North Hertfordshire Community Safety Partnership

Overview report executive summary into the death of

Christopher June 2018

Author: Tracy Hawkings

Completion Date – November 2022

SUMMARY OF CONTENTS

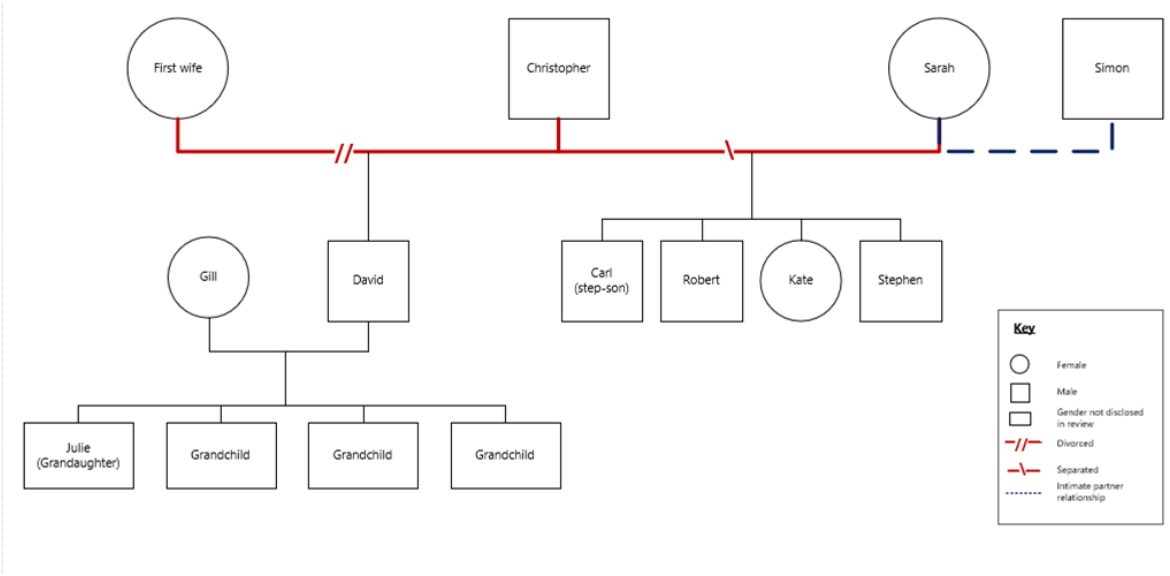
1.0 THE REVIEW PROCESS

1.1. This summary outlines the process undertaken by North Hertfordshire Community Safety Partnership (NHCSP) domestic homicide review panel in reviewing the homicide of Christopher who was a resident in their area.

1.2. The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:

- 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

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



1.4. 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.

1.5 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.

1.6 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.

1.7 In 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.

1.8 The process began with an initial meeting of the North Hertfordshire Community Safety Partnership on 12/03/19 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Christopher and Sarah prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.9 Nine of the twelve agencies contacted confirmed contact with Christopher and Sarah and their children and were asked to secure their files.

2.0 CONTRIBUTORS TO THE REVIEW

2.1. The contributors to the DHR were:

- Hertfordshire Police – IMR
- Hertfordshire County Council's Adult Social Care 0-25 service – IMR
- Hertfordshire Partnership University NHS Foundation Trust – IMR
- GP Surgery – Hitchin, Hertfordshire – Chronology
- East and North Hertfordshire NHS Trust – Chronology
- Hertfordshire County Council Children's Services - Chronology

2.2. Independence and Impartiality are fundamental principles of delivering DHRs 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.

3.0 THE REVIEW PANEL MEMBERS

3.1. The Panel for this review was made up of the following representatives;

- Elizabeth Hanlon – Independent Chair
- Dawn Bailey – Lead Nurse Safeguarding Adults, West Hertfordshire Hospital Trust
- Tracey Cooper - Associate Director Adult Safeguarding – Herts Valleys and East and North Clinical Commissioning Groups (Health Representative)
- Rebecca Coates – Community Protection Manager, North Hertfordshire District Council
- Sarah Taylor - Development Manager, Domestic Abuse – Hertfordshire County Council (Local Authority Representative)
- Louise Coulson - Senior Service Manager, Refuge, IDVA Service
- Stephen' O'Keeffe - Detective Chief Inspector - Hertfordshire Constabulary (Police Representative)
- Nicola Alsten – Service Manager 0 -25 Service, Hertfordshire County Council
- Katie Dawtry - Development Manager – Domestic Abuse, Hertfordshire County Council
- Enda Gallagher Lead Nurse Adult Safeguarding, East and North Hertfordshire NHS Trust
- David Scholes – Chief Executive – North Hertfordshire District Council
- Karen Hastings – Consultant Social Worker – Hertfordshire Partnership University NHS Foundation Trust.
- Tracy Hawkings - Independent Consultant and Overview Report Author

3.2. The Panel met on five occasions. The independence of Panel members was confirmed during the Panel process.

4.0 DHR PANEL CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1. 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.

