Domestic Homicide Review (DHR)

North Hertfordshire Community Safety Partnership
Overview report into the death of
Christopher June 2018

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SUMMARY OF CONTENTS

PREFACE

I would like to begin this report by expressing my sincere sympathies, and that of the Panel, to the family and friends of Christopher. I am sorry for their loss and hope that in some way this report provides an insight into his life.

I would like to thank the Panel and those that provided chronologies and Individual Management Reviews for their time and cooperation.

1.0 INTRODUCTION

1.1 This is the report of a Domestic Homicide Review (DHR) undertaken by North Hertfordshire Community Safety Partnership. It examines agency responses and support given to Christopher, a resident of Hertfordshire prior to his death which is believed to have occurred sometime in June 2018.

1.2 Christopher was a white British Male. He lived in Hertfordshire all his life and was aged sixty-nine at the time of his death. Christopher was a farmer and owner of an agricultural and livestock business.

1.3 He had one grown up son as a result of his first marriage which ended in divorce in 1979. He met Sarah in 1992/93 and married her in 1997. They had three children who were born between 1995 and 2000. At the time of their meeting, Sarah had a young child from a previous relationship, who Christopher brought up as his own. Christopher and Sarah separated in 2015.

1.4 The couple remained on amicable terms following their separation, but this changed in 2017/18, after Sarah become involved in a relationship with Simon. Sarah initiated divorce proceedings in March 2018. Christopher did not agree to the divorce and made it known, he wanted a reconciliation. Three months later in June 2018, Christopher was reported missing. His decomposed body was found on land owned by his wife in February 2019. His wife Sarah and her new partner Simon were subsequently convicted of his murder.

1.5 The primary purpose of a Domestic Homicide Review (DHR) is to enable learning where a person has died as a result of domestic abuse. For the learning to be shared as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly what needs to change in order to reduce the risk of such tragedies happening again in the future.

1.6 This report will consider the contact that agencies had with Christopher between October 2014 and 10th February 2019. These dates provide an overview of the period of time when it first became apparent there were difficulties in the marriage between Christopher and his wife, Sarah, and after the date his body was discovered.

1.7 In addition to agency involvement, the review has also sought to examine the past to identify any relevant background or specific risks to Christopher and whether there were opportunities to provide further support to him. The report considers whether there were any barriers to accessing services. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer. This report also summarises the circumstances which led to the review being undertaken in this case.

1.8 Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have sought the views of family members and made every attempt to manage the process with compassion and sensitivity.

2.0 TIMESCALES

2.1 The North Hertfordshire Community Safety Partnership commissioned this review on 12th March 2019. The review adhered to the processes detailed in the Home Office Statutory Guidance for the conduct of Domestic Homicide Reviews published in December 2016.

2.2 The decision to commission the review was taken by the Chair of the North Hertfordshire Community Safety Partnership. Due to the circumstances in which the body was discovered and uncertainty as to the cause of death, there were early discussions with the Home Office before they were formally notified of the decision to conduct a review on 11th April 2019.

2.3 This review did not commence until 29th September 2019. This was at the request of the police and Crown Prosecution Service, who wanted to delay the commencement of the review to allow the criminal investigation and judicial proceedings to conclude. The trial date was set for September 2019, and it was agreed this would be the appropriate time to have the initial DHR meeting.

2.4 The Home Office Statutory Guidance advises that where practically possible, the Domestic Homicide Review should be completed within six months of the decision to proceed with the Review. For this reason, an initial timetable was drawn up to ensure that agencies complied with the request. It was not possible to complete the DHR in six months due to the on-going criminal proceedings, which did not conclude until 2019, and the appeal process period that followed. This caused a delay in the Independent Chair and Overview Report Author contacting the family of Christopher to establish if they wanted to take part in the review. In addition, further delays were caused by the COVID-19 pandemic, which resulted in DHRs in Hertfordshire being paused for a number of months. The Home Office were notified of the delay and have been kept updated throughout.

2.5 Both the Independent Chair and Overview Report Author were formally appointed at the first DHR Panel meeting on 29th September 2019. During this meeting, the draft terms of reference were discussed and finally agreed at the Panel meeting held on 7th January 2020

2.6 The Panel met on five occasions and contact was made with Panel members on a regular basis to clarify issues and matters of accuracy about their agency's involvement with the family.

2.7 The review concluded in May 2021. The North Hertfordshire Community Safety Partnership were updated regarding the progress of the review throughout the process.

3.0 CONFIDENTIALITY

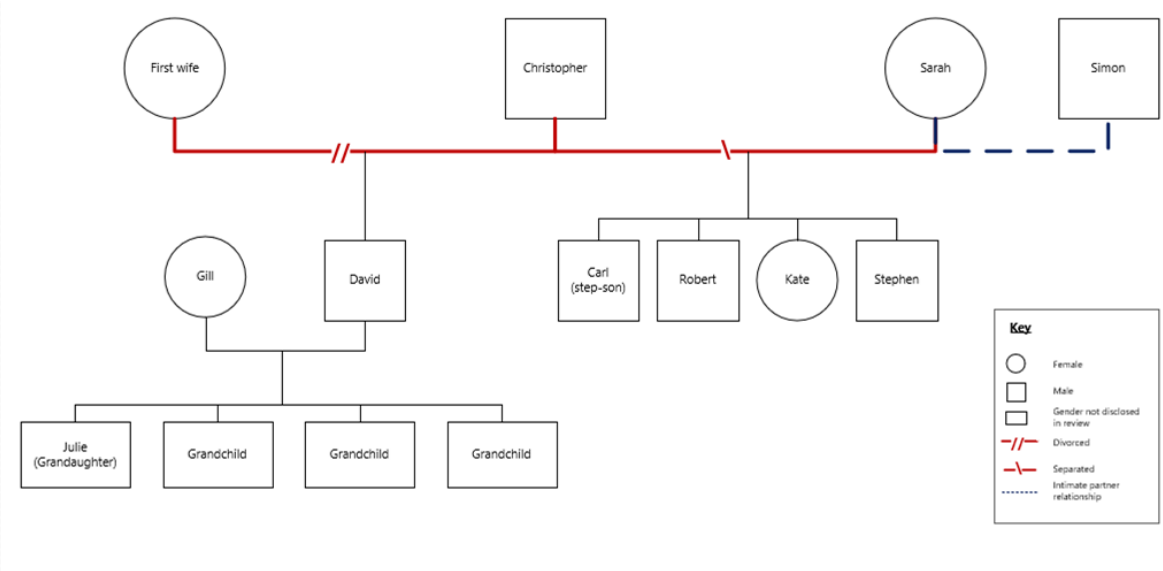
3.1 The findings of each review are confidential. The information obtained as part of the review has only been made available to participating professionals and their line managers. The family of Christopher were provided with a copy of the terms of reference during the early stages of the review and a copy of the DHR prior to submission to the Home Office. The family were also advised about confidentiality.

3.2 Before the report is published, North Hertfordshire Community Partnership will circulate the final version to all members of the review Panel and the victim's family members. The family will be notified of the publication date, once known.

3.3 The content of the overview report has been anonymised to protect the identity of the victim, relevant family members and all others involved in this review. The pseudonyms agreed with the DHR Panel and family are as follows:

Christopher - Male who was murdered. Aged 69 years. White British
Sarah - Estranged Wife of Christopher and person responsible. Aged 51 years. White British
Simon - New partner of Sarah and person responsible. Aged 53 years. White British
David - Eldest son of Christopher from his first marriage
Gill – Wife of David and daughter-in-law of Christopher
Julie – Grand-daughter of Christopher
Robert - Eldest son of Christopher and Sarah
Kate - Daughter of Christopher and Sarah
Stephen - Youngest son of Christopher and Sarah
Carl - Son of Sarah from previous relationship and Stepson of Christopher

3.4 To assist the reader, the following genogram details Christopher's family.



4.0 TERMS OF REFERENCE

Statutory Guidance (Section 2.7) states the purpose of the Review is to:

4.1 Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

4.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

4.3 Apply these lessons to service responses, including changes to policies and procedures as appropriate;

4.4 Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working, and;

4.5 Contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice.

Specific terms of reference set for this review

4.6 To provide an overview report which articulates the life of the victim through his eyes to understand his reality in his dealings with those around him, including professionals. Each agency will be asked to:

4.7 Comment on the specific areas set out in the key lines of enquiry (Para 4.21 below)

4.8 To identify the history of the victim and perpetrator(s) and provide a detailed chronology of relevant agency contact with them. The time period to be examined in detail is the date the couple are believed to have started experiencing problems in their relationship (October 2014) and the date of the discovery of the victim's body in 2019.

4.9 To examine whether there were signs or behaviours exhibited by either the victim or perpetrator(s) in their contact with services which could have indicated the level of risk.

4.10 To report their involvement with the victim and/or the perpetrators, to assess whether the services provided offered appropriate interventions, risk assessments, care plans and resources. Assessment should include analysis of any organisational and/or frontline practice level factors which impacted upon service delivery.

4.11 To examine whether there any indicators or history of domestic abuse. If so, were these indicators fully realised and how were they responded to? Was the immediate and wider impact of domestic abuse between Christopher and Sarah and any children fully considered by agencies involved?

4.12 To consider whether there was any collaboration and coordination between agencies in working with Christopher and Sarah and any children, individually and as a family. What was the nature of this collaboration and coordination, and which agencies were involved with whom and how? Did agencies work effectively in collaboration and did services work effectively with those they were working with, including any children?

4.13 To consider what learning, if any, is to be identified in the management of either party. Is there any good or poor practice relating to this case that the Review should learn from? Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future.

4.14 To examine whether communication and information sharing between agencies or within agencies was adequate, timely and in line with policies and procedures.

4.15 To examine whether there were any equality and diversity issues or other barriers to the victim or perpetrator seeking help.

4.16 To examine whether the victim and/or perpetrator were assessed, or could have been assessed, as an 'adult at risk' as defined with the Care Act 2014. If not, were the circumstances such that consideration should have been given to this risk assessment?

4.17 To provide an assessment of whether family, friends, neighbours or key workers were aware of any abusive or concerning behaviour that occurred prior to the murder.

4.18 To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and are fit for purpose in assisting staff to act effectively where domestic abuse is suspected or present.

4.19 To examine the level of domestic abuse training undertaken by staff who had contact with the victim and/or the perpetrator and their knowledge and understanding of: indicators of domestic abuse (both for a victim and for a potential perpetrator of abuse); the application and use of the DASH risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC) and to appropriate specialist domestic abuse services.

Key lines of enquiry

4.20 The following key lines of enquiry will be explored further with the relevant agencies in the review:

4.21 Sarah's disclosure to professionals, from 2014 onwards, that there were difficulties in her relationship due to Christopher's controlling behaviour.

4.22 The feud between Christopher, Sarah and David (the child from Christopher's first marriage) over ownership of land and other assets. These were recorded as non-violent domestic incidents.

4.23 The response by professionals to threats made by Sarah that she knew people who could "sort the family out".

4.24 The timing of the revocation of Christopher's shotgun licence in light of the above.

4.25 The review is to look at agencies' involvement with the children and to identify whether there were any concerns raised regarding domestic abuse within the family structure and whether these had any impact.

5.0 METHODOLOGY

5.1 The methods for conducting DHRs are prescribed by the Home Office Statutory Guidance.[1] This guidance states that:
"Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safer interventions".

5.2 The Hertfordshire Domestic Abuse Partnership (HDAP) in partnership with the North Hertfordshire Community Safety Partnership (NHCSP) took the decision to commission the review on 12th March 2019. Those involved in making the decision were the Chair of the NHCSP and representatives from Hertfordshire County Council's Adult Care Services and Children's Services, local hospital trusts, probation service, Clinical Commissioning Groups, police, Refuge (provider of the Independent Domestic Violence Advocacy Service in Hertfordshire), Hertfordshire Partnership Foundation Trust, North Hertfordshire District Council and Hertfordshire Community Health Trust.

5.3 Following the decision to undertake the review, all agencies were asked to check their records to look for any prior interaction with Christopher or Sarah. The list of agencies contacted, and their involvement can be found at Appendix One of this report. A glossary of terms can be found at Appendix Two.

5.4 Where it was established there had been contact, it was ensured that all agencies promptly secured all relevant documents. The responses were compiled in a composite chronology for the DHR Chair and Report Author. Those who could make an appropriate contribution were invited to become Panel members. Agencies deemed to have relevant contact were then asked to provide an Individual Management Review (IMR) detailing the specific nature of that contact and to address the terms of reference.

5.5 The Panel made the decision not to seek information from the schools of the children of Christopher and Sarah. This decision was based on the amount of time that has passed between them leaving school and the date of Christopher's death. The ages of the children at the time of his death were 23, 21 and 18 years respectively.

5.6 The following agencies supplied IMRs:

- Hertfordshire Police
- Hertfordshire Partnership University NHS Foundation Trust, who provide health and social care for people with mental ill health, physical ill health and learning disabilities across Hertfordshire and neighbouring local authority areas.[2]

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. Home Office 2016.
[2] Information about the Hertfordshire Partnership University NHS Foundation Trust can be found here:

- Hertfordshire Children's Services' 0-25 Together service, which provides a range of statutory social care to meet the needs of disabled children within their families.[3]

5.7 The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could or should be made to agency policies and practice. Where changes were required, each individual IMR would also identify how these changes would be implemented.

5.8 Each agency's IMR covered details of their interaction with Christopher and his family and whether they had followed internal procedures. Where appropriate, the report writers made recommendations relevant to their own agencies. Participating agencies were advised to ensure their actions were taken to address lessons learnt as early as possible. As part of this process, IMR authors, where appropriate, interviewed the relevant staff from their agencies.

5.9 The findings from the IMR reports were endorsed and quality assured by senior officers within the respective organisations who are responsible for ensuring that the recommendations within the IMRs are implemented.

5.10 On request from the Independent Chair or Report Author, some authors provided additional information to clarify issues raised individually and collectively within the IMRs. Contact was made directly with those agencies outside of the formal Panel meetings. For example, information was sought from the police with regards to the criminal investigation, investigation into the harassment case and revocation of Christopher's firearms licence. Information was also sought from Hertfordshire Partnership University NHS Foundation Trust with regards to their training provision associated with domestic abuse.

5.11 Other information within this report has been obtained through access to information gathered by the police as part of the homicide investigation.

https://www.hpft.nhs.uk/about-us/

[3] Information about the 0-25 Together Service can be found here: shorturl.at/dguE0

6.0 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

6.1 The family of Christopher were contacted after the criminal proceedings had concluded and invited to contribute to the review. In March 2020, a letter was written by the Review Panel Chair to Christopher's eldest son (and his family) from his first marriage and his two sons and stepson from his relationship with Sarah. This letter informed them that a DHR would be taking place and invited them to take part in this process in whatever way they felt comfortable. The family were also provided with a copy of the Terms of Reference and the Home Office Domestic Homicide Review Information leaflet which provides information of the DHR process.[4] Advocacy was offered and a case worker from the homicide team within victim support engaged with the family.

6.2 The letter extended an offer for the family to meet with the DHR Chair and Report Author or to contribute in writing, if they preferred. Initially, three members of the family indicated they may want to participate in the review, but only one then responded to further contact and agreed a meeting date.

6.3 The DHR Panel then asked the Report Author to make further attempts to contact David and his side of the family. This was done and a meeting was arranged with Christopher's daughter-in-law, Gill, and his grand-daughter Julie was also present.

6.4 The DHR Chair also wrote to Sarah and Simon, asking whether they would consent to being spoken to as part of the DHR process. They were also provided with a copy of the Terms of Reference and Home Office leaflet. Neither party responded to the letter. In the letter to Sarah, a request was made for her to give consent for the release of information from the legal representatives she commissioned in relation to the post marital separation agreement. No response was received from her in respect of either matter.

6.5 As the review progressed, the DHR Panel felt it was important to gain information from those in Christopher's wider network, such as his friends or colleagues. The Report Author contacted one of his long-term friends and arrangements were made for meeting.

6.6 In addition, the DHR Chair wrote a letter to the law firm who represented Christopher with regards to the post marital separation agreement. A response was received from the law firm which stated they were unable to provide any information. The family had commissioned a new firm in relation to Christopher's estate. The letter was sent to the new firm, but no response was received.

[4] The leaflet is jointly produced by the Home Office and AAFDA (Advocacy After Fatal Domestic Abuse)

6.7 Between March 2019 and September 2020, the family have been supported by a homicide case worker from Victim Support (VS). The case worker has conducted eleven home visits, made over fifty telephone contacts and 40 contacts by text or e-mail.

