referred to workload pressures arising from organisational changes and an increase in work including the reporting of domestic abuse. It appears that in this case it affected the police, including witness service, health visitor services and the Children's Services.

Recommendation

R17 Hertfordshire Domestic Abuse Partnership should consider current trends in domestic abuse, anticipated future demands and the resourcing implications.

5 Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
CAADA	Co-ordinated Action Against Domestic Abuse now renamed safelives
CAF	Common Assessment Framework
CSP	Community Safety Partnership
DAISU	Domestic Abuse Investigation and Safeguarding Unit
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) Risk Identification and Assessment and Management Model
DHR	Domestic Homicide Review
DVO	Domestic Violence Officer
DVSPB	Domestic Violence Strategic Programme Board
GP	General Practitioner
HDAP	Hertfordshire Domestic Abuse Partnership
HV	Health Visitor
HRU	Harm Reduction Unit, Hertfordshire Constabulary
IDVA	Independent Domestic Violence Advocate
IES	Integrated Education System – electronic recording
IMR	Individual Management review
LADO	Local Authority Designated Officer
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service
S&SS	Specialist and Safeguarding Services
TAS	Targeted Advice Service