4.2. 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 DHR's 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 Review for Hertfordshire, Cambridgeshire and Essex. She is also 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.

4.3. 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 DHR's within Hertfordshire and works as an independent DHR Author and DHR Chair.

4.4. 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 deliver 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.

4.5. 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 (critical incidents, serious case reviews, domestic homicide reviews and post cases reviews). During that time, she had no involvement with Hertfordshire agencies nor with the policies, practices or operational oversight of the resources deployed in this case.

5.0 TERMS OF REFERENCE FOR THE REVIEW

5.1. 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:

5.2. Comment on the specific areas set out in the key lines of enquiry (Para 5.15 below)

5.3. To identify the history of the victim and alleged 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 February 2019.

5.4. 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.

5.5. To report their involvement with the victim and/or the perpetrator(s), 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.

5.6. To examine whether there any indicators or history of domestic abuse and/or coercive control. 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?

5.7. 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 any collaboration and did services work effectively with those working with any involved children?

5.8. 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.

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

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

5.11. To examine whether the victim and/or perpetrator were assessed, or could they 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?

5.12. 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.

5.13. 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 fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

5.14. To examine the level of domestic abuse training undertaken by staff who had contact with the victim and/or the alleged perpetrator, and their knowledge 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), or to appropriate specialist domestic abuse services.

Key lines of enquiry

5.15. The following are key lines of enquiry which will be explored further with the relevant agencies in the review:

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

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

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

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

5.20. 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.

6.0 SUMMARY CHRONOLOGY

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

6.2. 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 of his life and had acquired a significant amount of land, a farm and a number of farm holdings in the Hitchin 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.

6.3. 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.

6.4. As part of the review, Christopher's daughter in law Gill was interviewed. It is their 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.

6.5. Prior to 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.

6.6. The situation deteriorated further, over time, and Christopher found himself in the middle of arguments between the two families whom he loved. Sarah had a violent temper and there were occasions when she used violence towards Christopher, and he was seen with bruises on his face. Christopher would tell David and Gill, the injuries had been caused by Sarah during domestic arguments. She was also violent towards property and would frequently smash things and break them. On one occasion, Sarah punched

Christopher's 13-year-old grandson in the face. 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.

6.7. Upon the death of Christopher's mother, her grandson David inherited her farm and 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 as she 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.

6.8. 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 and caused Christopher to have mounting debts. The debts became so significant, Christopher had to take out a one million pound loan from the bank with David acting as a guarantor.

6.9. 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.

6.10. On 1st August 2013, Christopher attended his GP surgery and disclosed he was feeling low and his anxiety levels were getting out of control. 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.

6.11. Between September and October, Christopher had follow-up appointment with his GP and reported his anxiety/depression had improved since taking anti-depressants.

6.12. 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.

6.13. On 1st October 2014, the eldest child (Robert) of Christopher and Sarah 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.

6.14. 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.

6.15. 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 there were difficulties between her children. Sarah reported feeling isolated. The notes do not reveal whether or not there was any specific reference in the referral to Children's Services to the fact that Sarah referred to Christopher as controlling and there were no other referrals in relation to the potential for domestic abuse.

6.16. The CPN also 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 Fair Access to Care Services (FACS) criteria and also correctly identified Sarah as a carer and arranged for a carers assessment to be carried out.

6.17. The CPN referral to Children's Services was allocated to the Disabled Children 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.

6.18. 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 as a family. 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.

6.19. As a result of the referrals made by the CPN, there was significant engagement with the three children of Sarah and Christopher.

6.20. 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.

6.21. 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.

6.22. On 9th March 2015, Robert refused to engage with the autism assessment and stated he no longer wanted the support from the OT, albeit their assessment had concluded by this date.

6.23. Between 02/01/15 and 22/05/2015, their youngest son Stephen, received support from the Child and Adolescent Mental Health Service (CAMHS) and the Speech and Language Therapy (SALT) team in relation to his challenging behaviours and mood swings and to the Child Development Clinic (CDC) for an autism assessment. Stephen was not diagnosed with autism and although supported by CAMHS, in May 2015, he refused to attend further appointments.

6.24. 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. HPFT Learning Disabilities services offer support to individuals who have a mental health disorder as well as learning disabilities and autism. Kate was referred for assessment by the DCT. She received long term support from a clinical psychologist, psychotherapist and had 20 hrs a week one to one care package within the home.

6.25. 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 and tensions which existed 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 David and disharmony within the extended family.

6.26. 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.

6.27. 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 and the incident was classified as a standard risk non-crime domestic incident.

6.28. On 14th November 2015, Sarah contacted the police to report a domestic argument between Christopher and David during a pheasant shoot. She initially reported 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 later 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. The police notes record that Christopher did not disclose any information. 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. The situation was made worse by other family members who were 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. 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.