6.8 Both sides of Christopher's family were supported by police Family Liaison Officers during the criminal investigation and judicial proceedings.

6.9 On 30th May 2020, the DHR Chair and Report Author had a meeting with Robert (eldest son of Christopher and Sarah) which took place at his home address. Robert spoke very openly about both of his parents and the dynamics of their relationship.

6.10 A virtual meeting took place on 4th November 2020 with Gill and Julie and another meeting with Christopher's friend, Barry, took place on 11th November 2020. All information provided by the family and friend of Christopher appear in the chronology section of this report.

6.11 An explanation was given to family members about the ongoing process of the DHR review and the use of pseudonyms to protect their identity. The family indicated they were happy for the names to be chosen by the review Panel.

7.0 CONTRIBUTORS TO THE REVIEW

7.1 Those who contributed information to the DHR, and the nature of these contributions, are outlined in the table below.

Agency	Information provided
Hertfordshire Police	IMR
Hertfordshire County Council Children's Services 0-25 Together Service	IMR
Hertfordshire Partnership University NHS Foundation Trust	IMR
GP surgery in Hitchin, Hertfordshire, where Christopher and Sarah were registered	Chronology of contact
East and North Hertfordshire NHS Trust	Chronology of contact

7.2 The Panel considered whether an IMR should be requested from the GP surgery following a review of the chronology. To make an informed decision, the Panel arranged for the chronology to be thoroughly reviewed by the Named Nurse for Safeguarding for Hertfordshire Clinical Commissioning Groups. As a result, it was decided that an IMR was not required, as there was sufficient evidence contained within the chronology provided.

7.3 Impartiality is a fundamental principle of Domestic Homicide Reviews, and the impartiality of the Independent Chair, Report Author and Panel Members is essential in delivering a process and report that is legitimate and credible. None of the Panel members knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

8.0 THE REVIEW PANEL MEMBERS

8.1 The Panel for this review was made up of the following representatives:

Name	Job Title	Organisation
Elizabeth Hanlon	Independent Chair	n/a
Tracy Hawkings	Independent Consultant and Overview Report Author	n/a
David Scholes	Chief Executive	North Hertfordshire District Council
Rebecca Coates	Community Protection Manager	North Hertfordshire District Council
Dawn Bailey	Lead Nurse Safeguarding Adults	West Hertfordshire Hospital Trust
Tracey Cooper	Associate Director Adult Safeguarding	Herts Valleys and East and North Herts Clinical Commissioning Groups
Sarah Taylor	Development Manager, Domestic Abuse	Hertfordshire County Council
Louise Coulson	Senior Service Manager for the Hertfordshire Independent Domestic Violence Advocacy (IDVA) Service	Refuge
Stephen O'Keeffe	Detective Chief Inspector	Hertfordshire Constabulary
Nicola Alston	Service Manager for the 0 -25 Together Service	Hertfordshire County Council
Katie Dawtry	Development Manager, Domestic Abuse	Hertfordshire County Council
Enda Gallagher	Lead Nurse for Adult Safeguarding	East and North Hertfordshire NHS Trust
Karen Hastings	Consultant Social Worker	Hertfordshire Partnership University NHS Foundation Trust

8.2 The DHR Panel met on five occasions. Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference and the agreement and implementation of an action plan to take forward the recommendations in this report, are the collective responsibility of the North Hertfordshire Community Safety Partnership and the Hertfordshire Domestic Abuse Partnership.

8.3 It is worthy of note that the National Farmers Union (NFU) were approached to ascertain whether they held any information on Christopher and his family or had any general observations to make with regards to domestic abuse within rural communities. An invitation was also extended for a representative to become a Panel member. The NFU stated they were aware of the case and the background relating to the dispute over the division of Christopher's estate. They did not consider there were any unique aspects to the case which warranted their involvement. They indicated they would be willing to attend a meeting by exception if required.

9.0 INDEPENDENT CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 North Hertfordshire Community Safety Partnership appointed Elizabeth Hanlon as the Independent Chair of the Review Panel and Tracy Hawkings as the Overview Report Author on 29th September 2019.

9.2 Elizabeth Hanlon, is a former (retired) senior police detective from Hertfordshire Constabulary, having retired in 2015. She has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership Reviews and Serious Case Reviews. She has received training in relation to the chairing and writing of DHRs and has completed the Home Office online training. She also attends yearly conferences surrounding the learnings from domestic abuse and has attended conferences involving families whose loved ones have been murdered as a result of domestic abuse. She has written several Domestic Homicide Reviews for Hertfordshire, Cambridgeshire and Essex.

9.3 Elizabeth Hanlon is the current Independent Chair for the Hertfordshire Safeguarding Adults Board. This is an independent role, and as such she has no affiliation to any of the agencies involved in the review, nor was she working within Hertfordshire Police at the time of the reported incidents. She has not been a panel member on any other DHRs within Hertfordshire and works as an independent DHR Author and DHR Chair.

9.4 Tracy Hawkings is a former (retired) senior police detective from Essex Constabulary and has 30 years policing experience. During her service, Tracy was Head of the Crime and Public Protection Command, working extensively with partner agencies, including those working to improve policy and practice in relation to domestic abuse. Tracy has also previously been Head of Major Crime and an accredited senior investigating officer responsible for leading homicide investigations, including domestic homicides.

9.5 Tracy retired from the police service in March 2017 but has spent the last three years working as a safeguarding consultant specialising in undertaking reviews, such as critical incidents, serious case reviews, domestic homicide reviews and post cases reviews. During that time, she was not involved with Hertfordshire agencies nor with the policies, practices or operational oversight of the resources deployed in this case.

10.0 PARALLEL REVIEWS

10.1 No other reviews were conducted alongside this DHR.

11.0 EQUALITY AND DIVERSITY

11.1 Section four of the Equality Act 2010 defines protected characteristics as:

Age
Disability
Gender Reassignment
Marriage and Civil Partnership
Pregnancy and Maternity
Race
Religion and Belief
Sex
Sexual Orientation

11.2 In identifying the relevant equality and diversity issues retrospectively for Christopher and Sarah the Review Panel note that:

Age

11.3 Christopher was a white British Male. He lived in Hertfordshire all his life and was aged sixty-nine at the time of his death. At the time Christopher married Sarah, he was aged 49 and she was 18 years his junior. There is research available which is detailed within section 16 (page 57 & 58) of this report which shows a significant age gap in an intimate partner relationship can be a factor associated with domestic abuse, particularly coercive controlling behaviour and older male victims can be more susceptible to abuse because of their isolation from sources of support and other well-being factors.

Marriage and civil partnership

11.4 Christopher was married twice. He had one grown up son as a result of his first marriage which ended in divorce in 1979. He met Sarah in 1992/93 and married her in 1997. They had three children who were born between 1995 and 2000. At the time of their meeting, Sarah had a young child from a previous relationship, who Christopher brought up as his own. Christopher and Sarah separated in 2015.

11.5 The couple remained on amicable terms following their separation, but this changed in 2017/18, after Sarah become involved in a relationship with Simon. Sarah initiated divorce proceedings in March 2018. Christopher did not agree to the divorce and made it known, he wanted a reconciliation. Within months of this happening, Christopher was reported missing. The Panel identified that the risk to Christopher would have increased when he refused to agree to the divorce, as research has shown that separation significantly increases the risk to victims of domestic abuse. Dr Jane Monckton-Smith published an article on this subject in 2019, where she cites separation as being a key trigger for perpetrators to try and regain control.[5] Although the circumstances of this case are different in that the perpetrator was

[5] Monckton-Smith, Jane Dr – 2019 Homicide Timeline – Eight stage behaviour pattern of abusers who kill.

pursuing a divorce, the issue of the couple's marital status was a motivating factor for the murder.

11.6 This is backed up by research from 'Mankind', which found men who are separated or divorced are more likely to suffer partner abuse than those who are married. 8.5% of men who are separated or divorced (13.2% women) suffered partner abuse in 17/18 compared to only 1.5% of married men (2.1% married women).[6]

11.7 Christopher's marriage to Sarah was his second marriage. Christopher had one son and extended family from his first marriage and Sarah had a son from a previous relationship, who Christopher brought up. As time went on and Christopher and Sarah had a family of their own, tensions arose between both families which left Christopher at the centre of the acrimony. Much of the tension was caused over finances and the division of Christopher's estate which escalated to such an extent there were domestic incidents and harassment offences reported between Sarah and David and his family (Christopher's son from his first marriage). This ultimately led to Christopher becoming estranged and isolated from his eldest son and grandchildren.

11.8 In addition, at the point Sarah met Simon, a man much closer in age, and their relationship developed, she initiated divorce proceedings. Christopher made it known he did not agree to a divorce and wanted a reconciliation with Sarah. It is believed the motive for the murder was the fact Christopher refused to divorce Sarah combined with the fact, she wanted access to his residue estate.

Disability

11.9 Christopher did not have any acute learning needs or disabilities which would have impacted on any assessments or the services that were offered to him. Christopher's GP records show that he was prescribed antidepressants, but the DHR Panel did not see any information that identified that Christopher had any mental health impairment. Christopher is not considered an adult at risk according to organisational criteria based on national guidelines.[7]

11.10 Christopher did disclose to his GP he had suffered with suicidal tendencies and had self-harmed which he attributed to the combined stress of his marital breakdown, financial debts, and the stress of being a farmer and landowner. Information from his family reveal, he was estranged from his eldest son and his family for a long period of time following the domestic incidents associated with arguments over Christopher's estate. In addition, as Sarah's relationship with Simon developed, he became completely estranged from her as tensions mounted. There is no doubt, this would have had a detrimental impact on his mental health and well-being.

[6] Mankind Initiative – Male Victims of Domestic and Partner Abuse – 45 Key Facts March 2019 – stats from Domestic Abuse Crime Survey March 2018.

[7] The Care Act 2014. The Care Act replaced "No Secrets" and the terminology used in the Care Act is adult with care and support needs/ an adult at risk who as a result of their care and support needs cannot protect themselves from abuse/risk of abuse/effects of abuse.

Sex

11.11 The Panel have identified a potential barrier to accessing services related to Christopher's gender. Research has shown that domestic abuse amongst male victims is significantly underreported, with data from 2017/18 showing that only 49% of male victims disclosed abuse to another person. In addition, it is widely known there is a lack of support for male victims across support services. For example, there are very few male Independent Domestic Violence Advocates (IDVAs) nationally and only a small number of places available for male victims in refuges across the UK as a whole.[8] In Hertfordshire, many domestic abuse services are open to both men and women and there is also a programme specifically for male victims of domestic abuse.[9]

11.12 The DHR Panel also identified that Christopher may have faced additional barriers to accessing support due to the rural area in which he lived. A recent study by the Rural Crime Network on domestic abuse in rural areas highlighted that:

1. Abuse lasts, on average, 25% longer in the most rural areas
2. The more rural the setting, the higher the risk of harm
3. Rurality and isolation are deliberately used as weapons by abusers
4. Support services are scarce
5. Rural victims are half as likely as urban victims to report the abuse

11.13 Whist Hertfordshire has several county-wide domestic abuse services, these are likely much less visible in the county's more rural areas. The availability and visibility of public services in these areas, such as GP practices and police stations, may also be more limited, restricting victims' reporting options. Added to this, effective broadband and reliable phone signal may not always be available in rural areas, making searching and calling for help more difficult and increasing victims' feelings of isolation.

11.14 If Christopher had wanted to relocate to escape domestic abuse, the nature of his work could have created additional barriers for him compared to victims from more urban settings

11.15 The Rural Crime Network's report makes clear that the dynamics of domestic abuse in rural areas may be very different to those in more urban areas. If services are not aware of this, then this could mean that victims of domestic abuse in rural areas are less readily identified and do not have access to the right support for their unique needs.[10]

12.0 DISSEMINATION

[8] https://www.mankind.org.uk/statistics/- stats quoted from ONS crime survey on domestic abuse.
[9] WISE GUYS | Future Living Hertford | Hertford
[10] https://www.ruralabuse.co.uk/

12.1 This version of the overview report is for discussion by the Community Safety Partnership. Circulation is restricted to staff directly involved in the review and the managers within the following organisations:
North Hertfordshire Community Safety Partnership.
Hertfordshire Domestic Abuse Strategic Partnership.
Hertfordshire County Council.
Hertfordshire Constabulary.
North Hertfordshire District Council.
Hertfordshire Partnership University NHS Foundation Trust.
Herts Valley and East and North Hertfordshire, Clinical Commissioning Groups.
Refuge (providers of Hertfordshire IDVA Service).
East and North Hertfordshire NHS Trust.

12.2 In accordance with Home Office guidance for DHRs, all agencies and the family of Christopher are aware that the final overview report will be published. IMR reports will not be made publicly available. Although key issues, if identified, will be shared with the relevant organisations, the overview report will not be disseminated until the Home Office Quality Assurance Group agree it is fit for publication.

12.3 The content of the Overview Report has been suitably anonymised to protect the identity of the male who was murdered, relevant family members and friends. The overview report will be produced in a format that is suitable for publication with any suggested redactions before publication.

13.0 BACKGROUND INFORMATION (THE FACTS)

13.1 At the time of his death, Christopher lived on a farm in North Hertfordshire. He was reported missing in 2018 and his decomposed body was found on nearby farmland owned by his estranged wife, Sarah, in early 2019.

13.2 Christopher was born and brought up in Hertfordshire. He was a farmer who owned an agricultural and livestock farming business. He had been involved in farming all his life and had acquired a significant amount of land, a farm and a number of farm holdings in the Hertfordshire area. His estate was valued at several million pounds. Christopher had one child, David, from his first marriage, who was born in 1975. The relationship between Christopher and his first wife ended in 1979.

13.3 Christopher met Sarah in 1992 after she moved to the Hertfordshire area with her partner and young son. The partner of Sarah was employed as a farmhand and worked for Christopher. Information from family members reveal Sarah had an affair with Christopher which was the cause of the break-up with her partner. Within a short space of time, Sarah and her son moved in with Christopher in 1992/93 and they married in 1997. At the time of their marriage, Christopher was aged 49 and Sarah 31. They had three children together, Robert, Kate and Stephen who were born between 1995 and 2000.

13.4 The marriage between Christopher and Sarah broke down in 2015 and she moved out of the marital home into a nearby farm holding which was owned by Christopher. They entered into a post-marital deed of separation and Christopher signed over ownership of two farm holdings and land to Sarah: an estate of significant value. It is believed that a contributing factor to the break-up of the marriage was the strain placed on Christopher in running a large business, which left Sarah at home bringing up the children single-handedly. There were also tensions over the division of the estate belonging to Christopher. The separation of Christopher and Sarah, and the subsequent post-marital deed of separation, heightened pre-existing tensions between Sarah, Christopher and his son David and disharmony within the extended family.

13.5 In September 2015 and November 2015, there were two non-violent domestic incidents reported to the police. The first incident involved Sarah and David (Christopher's son) and the second incident involved Christopher and David. Both incidents involved arguments over Christopher's estate. Following the second domestic incident, Sarah made threats to harm David and his family which were overheard by a witness and reported back to them. This matter was reported to the police. Upon police attendance, the family also reported a driving incident in the weeks prior to the threats whereby Sarah drove her vehicle at David and his daughter whilst they were out walking. These matters were dealt with as an incident of harassment and Sarah received a warning (Police information notice).

13.6 During the late summer of 2017, Sarah and Christopher met Simon, who worked at a local

haulage company situated on the estate owned by Christopher. For a period from September 2017 to January 2018, Simon moved in with Christopher as his lodger. Christopher offered to help Simon when he discovered he had left his home due to marital problems. This arrangement ended in January 2018, when Christopher discovered Sarah and Simon had begun a relationship and he told Simon to move out. Simon went to live with a family member in the area but carried on his relationship with Sarah and was a frequent visitor to her home.

13.7 In March 2018, Christopher received a letter from a solicitor representing Sarah informing him that she wanted a divorce and intended to initiate legal proceedings. Following receipt of the letter, Christopher contacted Sarah and informed her he would not agree to a divorce. A few weeks later, he wrote Sarah a letter stating that he wanted a reconciliation, offering to sell his farm so that they could relocate somewhere together and make a fresh start.

13.8 The timing of the divorce letter coincided with a potential property development deal which would have included a significant financial offer to both Christopher, Sarah and other local farmers for the purchase of their properties and land.

13.9 On 26th May 2018, the grandson of Christopher contacted the police to report his grandad had been the victim of an attempted arson. A rag had been found tied around the steering wheel of a Land Rover belonging to Christopher and set alight. A can of petrol was found beside the vehicle. The vehicle had been parked in a barn at Christopher's farm. The fire appeared to have extinguished itself and there were no other signs of external damage.

13.10 None of the family knew why anyone would want to carry out this attack. Due to concerns for Christopher's safety, his son, David, arranged for one of Christopher's employees to move into his farm to provide extra reassurance and support.

13.11 The following week, Christopher was reported missing from his farm and numerous enquiries were carried out to trace him but to no avail. As a result of an internal review of the missing person enquiry, one of the recommendations was to fully investigate the arson as a stand-alone crime and establish whether there were any links to the disappearance of Christopher. Forensic evidence subsequently linked Sarah's partner Simon to the crime.

13.12 Initially, some of Christopher's family members, including Sarah and Simon, were treated as significant witnesses and their accounts obtained. Simon and Sarah were later declared as suspects and arrested on 19th September 2018 for conspiracy to murder and were formally interviewed. They were initially released on bail, but subsequently rearrested when police recovered deleted WhatsApp messages between Sarah and Simon which clearly demonstrated their intention to kill Christopher. In excess of 28,000 messages were recovered from phones belonging to Sarah and Simon which revealed they had been planning Christopher's murder for several months and had secretly revelled in violently pornographic fantasies of torturing and maiming the landowner, who vanished just days before his 70th birthday. The messages also revealed their intention to harm Christopher's son David and his family. Sarah and Simon were charged with conspiracy to murder and arson. At this point, the body of Christopher had not yet been found.

13.13 In early 2019, the decomposed body of Christopher was found on a riverbank on farmland owned by Sarah. The subsequent post-mortem examination could not determine a cause of death, but the forensic pathologist believed he had sustained a fracture to his neck which would be consistent with strangulation.

13.14 In late 2019, following an eight-week trial at St Albans Crown Court, Sarah and Simon were both found guilty of murder and arson. They were sentenced to life imprisonment and have to serve a minimum of 22 years before being considered eligible for parole. Both entered appeals against conviction which were rejected. In delivering the verdict, the Trial Judge said of Christopher “He loved Sarah to the end, despite whatever she did to him and however much she did not deserve that love."

13.15 An inquest was initially opened and adjourned by HM Coroner in Hertfordshire. Following the outcome of the criminal proceedings, the coroner decided not to hold a full inquest, accepting the findings of the criminal court.

14.0 CHRONOLOGY

14.1 This section of the report gives an overview of information about Christopher and Sarah as provided by family members and professionals. It provides context of the dynamics of the relationship between Christopher and Sarah and a chronology of their contact with professionals.

14.2 The DHR Author conducted interviews with the following friends and family members of Christopher's:
Gill – daughter in law to Christopher married to his son David
Julie – granddaughter of Christopher (daughter of David and Gill)
Robert – Eldest son of Christopher and Sarah
Barry – Friend of Christopher and acquaintance of Sarah

Information provided about Christopher

14.3 Christopher was born into a farming family. His parents ran a farming and livestock business and when old enough, Christopher became a partner in the business and eventually took it over following the deaths of his parents. The family estate included farms, farm holdings and land which was worth several million pounds. Christopher is described as a man who worked incredibly hard, who was passionate about farming and devoted his life to it. He had a tremendous affinity with animals and was a kind and compassionate man.

14.4 Christopher married his first wife around 1970 and they had one son, David, who was born in 1975. His wife ended the relationship and moved out of the family home, leaving Christopher to bring up David as a single parent. They divorced in 1979.

14.5 Christopher met Sarah in 1992/93. They had their first child, Robert, in 1995 and married in 1997. They had two other children, Kate and Stephen, who were born between 1997 and 2000.

14.6 Christopher loved his family but became conflicted as ill-feeling grew between his eldest son, David, his second wife, Sarah, and their children.

Information provided about Sarah

14.7 There is little information available about Sarah before she moved to Hertfordshire in the 1990's with her then partner and young son. Sarah's partner had been employed as a farm hand and was employed by Christopher. Sarah had an affair with Christopher, which was discovered after some love letters exchanged between them were found by David and her partner on part of the farmland they were working in. Sarah ended her relationship with her partner and she and her son moved in with Christopher after a short period of time.

Relationship between Christopher and Sarah (information provided by Gill and Julie – daughter in law and granddaughter)

14.8 It is the opinion of Gill that Sarah set her sights on Christopher from an early stage because he was a wealthy landowner with assets, and she knew her lifestyle would greatly improve.

14.9 Prior to Christopher meeting Sarah, Christopher was very close to his son, David, but their relationship became strained over time. As David matured, married and had a family of his own, Sarah kept Christopher away from family functions and made it very clear that David and his family were not welcome to visit Christopher at his marital home. If anyone did visit, Sarah made them feel uncomfortable, and the atmosphere became very strained.

14.10 The situation deteriorated further over time, and Christopher found himself in the middle of arguments between the two families he loved. Sarah had a violent temper and there were occasions when she used violence towards Christopher, after which he was seen with bruises on his face. Christopher would tell David and Gill that the injuries had been caused by Sarah during arguments. She was also violent towards the property and would frequently smash things or break them. The incidents between Christopher and Sarah were not reported to the police because Christopher was a proud man and would never want to admit to being the victim of domestic abuse. In addition, he was besotted by Sarah and would not have wanted to get her in to trouble. On one occasion, Sarah punched Christopher's 13-year-old grandson in the face. This incident was not reported to the police by the child's family out of concern that Sarah would make counter-allegations.

14.11 Upon the death of Christopher's mother, her grandson David inherited her farm and some of the family land. This was done with Christopher's prior knowledge and consent and had been discussed before her death. It is believed she did this due to her concerns over Christopher's relationship with Sarah. This caused friction between Christopher and Sarah, who was angry he had agreed to hand over property and land which Sarah believed was rightfully his. This was the start of a long running family feud over the division of Christopher's assets.

14.12 Following the death of his mother, Christopher made Sarah a partner in the family business. This caused further division between the parties, as David believed Sarah diverted funds from the business account which caused Christopher to have mounting debts. The debts became so significant that Christopher had to take out a one-million-pound loan from the bank, with David acting as a guarantor. This was an indicator of possible financial abuse.

14.13 Christopher and Sarah separated in 2014/15. Sarah served divorce papers on Christopher but later withdrew them as a result of a post-separation financial agreement being reached in which Christopher signed over ownership of two farm holdings and land to Sarah. According to Gill, Sarah stipulated the holdings and land she wanted because she knew this would prove very profitable in future negotiations associated with a forthcoming property development deal.

14.14 After Christopher and Sarah had separated, there were a series of incidents linked to domestic disputes and threats which occurred between September and November 2015 (detailed below), following which Christopher became estranged from his son David until shortly before his death.

14.15 In March 2018, Sarah initiated divorce proceedings for a second time. As part of the divorce settlement, Sarah wanted half of Christopher's residue estate. Christopher made it known he would contest the divorce and the demands for additional assets.

14.16 It was at this point that Christopher turned to his son David and family for support and they reconciled. David was so concerned for the general well-being of his father that he asked one of the employees of the family business, Barry, to check in on his father daily and occasionally cook for him.

14.17 Gill and her family were aware that Sarah had entered another relationship with Simon but did not know him or have anything to do with him. They do believe, however, with the benefit of hindsight, that the risk to Christopher increased significantly from this point in time.

Information about Simon (From the police)

14.18 Simon was a 53 year old local man who was married with two grown up children. He worked for a haulage company which was based on Christopher's land. He was employed to oversee a project on the farm owned by Christopher and did some additional work at Sarah's farm. He was befriended by both Christopher and Sarah and when Christopher discovered he was in the process of separating from his wife, he offered him lodgings at his farm. Simon moved in with Christopher in September 2018 and remained living there until January 2019. Simon also rented a small silo from Sarah and as time went on their friendship developed into a relationship. When Christopher became aware of this, he told Simon to move out of the farm and he left to live with a local family member but continued to work at the farm and remained in regular contact with Sarah.

Information from Robert (Eldest son of Christopher and Sarah)

14.19 Sarah is described by her son, Robert, as hard-working and the main carer for him and his two siblings. He referred to the relationship between his parents as 'traditional'. When asked what he meant by the term 'traditional', Robert described how Christopher had responsibility for running the family business, working long hours, looking after the farms and estate and Sarah had the main responsibility for caring for their children. As the children got older, Sarah became more involved with the business. Robert stated he had a happy childhood and loved being part of the farming community.

14.20 Robert felt his father always favoured his son David, from his first marriage, and treated him much better than the three children he had with Sarah. He said whatever David wanted he got. Robert thought part of the reason for the favouritism towards David was because of the

guilt Christopher felt following the break-up of his first marriage. Christopher tried to make it up to David by giving him material things.

14.21 Sarah was very upset and angry that Christopher had given part of his estate to David following his mother's death, and this was a constant source of conflict between them, both during their marriage and following their separation. Robert believes his parent's marriage ended because of the friction caused between them over the situation with David. Robert does not believe he saw any indicators of domestic abuse between his parents, stating that they argued from time to time but that this was "nothing serious".

14.22 Christopher and Sarah remained on very good terms after their separation and Christopher remained a frequent visitor to Sarah's home. He would often stay for two to three days at a time.

14.23 Robert described how the situation between his parents changed significantly when Simon came on the scene. Sarah met Simon in September 2017 and he became a regular visitor to the home of Sarah. This caused tension with Christopher who was convinced they were having an affair. Robert described his mother as distancing herself from Christopher during this period, which caused him upset. Despite being challenged by both Christopher and Robert over her relationship with Simon, Sarah denied any involvement with him, stating they were just friends.

14.24 Robert was aware that within a few months of Sarah meeting Simon, she decided she wanted a divorce and served legal papers on Christopher in March 2018. Christopher told Sarah he would never agree to a divorce. Robert found it difficult to accept his mother had been involved with the murder of his father and felt that Simon would have been the driving force.

Information from Barry (Friend and employee of Christopher)

14.25 Barry was a long-time friend and employee of Christopher and knew him before he met Sarah. He described Christopher as a workaholic. He was passionate about being a farmer and was so dedicated he never took a day off or had a holiday. He devoted every waking minute to farming his land and looking after the livestock.

14.26 He described Sarah as a very hard unpleasant woman, who had a vicious temper. Sarah gave Christopher a very hard time throughout their marriage and was the cause of the ill-feeling between Christopher and David. Christopher struggled with juggling the running of his farms and business and looking after the children, all of whom had their own difficulties. Barry was not aware that Sarah had been physically violent towards Christopher but did witness her being verbally aggressive towards both him and the children.

14.27 Barry witnessed the aftermath of a dispute between Christopher and David which took place in November 2015. He was present when Sarah made threats towards David and his family

and he later provided a witness statement to the police. This incident is described further at paragraph 14.66.

14.28 Following this incident, Christopher and David stopped speaking for a couple of years. During this period, Sarah persuaded Christopher to change his will and leave everything to her and their three children. In later times, however, Christopher had another will, drawn up, which made David a beneficiary.

14.29 Barry would visit Christopher most evenings and cook him a meal. He would sometimes stay overnight with him. Barry and Christopher became very close during this period and Christopher would often refer to Sarah and say how much he loved her and wanted a reconciliation. Christopher was besotted by Sarah and blind to what she had done. Sarah always got her own way, and Christopher gave her everything she asked for. He was desperate to stay married to her and would have done anything to keep her in his life.

14.30 Barry described Christopher as man in turmoil over the ill-feeling between his family. He said Christopher was a "weak man" when it came to Sarah and she took everything from him.

Property Deal (Information from Gill and Barry)

14.31 The ill-feeling between the parties worsened when an opportunity emerged concerning a potential property development deal. A property developer was offering a large financial settlement to local farmers for the purchase of local farmland. All parties were likely to receive significant sums of money for the sale of land and estate. As Christopher's estate was still in dispute, the parties failed to agree on the division of land and the deal fell through.

Chronology of contact with professionals.

14.32 During the period under review (October 2010 to February 2019), Christopher, Sarah and their family had contact with four main agencies – Hertfordshire GP Services, Hertfordshire Partnership University NHS Foundation Trust, Hertfordshire Children's Services and Hertfordshire Police.

14.33 A chronology was provided by Christopher's GP surgery. Between 1st August 2013 and 13th March 2017, Christopher visited the surgery on several occasions. In addition, the GP surgery was very involved in making referrals in respect of the couple's three children to other agencies.

14.34 The IMR for HPFT includes information from the Adult Community Mental Health Team (ACMHT), the Child and Adolescent Mental Health Service (CAMHS) and the Learning Disabilities Adult Treatment Service (LDATS). The IMR author reviewed notes from all three services and interviewed a psychotherapist from the LDATS. These teams were involved with Sarah and her three children.

14.35 The IMR for HCS is largely concerned with the support offered to Kate, the middle child of Christopher and Sarah. It also details notifications from the police in respect of two incidents of domestic abuse.

14.36 The IMR from the police includes information in relation to two incidents of domestic abuse and a reported harassment in 2015, which took place during the ongoing family feud over the estate belonging to Christopher, and the arson to his vehicle which took place in June 2018 just days before his disappearance. There was other information relating to incidents on the farm, however these are unrelated to the events surrounding the murder of Christopher or the family feud which preceded it.

Key events which feature in the combined chronology:

14.37 On 1st August 2013, Christopher attended his GP surgery and disclosed he was feeling low and very anxious. He also suffered from tinnitus and was under the care of an Ear Nose and Throat (ENT) clinic. The notes record that Christopher had previous thoughts of suicide, but these had since passed. He was stressed due to the pressures of running his farming business and he recognised in himself that he was showing signs of depression. He was diagnosed as having mixed anxiety and depressive disorder and prescribed anti-depressants.

14.38 On 11th September 2013, Christopher had a follow-up appointment. The notes record the anti-depressants were helping his depression and he was coping better. He agreed to continue with the medication. The notes reveal there was also a slight improvement with his tinnitus.

14.39 On 24th September 2013, Christopher attended the GP surgery. The notes record, his tinnitus worsened when his anxiety levels were high, but he felt much better now he was on medication. The GP agreed to increase the dosage of anti-depressants to try and reduce the current anxiety levels of Christopher.

14.40 On 14th October 2013, Christopher attended the surgery for a medication review. Christopher reported that the increased dosage had dramatically helped with his anxiety levels and general well-being. His sleeping pattern and his tinnitus had both improved. There was a series of repeat prescriptions given over the following months.

14.41 On 7th November 2013, Sarah attended the Accident and Emergency department of a local hospital with her youngest son, Stephen, who had been caught smoking at school and had reacted to it by expressing a wish to die. A psychiatric assessment was carried out which concluded that Stephen should continue to see a therapist at an education support centre.

14.42 On 1st October 2014, the eldest child of Christopher and Sarah (Robert) was referred by the family GP to the Adult Community Mental Health Services (ACMHS) for an Autism Spectrum Disorder (ASD) assessment. At the time Robert was aged 18 years old.

14.43 On 14th October 2014, an initial assessment was carried out by a Community Psychiatric Nurse (CPN) to establish the health and social care needs of Robert. Sarah was present throughout and disclosed to the CPN that she was going through a divorce and referred to her ex-partner, Christopher, as 'controlling'. She described how she was struggling to care for her other children because of their individual needs. She believed Robert was affected by the frequent criticism he received from Christopher. Sarah felt Christopher favoured his son from his first marriage and treated their three children differently.

14.44 During the assessment, the CPN contacted Children's Services to make a referral for support for Sarah and the children. The referral was in relation to Sarah struggling to cope with her children's behaviour, the fact she was going through a divorce and receiving school fines for the non-attendance of her youngest child. The notes record that Robert was not engaging with the ASD assessments and that there were difficulties between Sarah's children. Sarah reported feeling isolated. There is nothing in the notes to suggest that the referral to Children's Services mentioned the fact that Sarah had said Christopher was controlling. Furthermore, no referrals were made to specialist domestic abuse services.

14.45 The CPN made a referral for Robert to the ACMHS Occupational Therapist for an assessment of his daily living skills to identify if there were any needs under the Fair Access to Care Services (FACS) criteria. The CPN also correctly identified Sarah as a carer and arranged for a carers assessment to be carried out.

14.46 The CPN referral to Children's Services was allocated to the Disabled Children's Team (DCT) for assessment. The duty officer contacted the colleges that Stephen and Kate attended and based on the information received, decided that neither of them met the criteria to receive a service from DCT. They did agree that Kate needed to be reassessed and advised Sarah to contact her GP for a referral and for the college to consider initiating a common assessment framework procedure, with a view to requesting support from the team around a family service.