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

6.30. On police attendance they established some background detail 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, an employee of Christopher was present when Christopher was discussing the incident with Sarah. During the course of 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, which led to her report to the Police.

6.31. The incident was recorded as a first incident 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.

6.32. 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 of time 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 when Christopher discovered Sarah and Simon had begun a relationship and he told Simon to move out. This took place in January 2018[1].

[1] Source – Evidence gathered by the police during the homicide investigation.

6.33. In March 2018, Christopher received a letter from a solicitor representing Sarah informing him 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 her a letter stating he wanted a reconciliation and offered to sell his farm in order that they could relocate somewhere together and make a fresh start.

6.34. 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.

6.35. 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 appears to have extinguished itself and there were no other signs of external damage.

6.36. None of the family knew why anyone would want to carry out this attack, but due to his concern over the safety of Christopher, his son, David, arranged for work colleague (Barry), to move in with his father to provide extra reassurance and support.

6.37. The following week, on 4th June 2018, Christopher was reported missing from his farm in Hitchin by his grandson 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 if there were any links to the disappearance of Christopher. Forensic evidence subsequently linked Simon to the crime.

6.38. Initially the family members of Christopher, including Sarah and Simon were treated as significant witnesses and their accounts obtained. They 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 evidence was found via 'WhatsApp' messages exchanged between Sarah and Simon which clearly demonstrated their intention to kill Christopher and hurt his family from his first marriage. Sarah and Simon were charged with murder and arson. At the point of Sarah and Simon being charged with murder, the body of Christopher had not been found.

6.39. In February 2019, the decomposed body of Christopher was found on a riverbank on farmland owned by Sarah in Hitchin. 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 could be consistent with strangulation.

6.40. In 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 an appeal against conviction which was rejected.

6.41. 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.

7.0 KEY ISSUES ARISING FROM THE REVIEW

7.1. The review identified areas where operational practice could be improved, and these have been addressed in the recommendations that have been made. These changes will enhance current operational delivery and ensure that victims and their families receive the highest standards of care and support.

Key Issue 1 - Professional curiosity – All agencies

7.2 The review has identified there were opportunities for professionals to exercise professional curiosity in their dealings with Christopher, Sarah and Christopher's son David and his family.

- Practitioners from HPFT should have explored further detail with Sarah when she described Christopher as controlling.
- Christopher's GP could have probed the reasons behind his marital breakdown and financial difficulties which he gave as a contributory factor for his anxiety and depression.
- The police could have probed further into information provided to them by Christopher's son David that Sarah was abusing him financially.

Key Issue 2 – Utilisation of case chronologies when completing assessments

7.3 The review has identified, it would be beneficial for professionals to consider all information about a family when conducting assessments. This may have highlighted the fact, there were difficulties within the relationship of Sarah and Christopher which were affecting their children emotionally.

Key Issue 3 – Link between mental health/depression anxiety with domestic abuse.

7.4 Domestic abuse is often an underlying cause of depression/anxiety or other mental health conditions. Christopher was diagnosed with anxiety and depression and gave the underlying cause to be linked to a marital breakdown and associated financial problems. This should have been explored further by his GP.

Key Issue 4- Link between trauma and autism

7.5 Professionals might have considered the association with signs and symptoms of autism and their similarities to presentation of trauma in young people. All three children of Christopher and Sarah had

assessments for autism and one of them was formally diagnosed with the condition. Their youngest son had suicidal thoughts and was referred to (Insert). It does not appear as though a holistic approach was taken when considering the children and their difficulties and linked it to the possibility that they were experiencing difficulties within the home.

Key Issue 5 – Professional awareness that financial abuse is an indicator of domestic abuse.

7.6 Professionals failed to recognise that financial abuse is an indicator of domestic abuse and did not explore this in sufficient depth when it became known there were concerns that Christopher may have been financially exploited by Sarah.

Key Issue 6 – Domestic Abuse Service provision

7.7 The review has identified there may be a need to review the domestic abuse support services available for service provision for male victims of domestic abuse and for those victims living in more rural areas

Key Issue 7 – Identification and referral to Improve Safety

7.8 The review has identified, the professionals involved did not give enough consideration and adopt a holistic approach to identifying the issues which were affecting Christopher and his family and as a result did not make appropriate referrals to improve their safety.

8.0 CONCLUSIONS

8.1 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. Information from Christopher's family revealed Sarah's intention to gain further assets from Christopher in a divorce settlement. 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.

8.2 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.

8.3 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.

8.4 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.
- 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.

9.0 LESSONS TO BE LEARNED

Lessons to be learnt for HPFT.

9.1 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 this 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

9.2 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.

9.3 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)

GP Surgery, HPFT and Social Care

9.4 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)

9.5 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)

9.6 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".[2]

Police

9.7 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.

9.8 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).

[2]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.

9.9 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)

HDAP

9.10 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)

9.11 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. [3]

(Recommendation Eight)

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

10. 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 CCGs 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. 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. [4]

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