14.47 On 23rd October 2014, Sarah had a carer's assessment. The assessment was completed by the CPN. During that assessment, Sarah explained she was responsible for all the care giving in the family. She stated that her husband had not been part of the family for many years and that they had never gone on holiday. She described struggling with the needs of her other two children who were, by then, aged 17 and 13 years old. From that assessment she was given information on Carer's Support. There was a follow up home visit and telephone contact as part of the process.

14.48 On 8th December 2014, Christopher attended an appointment at his GP surgery. The notes record an improvement in his mood and tinnitus. He had stopped taking anti-depressants but still had dark days. Christopher disclosed to his GP that he was currently going through a difficult period due to the recent breakup of his marriage. He was also having difficulties relating to his farming business and separating his finances with his wife. In addition, his tinnitus was still causing him to have sleep disruption. He had thought about self-harm but

had never acted on the feelings and there were people he could talk to who would help him get through. A follow up appointment was made.

14.49 On 2nd January 2015, the youngest child of the couple (Stephen), then aged 13 years old, was referred to the Child and Adolescent Mental Health Services (CAMHS) and the Speech and Language Therapy (SALT) department by the family GP. The referrals were made because Stephen was exhibiting challenging behaviour and mood swings. He had previously disclosed suicidal thoughts and was struggling with school attendance. The school SALT had reported being unable to assess Stephen as he was volatile and emotional.

14.50 On 5th January 2015, Christopher attended a follow up appointment with his GP. He disclosed he was struggling to cope with the issues within his marriage and was in significant debt. He had consulted with a solicitor who was now involved with his case.

14.51 On 23rd January 2015, Sarah and Stephen attended a Choice assessment with the CAMHS Child & Adolescent Psychotherapist. Sarah was concerned Stephen may have autism and explained his background history of anxiety and school refusal. The psychotherapist spoke to North Hertfordshire Educational Support Centre. During this visit, it was decided that Stephen should have further appointments with the Child Development Clinic in relation to his Autism Spectrum Disorder (ASD) and an appointment with CAMHS in relation to his suicidal thoughts. The notes record that Christopher was to be invited to the CAMHS appointment.

14.52 On 6th February 2015, Stephen and Sarah attended a follow-up Choice appointment with the Child & Adolescent Psychotherapist. Advice was given to Sarah about how to communicate more effectively with Stephen.

14.53 On 16th February 2015, Christopher re-attended his GP surgery for a medication review. During the consultation, Christopher told the GP his gun license had been revoked.[11] The reason he gave for the revocation was because he was suffering with tinnitus. He told the GP he needed to keep guns in his house on behalf of his son, David. Christopher said his solicitor wanted a medical report to support the fact he was fit enough to keep the guns at his home. The GP advised Christopher to get his solicitor to make a written request outlining their requirements. There were other visits, but nothing relevant recorded in the notes concerning his relationship or on-going problems with Sarah.

14.54 On 9th March 2015, Robert turned down the autism assessment and also stated he did not want the occupational therapy assessment to continue (although this had already concluded on 19th February). The reason for this is not recorded. Robert was provided with contact details and information on to how to self-refer to the service if he felt he needed support. Both Robert and Sarah were discharged from the service on this date.

[11]There is an intelligence report held in police systems which confirms the shotgun licence was revoked in February 2015 due to Christopher's erratic behaviour. This is not explained further.

14.55 On 31st March 2015, Kate was assessed by the Adult Community Mental Health Team as there were concerns that she may be experiencing mental health problems. Kate had a previous diagnosis of Autistic Spectrum Disorder, ADHD and sensory issues. This assessment concluded that Kate should be transferred to HPFT Learning Disabilities Service. This referral was initially rejected on the grounds she had no additional health or mental health needs. HPFT Learning Disabilities services offer support to individuals who have a mental health disorder as well as learning disabilities and autism.

14.56 On 27th April 2015, a CAMHS social worker telephoned Christopher to speak to him about Stephen. Christopher advised the social worker that she should speak with his wife. The social worker spoke to Sarah later the same day who confirmed that the situation had improved in that Stephen was more talkative. Sarah said she did not know why Stephen had been referred to CAMHS as the school wanted him to be seen at the Child Development Clinic (CDC) for the autism assessment. A plan was agreed for follow up after the CDC appointment. By 7th May 2015, Stephen had been seen at the Child Development Clinic. They did not diagnose Stephen with autism, and it was agreed CAMHS would continue to offer support.

14.57 On 11th May 2015, Stephen and Sarah attended a CAMHS partnership appointment with a CAMHS social worker. During that meeting, Sarah talked about the strain of caring for her middle child, Kate. Stephen became quite angry when discussing his autism assessment and disagreed with his mother over several issues during the appointment. This was a similar reaction to that of his brother Robert who disagreed with Sarah over the need for his assessment.

14.58 Stephen did not attend the next appointment due on 22nd May 2015. The social worker telephoned and spoke to both Stephen and Sarah. Stephen refused to attend any further appointments with CAMHS. The social worker agreed to do a follow up call the following week, which took place on 3rd June 2015. During the call, Sarah reported an improvement in Stephen's behaviour. He was discharged from the service at this point. The GP and Child Development Centre were both informed of his discharge. During the call, Sarah described struggling to get support for Kate and was advised that the Hertfordshire Autistic Resource Centre may offer some assistance.

14.59 On 26th June 2015, Sarah self-referred for a carers assessment as she was struggling to cope with the challenging behaviour of her children and at the same time was experiencing problems in her relationship with Christopher. Hertfordshire Children's Services' Transition Team (now the 0-25 Together Service, which still sits within Children's Services with a dedicated 'Preparing for Adulthood' team) became involved in September 2015 and had very active involvement from then on. A Care Act 2014 needs assessment for Kate was quickly completed and a care plan implemented. Sarah received two carer's assessments compliant with the Care Act 2014. The care package provided 20 hours a week of one to one support for Kate.

14.60 On 19th September 2015, Sarah contacted the police to report a heated verbal argument with David. The argument was in relation to an on-going civil dispute over farmland. There were no allegations of criminal conduct and no further action was taken. The incident was classified as a standard risk non-crime domestic incident. A non-crime domestic means a domestic incident has occurred, but the circumstances do not amount to a criminal offence which would require further investigation.

14.61 On 14th November 2015, Sarah contacted the police to report an argument between Christopher and David during a pheasant shoot. She initially reported that David was in possession of a shotgun and said she was frightened to go out as she had an autistic child in the house. She later changed this account and said David was in possession of a baton, which was then identified as a beating stick used during the pheasant shoot. At the time the police attended, both Sarah and Christopher were present and were spoken to. Sarah provided all the information to the police and the police notes record that Christopher would not disclose any information, albeit, he did ask the police to speak to his son. The notes do not make it clear whether or not Sarah and Christopher were spoken to individually or together.

14.62 The police subsequently spoke to David at his home address. He stated the argument with his father was in connection with on-going family matters concerning ownership of their farmland. David had always been given the impression from Christopher that he would inherit his father's estate. He stated his stepmother Sarah was taking advantage of Christopher and using all his money to clear her debts, a clear indicator of economic abuse. The situation was made worse by other family members "taking sides", which was causing additional stress to both Christopher and David. David was advised to meet his father in a neutral setting with no other family members present which he agreed to do. The incident was classified as a non-crime standard risk domestic incident. This means those attending did not consider any criminal offences had been reported. Following this incident, a referral was made to the firearms licensing officer, as Christopher had firearms stored at his property which belonged to his son David.

14.63 On 16th November 2015, Julie (Christopher's granddaughter) reported that Sarah had made threats towards her and her family in the presence of a third party (Barry) which made her feel intimidated and vulnerable. This followed the domestic incident reported on 14th November and was directly linked to it.

14.64 On police attendance, they established that there was a long-standing family feud based around the assets and estate of Christopher. There had been a recent disagreement between Christopher and David over the estate, which saw Sarah receiving a large proportion of the family business. Julie also reported a driving incident which had occurred a few weeks before, where Sarah had deliberately driven at her and David when they were out walking. Following the domestic incident on 14th November, Barry (Christopher's employee) was present when Christopher was discussing the incident with Sarah. During the conversation, Sarah became angry and said David and his family were greedy. When challenged by Barry about the comment, Sarah said "I have friends in the North, they will come down and sort the family for

me". Barry subsequently repeated the conversation to David and his daughter, who reported it to the police.

14.65 The incident was recorded as a first incident of harassment and a Police information (Harassment) Notice was served on Sarah. The notice recorded details of the threat made and was served on Sarah who signed it to acknowledge she had received a warning. It must be noted that the notice has no statutory status, no formal process had to be followed and there was no limit on the period for which it took effect. This incident was not recorded as a domestic incident and therefore a risk assessment was not completed.

14.66 On 11th January 2016, Kate was assessed by the HPFT Learning Disabilities Adult Treatment Service (LDATS) following a re-referral by a Community Care Officer from the County Council's Transition Service, which is part of their Community Learning Disabilities Service. Sarah had reported concerns that Kate was talking to herself and had become obsessed with family members smoking. The assessment was carried out by a clinical psychologist and trainee clinical psychologist at the family home. During part of the assessment, the psychologist took Kate for a walk and spoke to her alone.

14.67 The notes from the clinical psychologist record that the family were finding things difficult at that time and that Sarah was struggling with the demands placed on her by Kate. She talked about being worried for the future of Kate and said she had seen a GP as she was feeling depressed.

14.68 On 13th January 2016, Sarah was offered an appointment with the trainee clinical psychologist without Kate being present. Sarah stated her main concerns were for Kate's future if anything were to happen to her. Sarah described finding it hard to talk about her feelings as there was a family culture of being 'strong'. The rest of the appointment was used to answer her questions about autism. Sarah had been offered the opportunity to attend the Angels Support Group, a support group for parents of children with Autism Spectrum Disorder and ADHD, but had not been able to attend the group due to time pressures and caring responsibilities for her other children.[12] Kate was offered ongoing support from the trainee clinical psychologist, and the family (Sarah and siblings) were included in terms of developing their understanding of Kate's needs and behaviours.

14.69 On 8th March 2016, Sarah had an appointment with the trainee clinical psychologist to help her understanding of Kate's diagnosis. During that appointment, the psychologist spoke to the organiser of Kate's animal care course at her local college. Though Kate had previously been preoccupied with girls from the childcare course following an altercation, the college reported there had been an improvement and that Kate seemed happy.

[12] More information about the Angels Support Group can be found here: https://directory.hertfordshire.gov.uk/Services/7248

14.70 On 5th April 2016, the trainee clinical psychologist contacted Sarah who reported that Kate did not want to go to college because she was being bullied and had been hit over the head by another pupil.

14.71 On 23rd May 2016, there was a Network (multiagency) meeting at the family home. Sarah and Kate were present. Following this, it was agreed Kate could be offered individual sessions with a clinical psychologist to conduct an assessment as she was suffering with low moods and anxiety. Kate had been assessed for respite care, but this heightened her anxiety through fear she would be removed from the family home and not be able to return.

14.72 On 28th June 2016, there was the first direct psychology session at home with Sarah and Kate. During that appointment, Kate disclosed she was worried about her family smoking and about being bullied at college. Further psychology sessions took place in June, July and August. Notes indicate no concerns around safety or domestic abuse.

14.73 On 22nd August 2016, a referral was made to a specialist learning disability psychotherapist to allow Kate the opportunity to speak about separation anxiety, the conflict she experienced at home (with siblings) and her experiences at college. The clinical psychologist ended involvement at this point.

14.74 Between 20th October 2016 and 5th January 2017, Sarah and Kate attended appointments with a psychotherapist. He was concerned Kate's sleep problems and anxiety may be linked to the childhood trauma of being bullied constantly (as reported by Sarah) and that she may have mild PTSD as a result. Appointments continued thereafter on a fortnightly basis until her discharge on 5th January 2017.

14.75 On 26th May 2018, the Christopher's grandson contacted the police to report an arson to Christopher's Land Rover, which was parked in an outbuilding at Christopher's farm. The vehicle had been entered and a petrol-soaked rag tied around the steering wheel of the land rover which was then set alight. A petrol can was found next to the vehicle. The interior of the vehicle sustained damage. This incident was recorded as a crime of arson. Initially, the police did not link this incident with the previous domestic or harassment incidents.

14.76 In early June 2018, Christopher was reported as a missing person. An internal review was conducted and based on the circumstances of Christopher's disappearance and the family history, the case was allocated to the Major Crime Unit who initiated a murder investigation. Sarah and Simon were subsequently charged with murder and arson. Forensic evidence linked Simon to the arson attack committed on 26th May 2018.

15.0 OVERVIEW

15.1 The overview will summarise what information was known to the agencies and professionals involved with Christopher and his family. It will also include any relevant facts or information known about Christopher.

Overview of GP Involvement

15.2 The GP surgery provided information which showed Christopher was struggling with depression and anxiety associated with his marital difficulties, stress caused by the financial situation which arose as a result (which may have involved economic abuse) and the general stress of his profession as a farmer. Christopher did disclose there were times when he had dark days and felt like harming himself. He was provided adequate and supportive clinical care and advised to self-refer for CBT counselling. His main interaction with the GP surgery was between 2013-15. The notes do not reveal whether the GP explored the potential for domestic abuse.

15.3 The GP surgery was also heavily involved in making referrals to either HPFT or Children's Services in respect of the couples' three children. The GP surgery was aware that all three children were experiencing emotional difficulties which may have been affected by the acrimony between their parents. They do not appear to have considered whether or not the children may be experiencing trauma as a result of this.

Overview of HPFT Involvement

15.4 The three children of Christopher and Sarah all experienced behavioural and emotional challenges. Their middle child was diagnosed with autism spectrum disorder and the other two children were referred for autism assessments. The youngest son of the couple had threatened suicide and was reported to be highly emotional and volatile by the school SALT. As Sarah was the parent who attended all appointments with the children, the only insight professionals had into her relationship with Christopher was based on her accounts alone. There were no direct disclosures of domestic abuse, but she did portray Christopher as a controlling man, who she says was critical of their children. She believed Christopher had more time for his family from his first marriage.

15.5 The DHR Panel do not feel that the professionals in HPFT who spoke to Sarah picked up on the significance of her description of Christopher being a controlling man. The word 'control' features within the legal definition of domestic abuse and is defined as "a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour". This aspect was not explored further by the professionals involved but was an indicator that there may have been domestic abuse within the relationship and should have prompted further questions.

15.6 Robert, the eldest child of Christopher and Sarah, was referred to HPFT for an autism assessment by the family GP. The CPN who interviewed him for his initial assessment made a referral to the ACMHS Occupational Therapist, so they could assess their daily living skills to identify if there were any needs under Fair Access to Care Services (FACS) criteria. The CPN also identified Sarah as a carer, arranged a carers assessment for her and assisted her in contacting Children's services for support for the family.

15.7 Robert was offered an Asperger's assessment and further assessment of their daily living skills but, in the end, both were declined. There was nothing in the presentation of Robert to indicate any severity of disorder which would necessitate compulsory treatment; he was generally managing well with day to day living.

15.8 Sarah did disclose to the CPN that her ex-partner, Christopher, was controlling. The notes do not show if this was explored further in terms of potential abuse within the family. Although coercive and controlling behaviour did not become a standalone offence until 2015, the terminology had featured in the definition of domestic abuse since 2012. The DHR Panel feel this aspect should have been explored further by the professionals involved.

15.9 Stephen, accompanied by Sarah, was seen at the Choice appointment, which was held within the 28-day time limit for a standard referral as required by the CAMHS Operational Policy. The aim of a Choice & Partnership Approach Appointment (CAPA) is for the child and their family to come to a shared understanding of the child's difficulties and to identify the kind of help they can get. Stephen was offered ongoing CAMHS support, which included advice and support for Sarah in terms of adapting her communication style to suit the needs of Stephen. At the end of contact, this approach appeared to be positive, and Sarah reported the situation had improved.

15.10 The CAMHS Social Worker contacted Christopher to try and engage him in the treatment plan for Stephen (as part of the partnership approach) but he deferred to Sarah, asking the Social Worker to speak to her. Christopher did not attend any appointments with Stephen or his other two children. This appears to be in line with information provided by Sarah referring to the way that tasks were divided with her as primary care giver for their children.

15.11 Stephen declined further contact with CAMHS. There would be no grounds to enforce a service on Stephen, particularly as his mother had reported good outcomes from the support offered until that point in time. The support offered was in line with that expected at the time. The CAMHS notes show no indication of any risks to Stephen from either parent or any history of domestic abuse. In addition, thorough background information was obtained by the CAMHS practitioners from other agencies, and this did not reveal any concerns regarding domestic abuse between Christopher and Sarah. The review has established that although the assessment processes used by practitioners do not specifically ask standardised questions relating to domestic abuse, they do cover familial relationships and wider social networks in

an effort to explore, identify and address problems and stressors which may be a contributing factor to the presenting behaviour.

15.12 Of the three siblings, Kate has had the most extensive contact with services. Sarah was the main point of contact, and she was also offered support and advice by the Learning Disabilities Adult Treatment Service (LDATS).

15.13 Throughout this time there were no allegations of domestic abuse between Christopher and Sarah. There was, however, discussion about conflict between Kate and her siblings who had difficulty tolerating her behaviour and tics. There was recognition of the impact that this discord and bullying had had on Kate and a referral was made for psychotherapy to help her with that. Social care support was provided by Hertfordshire County Council in terms of Kate's wider needs.

15.14 The IMR author interviewed the psychotherapist who saw Kate at that time and who has been counselling her since the death of Christopher. He stated he only met Christopher once as it was always Sarah who brought Kate to appointments.

15.15 The psychotherapist said that he was struck by the big age difference between the couple, but otherwise there was no disclosure of concern about their relationship during that initial period prior to Christopher's death. At that time, Kate talked a lot about her siblings and mother, but less about Christopher. By this point, Sarah and the children had moved to their new home, and the focus for Kate's treatment was on the impact of bullying and on supporting her to cope with her anxiety and attachment difficulties. The psychotherapist had no concerns for the safety of Kate or her wider family. The notes from LDATS show there was no indication or disclosure of a history of domestic abuse in the family. The assessment process allows for general exploration of family dynamics, there is a psychotherapy checklist form which does cater for general enquiries but not specific inquisitive questions around domestic abuse. This may have been a missed opportunity for the psychotherapist to be more inquisitive when completing his assessment about what was going on within the family dynamic. By this time, Christopher and Sarah were separated and there does not appear to have been any inquiry as to the impact this may have had on Kate or her understanding of the reasons for the separation.

Overview of Involvement from HCS

15.16 Christopher had no involvement with HCS. All interactions were with Sarah and their three children. It is clear from the chronology that Sarah was very active in her efforts to get support from agencies. Sarah first made contact to Children's Services in 2014 requesting help with her youngest two children. Sarah had made previous requests for help and support, but none was forthcoming initially.

15.17 Whilst there were some attempts of passing on referrals for services, particularly evidenced by the deputy head of Stephen's school, the referrals were deemed as not meeting the HCS

criteria for intervention. The concerns were regarded as low level in terms of risk towards the welfare of the children.

15.18 It is recorded that Sarah was with a CPN when she contacted the service on 17th October 2014. The fact that Sarah was with a CPN was not questioned or followed up. It can be assumed that Sarah was seeking help with, or via, mental health services as well as approaching social services. It also may be Sarah was with a CPN in relation to Stephen as it was recorded, he had episodes of suicidal ideation and depression, but this is not clear in the notes.

15.19 In September and November 2015, two domestic violence police incident notifications were received by the Early Help Intake Team, a 'front door' low level intervention team. The Early Help Service works in partnership with other professionals, parents and carers to intervene early when families need more support. The aim is to address problems at the earliest opportunity, before they can escalate, to enable families to support their children to reach their full potential.

15.20 A standard response letter was sent by the Early Help Intake Team to Sarah following the incident on 14th November 2015 outlining the impact and risks to children when witnessing domestic violence. This standard letter was procedure at the time. The process has now changed, and contact is made in most cases by telephone where safe to do so. On the rare occasion where a letter is required, it will only be sent once it has been established it is safe to receive and it will be delivered by hand by prior arrangement.

15.21 Prior to 2015, the procedure was that if six domestic abuse notifications were received, an automatic referral would be generated to the Assessment Team in Hertfordshire Children's Services. This changed in 2015, when the MASH (Multi Agency Safeguarding Hub) came into existence. The MASH assessed each notification on an individual basis. With both systems, the response in this particular case would have been the same, in that they were viewed as low level risk. A full overview of the MASH process can be found in Appendix Three.

15.22 Once the Transition Team from Children's Services (now the 0-25 Together Service) became involved in September 2015, there was very active involvement. A Care Act 2014 needs assessment for Kate was quickly completed and a care plan implemented which included the provision of one to one support. Sarah received two Carers Assessments in compliance with the Care Act 2015.

15.23 Within these assessments, there was no explicit reference to domestic violence or control or coercion by Kate or Sarah. The key workers involved with the family did not indicate any concerns around domestic violence, control or coercion within the family home.

Overview of Police Involvement

15.24 It is the police who provide the most significant information with regards to the dynamics between Christopher and Sarah and their extended family during the period under review.

15.25 On 19th September 2015, Sarah reported a heated verbal argument with David in relation to the farmland which was subject of an ongoing civil dispute. This was the first reported domestic incident to police and highlighted the animosity between Sarah and David and the feud developing over Christopher's will in relation to the farmland and estate. It appears their disagreement related to who would inherit the estate in the event of a divorce. Police attended and recorded the incident as a non-crime standard risk incident of domestic abuse, naming Sarah as the victim. A notification was sent to Children's Services. It appears the ill-feeling continued despite the fact a settlement had been agreed and signed in August 2015, according to which Sarah received a proportion of Christopher's estate which included land and two farm holdings.

15.26 On 14th November 2015, Sarah called the police stating David was "kicking off" with Christopher during a pheasant shoot and reported that he was in possession of a shotgun. The police attended and spoke to Christopher, who did not disclose any information. Sarah reported that the argument was over a shoot that was organised without Christopher's knowledge and on land where sheep were grazing. Officers later spoke to David at his home address, and he agreed to speak to Christopher at a neutral location to try and resolve their differences. No criminal offences were disclosed, and a non-crime standard risk domestic was recorded.[13] A referral was made to the Firearms Licencing Officer for their attention, as guns were held on the farm premises. A notification was also sent to Children's Services.

15.27 In the crime log, more background detail was recorded about the reasons for the dispute and on-going family feud which makes clear that Christopher and David were in dispute over money and ownership of the land and other assets. David was of the opinion Sarah was taking financial advantage of Christopher, which strongly suggests he thought that Christopher was a victim of economic abuse. However, this does not seem to have been acted upon by police and certainly not explored in any depth.

15.28 It is clear Christopher was caught up in the middle of the feud between Sarah and David over the division of his assets.

15.29 In dealing with the incidents on 19/09/15 and 14/11/15, the police gave advice to all parties and recorded both incidents as standard risk domestic disputes. The incident in November was correctly referred to the firearms licencing Officer to ensure that all the regulations in relation to firearms held at the farm were being adhered to. A TAS (Targeted Advice Service) referral was made in respect of Kate as a child aged under 18. Officers in attendance at domestic disputes at that time were actively encouraged to signpost those involved to local

[13] Risk assessed using the Domestic Abuse, Stalking and Honour-based abuse (DASH) risk indicator checklist.

support agencies and charities whose details were listed on the DASH risk assessment forms.[14] Sarah was named as person reporting both incidents and David as the person responsible. However, when attending officers spoke to David, he made an accusation that Sarah was financially abusing Christopher by using his assets to pay off her debts. The incident was managed as an on-going family civil dispute over assets and land and not investigated as a potential crime. It must be noted, however, that Christopher was present when police attended and was spoken to by them. He did not disclose any information to the police. It is unclear from the paperwork, whether or not Christopher was spoken to alone or whether Sarah was present throughout which may have inhibited Christopher's ability to speak freely.

15.30 On 16th November 2015, Christopher's granddaughter, Julie, called the police to report an incident whereby Sarah had made threats towards David and his family in the presence of a third party (Barry) who later relayed the information back to them. This caused Christopher's granddaughter to feel intimidated and vulnerable.

15.31 Neither David nor his daughter were present when the comments were made. The crime text states: "This is a long-standing family feud of over 20 years based around the assets of the family business and Will of Christopher. Sarah made comments that she knew people up North who would "sort the family out". On police attendance, Christopher's granddaughter also reported an incident which had occurred a few weeks earlier. She described being out walking with David when they saw Sarah driving her car. She described Sarah deliberately driving on to the pavement towards them in an attempt to run them over". Christopher's granddaughter informed the attending officers that she believed Sarah wanted to get rid of her family and she believed there was a genuine risk to their safety.

15.32 Officers later visited Sarah and an 'Allegation of Harassment' Police Information Notice was completed and handed to Sarah, who signed as the recipient of the notice. The notice cited details of the threat made which had caused distress. There was no mention of the driving incident on the notice which had occurred some weeks before. The IMR author reported that they felt this action was appropriate in the circumstances. This was on the basis the threat was made in the heat of the moment and was an idle threat. The DHR Panel do not agree with this assertion, and this is commented on further at paragraph 16.23.

15.33 It is important to note there was no specific threat to kill made by Sarah, albeit this may have been her intended meaning. Guidance on the CPS website states that this offence should only be considered for the most serious of cases as it is very difficult to prove, and other legislation should be considered. It was therefore appropriate that the police considered this to be a case of harassment.

15.34 Police Information Notices (PINs) should be signed to evidence that a suspect has been notified that their behaviour constitutes harassment and that any future conduct would be considered a full offence.[15] Details of the PIN can then be used in any legal proceedings.

[14] Information provided by the Chief Inspector at the Domestic Abuse Incident and Safeguarding Unit.
[15] The offence of harassment occurs where:

15.35 On 26th May 2018, the grandson of Christopher reported that Christopher had been the victim of an attempted arson. A rag had been found tied around the steering wheel of Christopher's blue Land Rover Defender vehicle and set alight. A can of petrol was found beside the vehicle. The vehicle had been put in the shed at his home the night before and was out of sight to passers-by. The fire appears to have extinguished itself and there was no other damage outside of the vehicle.

15.36 None of the family knew why anyone would want to carry out this attack, but due to his concern over his father's safety, David asked a work colleague (Barry) to reside with his father to provide extra reassurance and support.

15.37 The following week, Christopher was reported missing and numerous enquiries were carried out to trace him. As a result of an internal review of the missing person enquiry, it was recommended that third-party involvement be considered, and the investigation be handed to the Major Crime Unit to continue the enquiry.

15.38 One of the recommendations from the review was to fully investigate the arson as a stand-alone crime and then establish if there were any links to Christopher's disappearance. The review recorded "if something sinister had happened to Christopher, it is highly likely the arson incident is connected as it appears the crime is targeted towards Christopher." The arson investigation later formed part of the murder investigation.

Overview of Solicitor's Involvement

15.39 The review has identified that both Christopher and Sarah appointed solicitors to draw up the post marital deed of separation financial agreement and that Sarah consulted a solicitor with a view to initiating divorce proceedings on two occasions. A letter was written by the DHR Chair to the Christopher's legal representative who declined to release any information. Sarah was contacted and asked to provide consent for her legal representative to release information, but she did not respond. It is difficult, therefore, to know what information if any was disclosed by either party to their legal representatives with regards to domestic abuse. It has not been possible for the review to establish whether either of the legal representatives considered the possibility of financial abuse or considered it to be a type of mediation process which inevitably follows a marital separation/divorce. There has been a recent paper written by 'Safelives' which details the fact the knowledge of solicitors involved in family law, do not always adequately consider the prospect of domestic abuse, particularly coercive controlling behaviour when representing parties.[16]

There has been a "course of conduct" (not just one event); and
The perpetrator knows or ought to know that their conduct amounts to harassment.

[16] SafeLives – Verona Taylor-Blackford Interim Report March 2022. – "Hit and Miss" Family Lawyer's Understanding of Domestic Abuse

15.40 Safelives have responded to a report written by the Ministry of Justice Harms Panel on this subject and have prepared a training package for all persons involved in the family court process concerning domestic abuse. The training is aimed at improving knowledge on domestic abuse and coercive control and recognising the signs of trauma.[17]

[17] Domestic abuse training for family lawyers | Safelives.webarchive

16.0 ANALYSIS

16.1 This part of the review will examine how and why events occurred, information that was shared, decisions that were made and actions that were (or were not) taken. It will consider whether different decisions or actions may have led to a different course of events. The analysis section seeks to address the Terms of Reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted.

16.2 This analysis considers the previous sections of this report, the content of the IMRs and the chronology of events.

16.3 It is important to repeat that this review is not into the cause of Christopher's death, but in answer to the terms of reference. The purpose of the review is to examine the contact Christopher had with services and analyse whether those services were appropriate and whether there are lessons to learn from his tragic death.

16.4 The terms of reference asked professionals to consider several key questions, each of which are addressed below.

TO EXAMINE WHETHER THERE WERE SIGNS OR BEHAVIOURS EXHIBITED BY EITHER THE VICTIM OR PERPETRATOR(S) IN THEIR CONTACT WITH SERVICES WHICH COULD HAVE INDICATED THE LEVEL OF RISK (PARAGRAPHS 9.4-9.6)

Christopher

16.5 Christopher himself did not provide any information to professionals that would indicate he felt at risk from Sarah or Simon. The Panel have identified this may be because professionals did not enquire or because he was not spoken to alone (i.e.by Police). Christopher disclosed to his GP in 2013/14 that he was feeling depressed and suffering from anxiety as a result of a marital breakdown, debt (associated with a financial settlement with Sarah) and the pressure associated with running his farming business. The GP notes do not show whether the circumstances of the marital breakdown was explored further.

16.6 The DHR Panel considered the links between domestic abuse and mental health, referring to a recent spotlight report produced by SafeLives (a UK-wide charity dedicated to ending domestic abuse) which highlights these links both a victim's and perpetrator's perspective.[18] The report highlights the fact that victims of domestic abuse with mental health needs are more likely to present to their GP and other health professionals before accessing domestic abuse support services. The Panel feel this aspect could have been explored further by the GP when interacting with Christopher during this period.

[18] Spotlight report "Safe and Well: Mental Health and Domestic Abuse" Safe Lives May 2019.

16.7 The DHR Panel also considered the indicators of economic abuse and the extent to which professionals a) are aware of these and b) know that economic abuse is a form of domestic abuse. According to the most recent draft of the Home Office Domestic Abuse Bill (dated 17 March 2021):

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services".[19]

16.8 David firmly believed that Sarah diverted funds from the business account which caused Christopher to have mounting debts, a form of economic abuse whereby the perpetrator exploits their victim's ability to maintain economic resources.[20] Christopher disclosed to his GP that he was in debt, and that this was negatively impacting his mental health, demonstrating the important role for health professionals in exploring not just 'what's wrong' (i.e. anxiety and insomnia due to debt) but also the causes (i.e. economic abuse).[21]

Sarah

16.9 In Sarah's interactions with professionals from HPFT and HCS, she disclosed that she felt Christopher was a controlling man and this was not explored further by professionals. Christopher and Sarah seem to have conformed to stereotypical gender roles in their relationship with one another, whereby Christopher went to work, and Sarah stayed at home to look after the children and run the household. It was much later in their relationship that Christopher made Sarah a partner in his business, and she became actively involved.

16.10 The DHR Panel believe that practitioners from both HPFT and HCS could have been more professionally curious in their questioning of Sarah when she described Christopher as a controlling man. The fact it was not explored makes it difficult for the Panel to assess to what extent Christopher may have exhibited controlling behaviour, if at all.

16.11 The Panel considered whether Sarah could have been making false comments inferring domestic abuse, as recent research conducted on the experiences of victims and survivors of domestic abuse in Hertfordshire found that this was a common tactic used by perpetrators.[22] As perpetrators are adept at manipulating those around them, they may often present as victims, either because 'they see themselves as the aggrieved party, or because they are seeking to control or isolate their (ex)partner by using the response of agencies […] to further abuse'.[23] It is therefore possible that Sarah hoped professionals would record her as being the victim, something that would reduce the likelihood of Christopher being believed if he were to ever report domestic abuse.

[19] newbook.book (parliament.uk)
[20] What is economic abuse? - Surviving Economic Abuse
[21] Spotlight Report – Safe and Well – Mental Health and Domestic Abuse. May 2019
[22] The Domestic Abuse Pathways Project
[23] Responding to counter-allegations_0.pdf (safelives.org.uk)

16.12 There is an added layer of complexity to Sarah's disclosures due to her gender, as it is well known that domestic abuse is disproportionately perpetrated by men against women. This could mean that professionals are more likely to believe female victims of domestic abuse. In a recent consultation with victims and survivors of domestic abuse in Hertfordshire, male survivors reported that they were often not believed by professionals, such as the police, because of their gender. In fact, Sarah was recorded as being the victim when police attended a 'feud' between her and David (15.27), which could have left both David and Christopher feeling less able to report domestic abuse in the future.

16.13 Certainly in their interactions with the police, David and his family presented Sarah as being the controlling influence who exploited and manipulated Christopher's feelings for her. They reported she exploited him financially and during the review have stated she exhibited physical violence towards him during their relationship. The evidence gathered during the homicide investigation demonstrate she had a controlling nature and was heavily involved in the planning of Christopher's murder.

16.14 The family and friend of Christopher reported, Sarah made it very difficult for them to engage with Christopher after they had married. She made it very clear they were not welcome to visit him. Even after they separated, it appears as though Christopher was still under the control of Sarah and always took her side over that of his son David. The situation deteriorated to such an extent, Christopher became estranged from his eldest son, daughter in law and grandchildren for a long period of time. They only reconciled shortly before Christopher's murder.

16.15 The health representatives on the Panel reviewed whether any information was disclosed by Sarah to her GP or other health professionals in relation to her own mental well-being. There were no disclosures from Sarah to suggest she was struggling to cope with her own mental health or had any desire to harm Christopher, and her disclosures were in relation to her struggles to care with the needs of her children. However, further information may have been disclosed had this been facilitated by professionals.

The Children

16.16 The DHR Panel do not believe the professionals involved with the children considered a possible link between autism and childhood trauma which may have resulted from witnessing domestic abuse at home. All three of Christopher and Sarah's children were referred for autism assessments and other mental health concerns, including suicidal thoughts, and their middle child (Kate) was diagnosed with ASD and ADHD. However, there is nothing in professionals' notes to suggest they specifically enquired about domestic abuse or considered the fact that 'children with ASD are [more] vulnerable to traumatization due to their deficits in social communication and emotion regulation'.[24]

[24] The Effects of Psychological Trauma on Children with Autism Spectrum Disorders: a Research Review SpringerLink Published 9th July 2015

16.17 Research has indicated that "having autism can sometimes mean enduring a litany of traumatic events, starting from a young age, and for many, those events may add up to severe and persistent post-traumatic stress disorder (PTSD). This line of research is still in its earliest days, although some studies do indicate that autistic children are more reactive to stressful events , because they lack the coping skills that help them calm down, perhaps are more predisposed to PTSD".[25] [26] A recent study showed that the prevalence of trauma was much higher in adults diagnosed with ASD (32%) as opposed to typical adults who were not diagnosed with ASD (4%).[27]

16.18 The DHR Panel members considered the fact that, within the new Domestic Abuse Bill, children are recognised as victims of domestic abuse in their own right where they see, hear or experience the effects of domestic abuse and are related to the victim and/or perpetrator.[28] This addition to the Bill will likely help public authorities and frontline practitioners to understand the extent to which domestic abuse can impact children. However, the Panel acknowledged that professionals will need dedicated training and resources to ensure they are able to recognise the signs that a child might be a victim of domestic abuse, as Robert, Kate and Stephen may have been. Children will also need specialist support to help them recover, a service which may not be adequately provided. In a recent consultation with victims and survivors of domestic abuse in Hertfordshire, many of those consulted spoke of the impact of domestic abuse on their children. When asked what would help with this, many stated that dedicated therapeutic support would be of huge benefit.

Level of risk.

16.19 There were four incidents reported to the police which directly involved Christopher or those related to him. These included two domestic incidents and a report of harassment in 2015 and the arson to Christopher's vehicle in 2018, which preceded him being reported as a missing person soon after. In the police's interactions with Christopher in 2015 following the domestic disputes, he did not disclose that he felt at risk. It is not known whether Christopher was spoken to alone by the police during the two reported incidents of domestic abuse and this may have impacted on his opportunity to disclose any concerns. As Sarah reported both incidents, and both incidents involved David, the police's interactions were primarily with them and not Christopher.

16.20 The subsequent report of harassment, which included threats made and the driving incident, again involved Sarah and David. However, information provided to the police from Christopher's family indicated they believed they were at great risk from Sarah, following the threats she made to harm them. They also disclosed concerns that Sarah was financially abusing Christopher by taking his money to pay off her debts. There is no information to

[25] Article in 'Psychology Today' entitled "Intersection of autism and trauma". Lauren Gravitz Sept 2018
[26] Traumatic Childhood Events and Autism Spectrum Disorder C M Kerns 2015
[27] Autism Spectrim Disorder and Post Traumatic Stress Disorder: An unexplored co-occurrence of conditions. Narit Haruvi-Lamdam and others. Sage Journal - April 2020.
[28] newbook. book (parliament.uk)

suggest that the police followed up the concerns around potential financial abuse with Christopher himself, and this was an oversight on their part.

16.21 In dealing with the incidents, the police gathered information which demonstrated there was a long-standing family feud between Christopher, David and Sarah over the division of the estate. It is clear from information given to the police by David that he believed Sarah was financially abusing Christopher, particularly after their separation which is when a victim's risk of harm is likely to increase. Although not divorced, Sarah had already been provided a settlement in August 2015 and received a significant amount of property and land from Christopher as part of a legal separation agreement. In addition to the financial settlement, David alleged that Christopher took out a million pound loan to cover debts incurred by Sarah and this formed the basis of his concerns in relation to financial abuse. The police did not treat this as a potential criminal allegation of theft or fraud or as a form of domestic abuse. This may be because economic abuse is often perceived as an invisible form of abuse within intimate partner relationships. [29]

16.22 The threat from Sarah was made in the presence of Christopher and a third party, following the domestic argument with David on 19th September 2015. She made threatening comments regarding having friends in the north who would come and "sort the family out" (referring to David and his family), the IMR author for the police stated he believed the threats were idle and said in the heat of the moment: "it certainly does not appear she had access to resources to implement such action".[30]

16.23 The Panel believe the harassment case in 2015 (and the allegations of financial abuse) were not dealt with robustly enough by the police and that there was a course of conduct exhibited by Sarah which would have constituted a substantive offence of harassment. This included three incidents: the domestic incident between Sarah and David on 19th September 2015, the threats made following this and the driving incident both reported in 16th November 2015. The police knew this was all against a backdrop of the bitter feud over Christopher's estate. The Panel believe the incident was worthy of a more proactive response by the police and more urgent action to protect Christopher and his family should have been taken. The members of Christopher's family who were being threatened by Sarah, should have been risk assessed. Sarah had made a threat towards them when she said she knew someone who could 'sort the family out', she had exhibited the potential to harm or at least intimidate when she drove her car at David and his daughter. This should have indicated to professionals that Christopher, or his family were potentially at risk of serious harm or homicide. Even if she had not planned to carry out this threat, the fact the threat was made in the first place is indicative of an attempt to control Christopher and his family through fear.

16.24 As it was, this incident was dealt with by Sarah being served a Police Information Notice which did not take in to account the driving incident which had occurred before the threats were made. Had the police dealt with this as a substantive offence, they would have had additional

[29] Economic Abuse as an Invisible form of Domestic Abuse – Judy L Postmus et al Sage Journal March 27, 2018.
[30] Quote from Police IMR

powers which could have included her arrest and formal interview which may have led to a stronger sanction such as a caution or criminal charge (depending on the evidential test). It may have also afforded the opportunity to impose bail conditions or apply for a restraining order.

16.25 It is possible that the police did not consider the driving incident or threats as an incident of domestic abuse because Sarah was not an immediate family member. Albeit separated from Christopher, Sarah was a step-parent to David and could have been considered as personally connected, meaning any abusive behaviour perpetrated against him could have been considered as domestic abuse. Furthermore, consideration should have been given to the fact that Sarah could have been threatening to harm members of Christopher's family as a way to control Christopher, something that would now be acknowledged as a form of domestic abuse in its own right under the new definition of domestic abuse in the Domestic Abuse Bill.[31]

16.26 In July 2017, a joint report was published by the HMIC and HMCPSI[32] which recommended that all police forces stop using PINs, as the inspectorate had found that many cases of harassment reported not dealt with appropriately or thoroughly. The inspectorate reported: "we found many examples of inappropriate use of a PIN, where what was required was a robust investigation with positive action to protect the vulnerable victim. Instead, a PIN had been issued as a means of 'solving' the crime, with little consideration of the likely need for the future protection of the victim". Hertfordshire Constabulary, no longer, use PINS as a means to deal with harassment cases.

16.27 There were a number of recommendations which came from the report, which included a recommendation for the College of Policing to produce guidance for police forces to more effectively deal with stalking and harassment cases. In November 2020, the College of Policing provided Authorised Professional Practice on stalking and harassment cases.[33] This included guidance on investigations and safeguarding measures. This guidance superseded previous guidance issued by the NPIA in 2009.[34]

16.28 Following the harassment incident, there then followed a two-year period where Christopher and his son David stopped speaking due to the incidents outlined above and Sarah's demands for money from Christopher. They only reconciled in early 2018, after the relationship between Sarah and Christopher became further strained because of Sarah's relationship with Simon and the fact she served divorce papers on Christopher. At this point, Sarah made it clear to Christopher that he was no longer welcome to visit her home. Christopher became isolated and vulnerable at this stage and turned to his eldest son David for support.

[31] newbook. book (parliament.uk)
[32] "Living in Fear" report following a HMIC/HMCPSI Inspection – published July 2017
[33] College of Policing Authorised Professional Practice on stalking and harassment – Nov 2020
[34] ACPO – NPIA Guidance on Investigating stalking and harassment

16.29 The arson reported to the vehicle belonging to Christopher in 2018 was attended by police officers. Both Christopher and other family members were spoken to and asked if they had any idea who might be responsible. They could not provide any information to the police to assist in this regard. David was concerned for Christopher and arranged for a family friend and employee (Barry) to lodge at the farm with Christopher to keep an eye on him and his property. It was only after Christopher was reported as missing, and the case taken over by the Major Crime Team, that evidence was later gathered against Simon who was subsequently charged with this offence.

16.30 The DHR Panel having the benefit of all the facts have considered this case in the context of the academic study of Dr Jane Monckton Smith entitled "The eight stages of Murder". Although this study and her subsequent publication of a book[35], relates primarily to female victims of domestic homicide (due to the fact the large majority of domestic murder victims are female), there are parallels which can be drawn with this case.

16.31 The article and book were written to try and help inform professionals in an effort to reduce incidents of homicide. Dr Monckton- Smith believes it is important for professionals to understand the significance of non-clinical risk assessments and to consider, understand and interpret additional information which does not necessarily appear in risk identification checklists which are currently used by the police service in their use of the DASH risk assessments. Dr Monckton-Smith argues there are certain factors like separation and escalation of control which better identify the imminent risk of homicide. The study concludes that where there is progression to stages 5-7, there is a much higher likelihood there will be attempts on a victims life. In the context of this case, the stages are set out in the table below:

8 stages of homicide		
Stages	Incidents	Time Line
Stage 1 **Pre relationship**	Nothing relevant known to professionals.	Pre 1992
Stage 2 **Early relationship**	1. Couple meet – Sarah's partner employee of Christopher's. 2. Sarah and Christopher start a relationship 3. Early co-habitation 4. Sarah pushes early commitment – Christopher became Step-father to Sarah's son. 5. Early pregnancy – Robert born 6. Marriage and 2 more children born on quick succession	1-4 All 1992/93 1995 1997 1997 and 2000

[35] In Control – Dangerous Relationships and How They End in Murder – Jane Monckton Smith – March 2021

Stage 3 Relationship	1.	Sarah violent – Christopher seen with injuries by his family.	Throughout relationship.
	2.	Sarah violent towards Christopher's grandson.	
	3.	Isolation of victim from family and friends.	Throughout relationship
	4.	Christopher diagnosed with depression and anxiety.	2014.
	5.	All three children seen by health practitioners – autism assessments and youngest son self-harmed (suicidal)	2015
Stage 4 Triggers	1.	David inherited land and farm from Grandmother. This caused ill-feeling between the parties.	Pre-2015
	2.	Separation of Sarah and Christopher. Sarah moves with children to farm holding nearby.	2015
	3.	Christopher informs GP he has marital problems and debts.	2014/15
	4.	Financial settlement agreed between Christopher and Sarah - so no divorce.	Agreed August 2015
Stage 5 Escalation	1.	Domestic incident between Sarah and David over estate.	September 2015
	2.	Domestic incident between Christopher and David over estate.	November 2015
	3.	Reported threat made by Sarah towards David and family. 'I know people in the north who can sort the family out'	November 2015
	4.	Driving incident reported– Sarah drives her car at David and Daughter.	Oct/Nov 2015
	5.	Concerns raised by David over Sarah's financial exploitation of Christopher.	November 2015

	6.	Leads to David's estrangement from Christopher.	2015-17
Stage 6 C Change to thinking	1.	Sarah began relationship with Simon.	2017/early 2018
	2.	Sarah and Simon much closer in age.	March 2018
	3.	Sarah initiated divorce proceedings and wanted further financial settlement.	March 2018
	4.	Christopher denies divorce and writes to Sarah asking for a reconciliation with Sarah.	
	5.	Prospect of additional financial gain through property deal.	
Stage 7 – Planning	1.	Seems to start in January 2018. Sarah and Simon want to start new life together.	Jan 2018
	2.	More than 28,000 whats app messages over a period of four months between Sarah and Simon which reveal about how they want to hurt/kill Christopher and his family. Revenge as motive explicitly mentioned.	Jan and June 2018 March 2018
	3.	Christopher is still refusing to divorce Sarah.	June 2018
	4.	The arson to Christopher's vehicle. Sarah text Simon on the day before the arson saying 'light my fire'	
Stage 8 Homicide	1.	Christopher reported as missing.	June 2018
	2.	Sarah and family infer he may have left home as depressed.	
	3.	Sarah and Simon interviewed by police and deny involvement.	
	4.	Whats app messages – reveal extent of planning.	

	5. Body found – made to look like accident/suicide	
	6. Victim blaming.	February 2019

16.32 The risk to Christopher increased significantly following the development of the relationship between Sarah and Simon, the prospect of a multi-million-pound property deal and the fact Christopher refused to divorce Sarah. These facts were not known to the police or any other agency until after his disappearance and it was not until all of the circumstances of the case were reviewed by a SIO following Christopher being reported as a missing person, that the case was allocated to the major crime team to investigate.

COLLABORATION, CO-ORDINATION, GOOD PRACTICE AND INFORMATION SHARING (PARAGRAPHIS 9.7-9).

16.33 The DHR Panel has found some evidence of collaboration and co-ordination between the relevant teams in HPFT and HCS in relation to the three children of Christopher and Sarah. Although the involvement of HCS was arguably slower that it should have been, and only after a number of referrals had been made, their contribution was effective when they did become involved.

16.34 Robert attended ACMHS for an autism assessment which he was offered but eventually declined. He was also offered an Occupational Therapy (OT) assessment of his daily living skills which found no significant indicators that any disorder was inhibiting his life. He was offered further support in learning to cook by the OT Assistant. He declined this support. There was no requirement for interagency working in Roberts' case, as his needs were not complex. However, the strain on Sarah in caring for her children was correctly identified by the CPN who then made a referral to Children's Services, reporting that Sarah was struggling with supporting Stephen and Kate. The CPN also made a referral for Sarah to have a carer's assessment. This is an example of good practice. However, although most of the information gathered by the CPN was shared when making the subsequent referrals, the notes do not record if there was a specific mention of the fact that Christopher was described as a controlling man, nor was this aspect explored further at the time Sarah disclosed this. The Panel feel this may be indicative of a lack of confidence in professionals to ask questions relating to domestic abuse, or a lack of knowledge around controlling behaviour and how this might exhibit.

16.35 As part of their assessment, the CAMHS team made appropriate contact with the Child Development Clinic and the Educational Support Centre that Stephen was attending to gain a

better understanding of his needs. The service also tried to engage Christopher with this process.

16.36 Kate has complex needs with a diagnosis of autism and learning disabilities. During the period in question, she received support from HPFT LDATS and Hertfordshire County Council's Transitions Team. It took some time for the LDATS team to work with Kate, as she did not present as someone with additional needs. However, contact from Sarah and the Transitions Team when Kate seemed to be responding to voices in her head triggered an urgent home visit. From this point there is evidence of consistent communication, responsiveness and joint working (including joint visits) between both services, collaboration over care planning, sharing of information and assessment outcomes. LDATS kept in good contact with the Transitions Team, keeping them informed of the progress of referrals and also when input was due to cease. They also attended multi-agency network meetings for Kate. A network meeting is a meeting of the key professionals involved in a clinical case

16.37 The police appropriately referred the reported domestic incidents to HCS and submitted a report through to the Firearms Licensing Officer reporting the fact a domestic incident had occurred and Christopher was a shotgun licence holder. However, a referral to a specialist domestic abuse service was not made either by the police or by HCS.

16.38 It is important to note that on 11th January 2016, Hertfordshire Police changed its approach to safeguarding victims of domestic abuse and formed the Domestic Abuse Investigation & Safeguarding Unit (DAISU). The DAISU is a county-wide team which deals with intimate relationship domestic abuse (at all risk levels), so-called honour-based abuse and forced marriage. The DAISU also deal with stalking cases where there is domestic abuse, with Local Crime Units within each Community Safety Partnership area responding to stalking cases which are not linked to domestic abuse. All non-intimate relationship domestic abuse (all risk levels) is dealt with in its entirety by the Local Policing Commands who can consult with DAISU as required.

16.39 Since the formation of the DAISU, there is a much improved service provision for victims of domestic abuse within Hertfordshire for both intimate and non-intimate victims. Every reported incident benefits from an individual needs assessment and is referred to the most appropriate support agency. The Victim Services Team assumes responsibility for triaging the non-intimate investigations and DAISU personnel deal with the intimate Domestic Abuse investigations. The DAISU officers assume responsibility for needs-assessing the standard risk victims; who are routinely referred to Catch-22 (the Constabulary's commissioned victim support provider). Medium-risk intimate DA victims are assessed by the DAISU Beacon Safeguarding Hub. High-risk DA victims are routinely referred to the IDVA Service and the majority of linked investigations attract a review from the DAISU's Specialist Safeguarding Unit who safeguard/safety plan as appropriate. Significant effort has been devoted to publicising the available provision, enhancing referral pathways and victim support.

16.40 All high-risk victims (assessed as high risk using a DASH risk assessment or by professional judgement) are referred to MARAC by the DAISU's safeguarding team or by the Officer in the Case (OIC). The Business Support Team within the DAISU work Monday to Friday and review all domestic abuse crimes and non-crimes and will make referrals to Children's Services and Health Visitors if they fit the referral criteria.

16.41 In the context of this case, the DAISU were not formed at the time the domestic incidents were reported. However, even if the DAISU had been in operation at the time, it is possible that the abuse experienced by Christopher and his family would not have fallen within the DAISU remit as they prioritise intimate partner abuse. There were no incidents of intimate partner abuse reported directly to the police. Concerns were raised indirectly that Sarah may be abusing Christopher from a financial perspective by Christopher's family. This followed a reported incident between Christopher and his son David and the subsequent threats made by Sarah towards Christopher's family.

16.42 At the time, the incidents were dealt with by local policing unit officers. There is nothing to prevent officers from the local policing commands within Hertfordshire to seek the support and assistance of the DAISU for domestic abuse incidents involving non-intimate partner incidents. The formation of the DAISU is seen as a positive step forward and provides additional support and guidance to both victims and non-specialist police officers.

TO EXAMINE WHETHER THERE WERE ANY EQUALITY AND DIVERSITY ISSUES OR OTHER BARRIERS TO THE VICTIM OR PERPETRATOR SEEKING HELP (PARAGRAPH 9.10)

16.43 The Panel have identified some potential barriers to Christopher seeking support. The first factor is Christopher's age. In a recent study relating to older male victims of domestic abuse, Christopher experienced many of the factors associated with this type of abuse. These include the fact he was subjected to many years of physical abuse at the hands of Sarah, he was the victim of coercive control particularly in the form of financial abuse and this impacted on his mental health, to such an extent he felt suicidal and self-harmed. He disclosed to his GP, the cause of his deteriorating mental health was the breakdown of his relationship and the subsequent financial difficulties he experienced as a result.[36]

16.44 In a recent study conducted by Dr Nikki Carthy she writes "There is a growing body of research that has looked at men's victimisation from female partners. This research has demonstrated that this is a prevalent form of domestic abuse. Abuse from a female partner often includes forms of physical violence (scratching, punching, and use of weapons), psychological violence through gaslighting, coercive control such as threats to take away children, as well as financial and administrative abuse through the legal system. Those patterns of abuse fit within the definitions of domestic and intimate partner violence and

[36] Bates, Elizabeth and Carthy, Nikki (2020) – Older Men's Victimisation - University of Cumbria

are similar to abuse tactics perpetrated to female victims; yet men are reluctant to disclose and seek help. Much of the support for men is still largely help-line focused and policy for male victims often sits under the violence against women agenda. For older victims help-seeking can have additional barriers. Older adults tend to be more isolated due to age and well-being factors.[37]

16.45 In the context of Christopher and Sarah's relationship, there was an 18 year age difference, which may have been a factor which when combined with other factors led to their marriage breakdown and his subsequent murder. There is limited research available on this subject, but a study in 2004 revealed there was a heightened risk of intimate partner homicide where there was an extreme age difference.[38]

16.46 The second factor is gender. Research has shown that male victims face additional barriers to disclosing domestic abuse, both to professionals and to their family and friends. In studies of male victims' experiences of domestic abuse, many men have reported feeling there is a stigma associated with being a male victim.[39] For many, this is linked to societal perceptions of masculinity and a feeling that they would be 'less of a man' if they reported domestic abuse. Arguably, this is highlighted by Barry's comment that Christopher was a "weak man" when it came to Sarah (14.31).

16.47 Many male victims also feel they will not be believed because they are 'physically bigger, or perceived to be physically stronger than their partner'. As Christopher's daughter-in-law and granddaughter described him as a "proud man" who would not want to disclose domestic abuse, it is possible that his personal sense of masculinity acted as a barrier to reporting.

16.48 Research has also found that male victims of domestic abuse often prefer to seek support from family, friends and colleagues than more formal sources. In some studies, informal help-seeking was shown to lead to formal help-seeking, as victims' informal networks made them feel believed and helped them to understand that what was being done to them was abusive. The fact that Christopher told members of his family, and not professionals, about the abuse he was experiencing could suggest he wanted help from more informal sources. Where this is the case, it is important that there an awareness at the community level about how domestic abuse can present and the support that is available, as this would increase the likelihood of informal help-seeking leading to formal help-seeking.

16.49 Christopher's family believe the fact he loved Sarah and did not want to get her into trouble also acted as a barrier to seeking help. In two studies, 'men discussed commitment to their

[37] Carthy, Nikki (March 2021) – What about the older male victims of domestic abuse – Centre for Applied Psychological Science

[38] Shackleford, Todd – Couple Age Discrepancy and Risk of Intimate Partner Homicide – Article in Violence and Victims July 2004

[39] Machado A, Hines D, Matos M. Help-seeking and needs of male victims of intimate partner violence in Portugal. Psychol Men Masc 2016; 17:255–64

relationship and concern for the perpetrator of the abuse as barriers to help seeking.[40,41] The desire voiced by study participants was for everything to be okay'.[42]

16.50 Whilst Christopher was a male victim of abuse, it could be that his family's perception of him still being in love with Sarah meant they felt the abuse "wasn't that bad", or that he would not be likely to speak out against Sarah (meaning it might have felt difficult for them to try and support him). There is a great deal of work required nationally and locally to debunk the myths around domestic abuse.

16.51 Although Christopher did confide in his family about the violence he suffered at Sarah's hands. he did not disclose abuse to professionals. This may have been because he was neither spoken to alone nor asked in the right way. In a recent consultation with victims of survivors of domestic abuse in Hertfordshire, many male survivors reported negative experiences with professionals. In many cases, they were not believed, especially when a female partner made a counter-allegation of domestic abuse, which for some men led to them being arrested. As Christopher's abuser was female, professionals may not have considered it possible for him to be a victim of domestic abuse, meaning they did not enquire.

16.52 The fact that Christopher lived in a rural location, and was incredibly busy running his estate, may also have limited his ability to seek help if he felt at risk. In addition, support services would also be less visible in rural areas, meaning both Christopher and his family may not have been aware that there were specialist domestic abuse services available to them. Rural communities, on the whole, may also be less aware of the signs of domestic abuse, meaning they are less likely to report.

16.53 A recent publication from the National Rural Crime Network, entitled Domestic Abuse in Rural Areas, states that people living in remote rural locations do not have the same access to services than those living in more populated areas. The report contains a number of key findings and recommendations for professional agencies to consider.[43] The report also highlights the fact that rural communities often side with the perpetrator. It is important that that a review is conducted in relation to the service provision of domestic abuse services for rural communities (see Recommendation Four)

16.54 The Panel have considered that it may also have been a lack of knowledge and availability of support services. Considering this case, the DHR Panel believe Hertfordshire should consider their service provision in relation to male victims and how services for male victims are promoted across communities (see Recommendation Five).

[40] Hines DA, Douglas EM. A closer look at men who sustain intimate terrorism by women. Partner Abuse 2010; 1:286–313
[41] Simmons J, Brüggemann AJ, Swahnberg K. Disclosing victimisation to healthcare professionals in Sweden: a constructivist grounded theory study of experiences among men exposed to interpersonal violence. BMJ Open 2016;6: e010847
[42] e021960.full.pdf (bmj.com)F
[43] NCRN – Domestic Abuse in Rural Areas 2020.

16.55 The fact that domestic abuse services are less visible in rural areas also means that it is even more important for professionals in rural areas (such as GPs, who residents in rural areas might be more likely to come into contact with) to spot the signs of domestic abuse early and to be fully aware of referral pathways into specialist support (see Recommendation Six).

16.56 Sarah did seek a significant amount of help from services in relation to their children. Although she disclosed the fact that Christopher was controlling, it does not appear that this aspect was explored by the professionals involved and may have been a barrier her to disclosing further information to them.

TO EXAMINE WHETHER THE VICTIM AND/OR PERPETRATOR WERE ASSESSED OR COULD HAVE BEEN ASSESSED AS AN 'ADULT AT RISK', AS DEFINED WITH THE CARE ACT 2014. IF NOT, WERE THE CIRCUMSTANCES SUCH THAT CONSIDERATION SHOULD HAVE BEEN GIVEN TO THIS RISK ASSESSMENT? (PARAGRAPH 9.11)

16.57 The Care Act 2014 was not enacted until April 2015, and after this date it took time for it to be fully embedded within local authorities. Most of the interactions with Christopher and Sarah took place in 2014 and early 2015. The Panel have concluded that neither Christopher or Sarah would have been considered as “adults at risk of abuse”. However, this would not have prevented staff from exploring indicators of domestic abuse and signposting to the appropriate agencies if appropriate.

POLICY, PROCEDURE AND TRAINING (PARAGRAPHS 12 AND 13)

Policy, Procedure and Training within HPFT

16.58 Since the Care Act 2014 brought in a statutory duty to investigate abuse, services have worked to develop staff awareness of domestic abuse. The Act also brought in safeguarding duties towards carers, in so far that any abuse they are experiencing is linked to their caring role. It is important to note that at that time neither Christopher nor Sarah would have been considered as “adults at risk of abuse”. However, this does not prevent staff from exploring indicators of domestic abuse and signposting to the appropriate agencies.

16.59 HPFT have responsibility for carrying out safeguarding enquiries for adults with functional mental disorders on behalf of the local authority. This has led to a strengthened approach to supporting staff to understand the impact of domestic abuse. The Corporate Safeguarding Team (which has expanded from two to four members of staff, plus two named doctors) take the lead in providing training and advice to professionals who are working with people who may be experiencing abuse. In 2020, HPFT ran monthly online training and plan to deliver bespoke sessions on coercive control in 2021. This training is supported by the DAISU.

16.60 There is also a new level 3 e-learning mandatory training package which includes a section on coercive control, with Hertfordshire-focussed case studies, and links to SafeLives web pages and the DASH risk indicator checklist. Staff are also encouraged to attend the Hertfordshire Safeguarding Boards' training sessions and conferences. The Corporate Safeguarding Team have also worked with individual teams to raise awareness of domestic abuse in different service user groups by running information sessions as part of the Strategic Business Units Quality & Risk Meetings. The training is delivered on a monthly basis and then the content is uploaded on to the agency website. Sessions have included inputs on coercion and control; safeguarding; asking difficult questions and dealing with difficult answers, understanding mental health and have been well attended.

16.61 Staff who are involved in delivering social care are also able to attend Hertfordshire County Council's own safeguarding training, which includes specific modules on domestic abuse. This joint approach to training social care staff provides them with the opportunity to have face to face classroom sessions with an adult safeguarding specialist.

16.62 Additionally, HPFT now have a number of Domestic Abuse Champions embedded in a range of services including acute Inpatient services, Mental Health Liaison Teams, Single Point of Access, Wellbeing Teams and Specialist Mental Health Teams for Older People. The Consultant Social Worker for Safeguarding Adults is the Strategic Lead for the Domestic Abuse Champions and the Strategic Lead for MARAC.

16.63 Refuge are also working in partnership with HPFT to improve awareness, access to advice and pathways to their services by co-locating IDVAs within the Community Mental Health Services in each quadrant. Additionally, the Trust Corporate Safeguarding Team is also working with Safer Places around their development of a refuge for individuals with complex needs in Essex (for Hertfordshire residents).

16.64 Last year, the Trust launched its first domestic abuse policy to support staff when they are receiving disclosures of domestic abuse, so that they understand the importance of conducting a risk assessment and know how to ensure a risk management plan in put in place for a victim through referrals to specialist domestic abuse services and to MARAC.

Policy, Procedure and Training within HCS

16.65 There are policies in relation to domestic abuse set out in Child Protection and Adult Safeguarding procedures. If staff were concerned about incidents of domestic abuse, they would follow either the Child Protection Procedures or Adult Safeguarding Procedures, depending on the age of the person.

16.66 In terms of domestic abuse training delivered via the Hertfordshire County Council Learning and Development service, there is a mandatory eLearning module for all new frontline staff which started in 2017. In the last two years, two classroom-based courses have also started.

One course is 'domestic abuse awareness for practitioners' and the second is 'advanced domestic abuse awareness for practitioners', both of which are designed for frontline workers who work with complex needs and families. The content includes awareness of coercive and controlling behaviour, safeguarding children and where frontline staff should signpost to for specialist domestic abuse support. The advanced course explores themes at a deeper level, as well looking at social worker intervention skills. The advanced course also includes impact of trauma on children's behaviour.

Policy, Procedure and training within the Police

16.67 All domestic abuse incidents reported to Hertfordshire Constabulary are initially attended by uniformed frontline intervention officers. They deal with the initial response, conduct a Domestic Abuse Stalking and Harassment (DASH) risk assessment, implement any immediate safeguarding measures required and conduct an initial investigation if the incident amounts to a crime. They record the incident on the newly introduced crime system 'Athena' as a 'crime' or a 'non-crime'. The Intervention Sergeant on duty will review and supervise the enquiry and if it is considered high risk, the Intervention Inspector on duty is informed to ensure appropriate safeguarding measures and investigation are being conducted. If an incident is recorded as a non-crime it means a criminal offence has not been reported or committed which requires further investigation. However, as all incidents are reviewed by a supervisor, the classification could be amended if required and a formal investigation initiated where appropriate.

16.68 Prior to January 2016, domestic abuse incidents were investigated by detectives on the Local Policing Command (LPC). The Harm Reduction Unit (HRU) would be involved in the safeguarding of all victims (intimate and non-intimate) for high-risk incidents. High risk incidents were those that scored 11 or more ticks in the DASH risk assessment or where there had been four or more incidents in a rolling twelve-month period. All other safeguarding matters were dealt with by the LPC investigation teams. Hertfordshire Police recognised this system did not provide sufficient access to specialist domestic abuse services for the vast majority of victims and made changes to their approach to domestic approach supported by other agencies.

16.69 Hertfordshire Constabulary now has a dedicated Domestic Abuse Investigation and Safeguarding Unit (DAISU), which not only provides oversight and supervision of domestic abuse crimes across the force but also provides a bank of specialist knowledge, advice and support to staff and officers across all areas of business to help ensure that victims of domestic abuse get the support that they need. DAISU members are responsible for ensuring victims are referred to domestic abuse support services, with a number of these services (including the IDVA service and an Independent Stalking Advocacy Service) being co-located in the DAISU.

16.70 The DAISU Standard Operating Procedure is a comprehensive and detailed document which covers the force-wide response to domestic abuse. This means that regardless of the role and

rank of the officer attending, they will have a greater understanding of the different parts of the policies and procedures which are relevant to their role.

16.71 To ensure that officers understand processes and policies around domestic abuse regardless of the role they are in, there is close supervision of tasks and quality assurance of paperwork submission and record keeping. For example, when a DASH book is completed, this must be reviewed and signed off by a supervisor. Handover files are also scrutinised and signed off by supervising officers before further quality assurance takes place within the DAISU. Daily management meetings on the Local Policing Command act also help ensure that the relevant policies and procedures have been followed or are tasked accordingly.

16.72 Detective Inspectors on the Local Policing Commands and within the Safeguarding Command are key in helping ensure that critical stages of the Standard Operating Procedure are adhered to. For example, authorisation of bail for high risk offenders.

16.73 As part of their initial training, all new officers receive comprehensive input on the initial investigation of crime, including domestic abuse. Areas covered include the definition of domestic abuse, how to complete a DASH risk assessment, principles of an evidence-led domestic abuse investigation, sources of gathering evidence (Investigative strategies), factors to consider on initial attendance as well as details of initial safeguarding requirements.

16.74 In the context of this case, it has already been established that the police could have dealt with the harassment allegation in a more robust manner. With regards to the concerns raised by Christopher's family in relation to financial abuse, a case is always made more difficult to investigate in circumstances when there is an absence of a formal complaint made from the aggrieved or the concern is received from a third party. It is highly unlikely the police would have been granted access to Christopher's finances without his permission or support. In addition, at the time the concerns were raised, Sarah and Christopher were still married and their assets could have been considered as joint assets as Sarah was a partner in the business. This was not a straightforward enquiry for the police to manage.

16.75 In 2019, as part of the 2018-2019 Domestic Abuse Improvement Plan, refresher training (aimed predominantly at frontline officers who provide the initial response and safeguarding to reports of domestic abuse) was provided across all teams to address particular issues that could improve conviction figures and safeguarding.

The training covered:

Data Quality on Athena Investigation
Obtaining Case Direction from DAISU
Child Risk Assessments
Evidence-Led Investigations
Risk Assessment factors
Effective use of Body Worn Video

Prisoner Handovers to DAISU
Coercive and Controlling Behaviour, Harassment and Stalking

16.76 Training days are scheduled at regular intervals, and investigation of domestic abuse incidents and safeguarding remain a priority on the agenda for those days. Officers are immediately updated on any learning or changes to process/policy through key messages at daily management meetings, briefing slides, e-mail correspondence and intranet updates.

16.77 The two recorded domestic incidents which feature in this case were both assessed as standard risk, according to the DASH risk assessment criteria. Although neither of the incidents were domestic arguments between Sarah and Christopher, they were caused because of tensions concerning his estate. History has taught us that often the victims of domestic homicides are those who have previously been risk assessed as standard or medium risk. The Panel were keen to explore as part of the review, the procedures/arrangements currently in place within Hertfordshire for standard and medium risk victims of domestic abuse. There is provision for standard and medium risk victims of domestic abuse which is supplied by Catch 22 (Herts Constabulary's victim support providers) or the Beacon Safeguarding hub. The hub aims to provide more people with access to help and to prevent repeat victimisation. It will also offer more support throughout the criminal justice process to raise convictions levels. Practical help includes a caseworker for each victim to support them through the process, as well as giving advice on benefits, alternative accommodation and liaising with investigating officers.

16.78 The incident involving the threats/driving incident reported on 16th November 2015 was not dealt with as a domestic incident and so a risk assessment was not completed. Police now have more training around domestic abuse and the DAISU has been formed providing a more dedicated and specialised approach to victims of domestic abuse, which demonstrates learning has already been taken from cases like this in Hertfordshire.

Training provided by Hertfordshire Safeguarding Children's Partnership

16.79 For the last two years, a team of clinical psychologists (Led by Dr.Warren Larkin) from the Herts and West Essex Trust have delivered training on behalf of the Safeguarding Children's Partnership on "Adverse Childhood Experiences, Trauma and Resilience".(ACE) This training is available to all staff working with children and young people across a multi-agency spectrum. The training is designed to help professionals understand the impact of trauma and adverse childhood experiences and how the traumatic life events of the people may be influencing their current behaviour or difficulties. It also provides guidance and advice to professionals across multi-agency disciplines in dealing with trauma and supporting those who have experienced trauma.[44] Information received from the Hertfordshire Children's Safety Partnership as revealed that 2394 professionals have attended 'ACE" training since 2019.

Provision of Domestic Abuse services in Hertfordshire

[44] ACE course descriptions.docx

16.80 Hertfordshire County Council commissions two services for high-risk victims, the Independent Domestic Violence Advocacy (IDVA) service, which is run by Refuge, and a safe accommodation service, which is run by Safer Places.

16.81 Whilst there is provision for standard and medium risk victims of domestic abuse in Hertfordshire, this is not provided by a single service, which arguably makes the pathway into services for lower risk victims more difficult. However, the Hertfordshire Office for the Police and Crime Commissioner have recently established the Beacon Safeguarding Hub, which co-locates in the DAISU specifically to support standard and medium risk victims. The hub was launched during national COVID restrictions in May 2020, a time when victims were even less likely to be able to get support for domestic abuse. It has been estimated that an additional 125 victims are now benefitting from a dedicated, needs-assessed service every month through the Beacon Safeguarding Hub.

16.82 In addition, Safer Places, who provide refuge accommodation and community outreach in Hertfordshire, also have caseworkers for standard and medium risk victims. The voluntary and community sector in Hertfordshire also does a lot of work around standard and medium risk victims, but again the pathway into these services may not always be as well known by professionals or visible to victims as they should be.

16.83 The review has identified that current support for standard and medium risk victims, although improved, could still be strengthened. It has been recognised by the DHR Panel that the current arrangements for service provision for standard and medium risk domestic abuse victims will vary depending from area to area. There is better service provision in the north and east of the county and the type of support varies from area to area. This inevitably means that not all standard and medium risk victims of domestic abuse have ready access to support services. This area forms the basis of a recommendation.

17.0 CONCLUSIONS/ LESSONS TO BE LEARNT

Lessons to be learnt for HPFT.

17.1 There were two key conversations with HPFT staff where Sarah referred to Christopher as being a controlling man and expressed resentment towards him in terms of his treatment of their children. The nature of the controlling behaviour was not explored at the time, however, this was in the context of an appointment where Robert was also present and the CPN may not have felt able to discuss this more fully. The CPN did help Sarah to self-refer to Children's Services and also offered a carer's assessment, recognising the strain she was under. Professionals should strive to create an environment where there is an opportunity for clients to speak freely. It is not clear from the information provided, whether the professionals involved with the children, spoke to them independently of Sarah and this may have been beneficial in this case in an effort to identify any tensions within the home which may have impacted on them.
(Recommendation One).

Lessons to be learnt for HCS

17.2 At the point the CPN made a referral to HCS, staff could have asked more questions to gain an insight into why mental health professionals were working with the family when Sarah was asking for help to care for her children. This may have created a fuller picture of the multiple issues affecting the family at this time.

17.3 Family history and case chronology might have been better utilised in the transition to adult social care, so that the relevant adult social care worker was aware of the previous domestic abuse incidents reported in 2015 and the history of the family feud.
(Recommendation Two)

Lessons to be learnt GP Surgery, HPFT and Social Care

17.4 Professionals need to be more alert to the fact that an underlying cause of depression, anxiety or other mental health conditions may be domestic abuse, and that interventions aimed at targeting domestic abuse are less likely to be effective if mental health needs are ignored. In addition, professionals need to be more aware of what domestic abuse support services are available to ensure victims are appropriately referred to specialist support.
(Recommendation Three)

17.5 Professionals might have considered the association between signs and symptoms of autism and their similarities to the presentation of trauma in young people. This may have provided further insight with regards to the dynamics within the family.
(Recommendation Four and Recommendation Seven)

17.6 There is emerging research in this area. For example, an article which appeared in a clinical social work journal in 2018 states that "high rates of comorbidity between ASD and other psychological disorders, including depression and anxiety, indicate that standard behavioural approaches are not adequately addressing issues related to mental health in this population. Research emerging since the publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is advancing our understanding of the nature of childhood stress and trauma in people with ASD and its subsequent impact on mental health and wellbeing. Mounting evidence for stress and trauma as a risk factor for comorbidity and the worsening of core ASD symptoms may intimate a shift in the way clinical social workers and other clinical practitioners conceptualize and approach work with this population to include trauma-focused assessment strategies and clinical interventions".[45]

Lessons to be learnt Police

17.7 The police in their handling of the harassment report and concerns over possible financial abuse could have taken a more robust response, especially when considering the pre-existing feud between the family. They should have also considered recording this as a domestic incident and completed a risk assessment.

17.8 The police did not pick up on the significance of the information provided by David, that Christopher was being financially exploited by Sarah and that this is an indicator of domestic abuse. It is not clear from the information provided that Christopher was ever spoken to on this own when police attended the domestic disputes or following the report of harassment. Although the Panel acknowledge, this was not a straightforward allegation, there were other enquiries which could have should have been carried out, the most important of which would have been to speak to Christopher himself.
(Recommendation Five).

17.9 It does not appear as though, the police, when attending the domestic disputes, spoke to Christopher independently of Sarah or David. They may have inhibited his ability to speak freely.
(Recommendation Five)

Lessons to be learnt HDAP

17.10 The review has identified there may be a lack of service provision for male victims of domestic abuse and for those who live in more rural communities within Hertfordshire.
(Recommendation Six)

[45]Article in Clinical Social Work Journal entitled Autism Spectrum Disorder: The Impact of Stressful and Traumatic Life Events and Implications for Clinical Practice. Samantha Fulds, January 2018.

Lessons to be Leant All agencies

17.11 The review has identified there were missed opportunities for the professionals involved with this case to identify the potential risks to Christopher and his family and make appropriate referrals to improve their safety. The Hertfordshire Domestic Abuse Partnership need to lead a programme of work in line with the Safelives' "Whole picture strategy" and include this within their domestic abuse Strategy. [46]
(Recommendation eight)

Conclusion

17.12 The murder investigation revealed the motive for the murder was Sarah's desire to be free of Christopher in order that she could pursue her relationship with Simon. Christopher had made it clear he would not agree to a divorce and wanted a reconciliation. In addition, there was a potential for a property development deal where both parties (and others) would stand to make a significant amount of money from selling their land. Information from Christopher's family revealed Sarah's intention to gain further assets from Christopher in a divorce settlement.

17.13 The risk to Christopher increased significantly at the point Sarah began her relationship with Simon. Their relationship began in late 2017 and by this time, the majority of contact with the professionals involved in this case had already taken place.

17.14 None of the professionals involved with this case were aware of Sarah's newly formed relationship with Simon and how the risk to Christopher significantly increased at this point. The motive for his murder was a combination of greed and the desire for freedom in order to pursue a new relationship.

17.15 The DHR Panel are of the view, however, that engagement with a specialist domestic abuse service in 2015 might have altered the course of events. The reasons this did not happen are likely due to the following factors:

Low level of risk identified, and professional judgement not being applied in relation to completion of a DASH risk assessment in all instances.
Not pursuing all lines of enquiry in relation to the harassment case or concerns around possible financial abuse.
The lack of clear pathways for support at that time, especially for standard and medium risk victims.
Procedures for supporting standard and medium risk victims not being as robust as those for high risk victims.
Lower visibility of support from domestic abuse services in the rural area in which Christopher and Sarah lived.

[46] Safelives' – The Whole Picture Strategy – October 2018 The Whole Picture - SafeLives' Strategy.pdf

Lower visibility of services for male victims of domestic abuse.
Failure to recognise that financial abuse is a form of coercive control
Failure to recognise the children of Sarah and Christopher may have been exposed to domestic abuse between their parents and their trauma may have manifested in signs of autism or other challenging behaviours.

18.0 RECOMMENDATIONS

Recommendation One - Hertfordshire HPFT

It is recommended that HPFT prepare a learning note of the key factors identified in this case and develop a training programme for practitioners to include:

1. The need to exercise professional curiosity when hearing of tensions within a domestic setting;
2. How to identify the risks and indicators of domestic abuse, including the increased risk during or following separation/divorce;
3. The importance of identifying the signs of coercive controlling behaviour;
4. Of where to go for support if they are unsure how to manage risks around domestic abuse.

Recommendation Two – Hertfordshire Children's Services

It is recommended that HCS prepare a learning note of the key factors identified in this case and provide training to raise awareness of staff:

1. Of the importance of utilising case chronologies when undertaking statutory assessments. Where there is a justified belief that other household members may be at risk, it is appropriate to consider all contacts received about and from a family, therefore not looking at domestic abuse incidents in isolation.
2. To exercise Professional curiosity when engaging with clients who are exhibiting signs of trauma and explore the underlying causes.

Recommendation Three – Integrated Care Partnership

It is recommended Hertfordshire Integrated Care Partnership commission the local CCG's to issue guidance and provide training for all GP practices in their area highlighting the need to ask questions overtly about domestic abuse when patients present with mental health conditions such as anxiety and depression. (The underlying cause could be associated with domestic abuse). The training should also include raising knowledge of referral pathways to services who can offer support.

Recommendation Four - Hertfordshire Domestic Abuse Partnership

It is recommended that HDAP ensure that a learning note is prepared and circulated to all front-line professionals in education, health and social care advising practitioners that trauma presentations can be similar to autistic behaviours or labelled as mental illness episodes. Professionals must ensure that trauma and abuse are considered before concluding alternative diagnosis. This should include information from the latest research in this area.

Recommendation Five – Hertfordshire Constabulary

It is recommended that Hertfordshire Constabulary issue guidance to all officers that:

1. Allegations/concerns regarding financial abuse is an indicator of domestic abuse and this aspect is covered in all training provision on the subject of domestic abuse.
2. The importance of creating an environment where all parties can be spoken to independently of one another at incidents of domestic abuse.
3. They consider the new domestic abuse bill and recognise children can be victims of domestic abuse, when exposed to it.

Recommendation Six - Hertfordshire Domestic Abuse Partnership

It is recommended that Hertfordshire Domestic Abuse Partnership commission a review, the purpose of which is to consider whether specialist domestic abuse services (and perhaps mental health services) in Hertfordshire are equally accessible to all, regardless of where in the county they live. Particular attention should be paid to what services are accessible to those living in rural areas and those available to male victims. Once complete, the information to be made available to all statutory agencies for onward dissemination to frontline staff.

Recommendation Seven – Hertfordshire Safeguarding Children's' Board

It is recommended HSCB ensure further training provision is made available on "Adverse Childhood Experiences and Trauma" and delivered to all multi-agency practitioners who are involved in working with children and young people.

Recommendation Eight – Hertfordshire Domestic Abuse Board

It is recommended the HDAP adopt the Safelives Approach to "The Whole Picture Strategy" and incorporate within their domestic abuse strategy a programme of work to improve Professional's knowledge and application of the "Identification and Referral to Improve Safety" Strategy. [47]

[47] The Whole Picture - SafeLives' Strategy.pdf

APPENDIX ONE – DETAILS OF AGENCIES CONTACTED AND SUMMARY OF INVOLVEMENT

Agencies Contacted	Involvement
Hertfordshire County Council - Adult Care Services (0-25 Service)	IMR
Hertfordshire Partnership University NHS Foundation Trust	IMR
Hertfordshire Constabulary	IMR
Hertfordshire County Council – Children's Services	Information for Chronology
East and North Hertfordshire CCG	Information for Chronology
West Hertfordshire Hospital NHS Trust	Information for Chronology
Refuge – IDVA Service	No Information
GP Surgery	Information for Chronology
National Probation Service	No Information
Bedfordshire, Northamptonshire, Cambridgeshire & Hertfordshire Community Rehabilitation Company.	No Information
West Hertfordshire Hospital Trust	Information for Chronology
East and North Hertfordshire NHS Hospital Trust	Information for Chronology

APPENDIX TWO – GLOSSARY OF TERMS

Abbreviated Term	Full Term
DHR	Domestic Homicide Review
HDAP	Hertfordshire Domestic Abuse Partnership
NHCSP	North Hertfordshire Community Safety Partnership
IMR	Individual Management Review
VS	Victim Support
NFU	National Farmers Union
ACMHT	Adult Community Mental Health Team
CAMHS	Child and Adolescent Mental Health Service
LDATS	Learning Disability Adult Treatment Service
CPN	Community Psychiatric Nurse
FACS	Fair Access to Care Service
DCT	Disabled Children's Team
SALT	Speech and Language Therapist
ASD	Autism Spectrum Disorder
CDC	Child Development Clinic
CAPA	Choice and Partnership Approach
TAS	Targeted Advice Service
PIN	Police Information Notice
OT	Occupational Therapist
LPC	Local Policing Command
HRU	Harm Reduction Unit
DAISU	Domestic Abuse Investigation and Safeguarding Unit
OIC	Officer in the Case

HERTFORDSHIRE domestic abuse PARTNERSHIP

APPENDIX THREE – HERTFORDSHIRE MASH PROCESS MAP.