

**Domestic Homicide Review (DHR)  
into the death of  
Adult A, January 2019.  
Overview Report Executive Summary  
Dacorum Community Safety Partnership**

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Amendments completed by Dacorum Borough Council and the Strategic Partnership Team

Completion date for first submission to Home Office: June 2021

Completion date for resubmission to Home Office: June 2026

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## 1.0 THE REVIEW PROCESS

- 1.1. This summary outlines the process undertaken by Dacorum Community Safety Partnership (DCSP) domestic homicide review panel in reviewing the homicide of Adult A who was a resident in their area.
- 1.2. The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members:
  - Adult A – Female who was murdered. Aged 50 at the time of her death and of Colombian descent.
  - Adult B – Husband/partner of Adult A and person responsible for her murder. Aged 56 at the time of the incident and of Colombian descent.
- 1.3 Adult B was found guilty of murder following a trial at St Albans Crown Court which concluded on 29/07/19. He was given a life sentence and is to serve a minimum term of imprisonment of 19 years before being considered eligible for parole.
- 1.4 The process began with an initial meeting of the Community Safety Partnership on 23/01/19 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Adult A and Adult B prior to the point of death were contacted and asked to confirm whether they had involvement with them.
- 1.5 Fourteen of the twenty agencies contacted confirmed contact with Adult A and Adult B and their children were asked to secure their files.

## 2.0 CONTRIBUTORS TO THE REVIEW

- 2.1 The contributors to the DHR were:
  - Hertfordshire Constabulary – IMR and two reports regarding ASB incidents with neighbours
  - Hertfordshire County Council, Children’s Services – IMR
  - Dacorum Borough Council – IMR

- Met/Lincolnshire/Hampshire Police – Information
- West Herts Hospital NHS Trust– Information
- East and North Herts NHS Trust – Information
- Hertfordshire Partnership University NHS Foundation Trust/IAPT– Information
- Hertfordshire Community NHS Trust – Information
- Herts Valleys and East and North Herts Clinical Commissioning Groups and East and North CCG – Information
- IDVA Service – Information
- Herts Community NHS Trust – Information
- LAWRS – Information
- For Baby’s Sake Trust - Information

2.2 A decision was taken by the DHR Panel not to invite colleagues and friends to take part in the review, due to the fact the police had gathered comprehensive witness statements from them and were willing to share the information with the DHR author.

2.3 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;

- Amanda Foley – Independent Chair (St Albans City and District Council)
- Dawn Bailey – Lead Nurse Safeguarding Adults, West Herts Hospital Trust
- Stephenie Evis, Named Nurse Adult Safeguarding – Herts Valleys Clinical Commissioning Group and East and North Herts Clinical Commissioning Group (Health Representative)
- Clare Landy – Specialist Safeguarding Practitioner, Herts Partnership NHS Trust (Mental Health Services)
- Sarah Taylor - Development Manager, Domestic abuse – Hertfordshire County Council (Local Authority Representative)
- Stephen O’Keeffe/Anna Borella - Detective Chief Inspector - Hertfordshire Constabulary (Police Representatives)
- Claudia Megele - Head of Quality Assurance and Practice, Children’s Services (HCC)

- Katie Dawtry – Development Manager – Domestic Abuse, Adult Care Services (HCC)
- Joe Guiton - Team Leader Community Safety and Children’s Services, Dacorum Borough Council
- Tracy Hawkings - Independent Consultant and Overview Report Author

3.2 The DHR Panel met on four occasions. The independence of panel members was confirmed during the process.

3.3 Although the IDVA service provided information for the Review Process and the DHR author consulted with the “Latin American Women’s Rights Service”, there was no independent body representing victims of domestic abuse invited to join the Panel and this has been acknowledged as an oversight.

#### 4.0 DHR PANEL CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1. DCSP appointed Amanda Foley as the Chair of the DHR and Tracy Hawkings as the Overview Report Writer on 25<sup>th</sup> February 2019.

4.2. Amanda Foley is the Chief Executive at St Albans City and District Council. She was appointed in 2017, previously holding the post of Head of Corporate Services. Amanda joined the Council in 2009 from Ofsted – the Government’s Office for Standards in Education, Children's Services and Skills – where she was the Head of HR Strategy. She has worked across a range of sectors and industries including banking, retail and the Civil Service. Amanda is independent of all the agencies involved within the review and also has no affiliation to any other Council.

4.3. Tracy Hawkings is a safeguarding consultant specialising in undertaking reviews (Serious Case Reviews, DHRs and Post Case Reviews). Tracy previously served as an officer with Essex Police 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.

4.4. Tracy retired from the Police service in March 2017 but has spent the last two years working in the field of public protection for Essex, Suffolk, and Wiltshire. 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.

4.5. Tracy has completed both modules of the Home Office on line training, “Introduction to the domestic homicide process” and “The chairperson’s responsibilities and the overview report”. She also attended the Police National Review Officers Course which covers the subject of Domestic Homicide Reviews in depth.

## 5.0 TERMS OF REFERENCE FOR THE REVIEW

5.1 The DHR Panel discussed the Terms of Reference at the first DHR Panel meeting and they were subsequently agreed. The overall aim of this Review is to:

- Establish what lessons are to be learned from the domestic homicide involving Adult A and Adult B regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- 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;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence homicide and improve service responses for all domestic abuse victims and their children through improved intra- and inter-agency working.
- Contribute to a better understanding of the nature of domestic abuse and highlight good practice.

5.2 The specific terms of reference set for this review are:

- Establish how effective agencies were in identifying Adult A’s health and social care needs and providing support.
- Establish the appropriateness of single and inter-agency responses to both Adult A and Adult B, both historically and within a month of Adult A’s death.
- Establish whether and to what extent the single and inter-agency responses to any concerns about domestic abuse and/or coercive control were effective.
- To establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where domestic abuse is a feature.
- Identify, on the basis of the evidence available to the review, the need and required actions to improve policy and procedures in Hertfordshire, and more widely.
- Identify, on the basis of the evidence available to the review, any positive or emerging good practice, policy and procedures in Hertfordshire, and more widely.

- 5.3 The review aims to identify the learning from Adult A’s case and for action to be taken in response to that learning with a view to preventing future homicides, ensuring that individuals and families are better supported.

## 6.0 SUMMARY CHRONOLOGY

- 6.1 Between 2009 and 2019, the family had contact with five main agencies – Dacorum Borough Council’s housing and ASB team, Hertfordshire Constabulary, Hertfordshire Children’s Service (Dacorum Fostering Service), Hertfordshire Partnership University NHS Foundation Trust and Hertfordshire GP services.
- 6.2 As part of the review process, a comprehensive and detailed chronology has been produced but is largely taken up with Adult A and B’s work with the fostering service, health and housing records and numerous incidents of ASB connected to their next-door neighbour. This will be detailed in a summarised format within this section of the report.
- 6.3 On 18/05/09, the family moved from London to Hemel Hempstead with two of their three children. As part of the application process, a credit check revealed the family had debts in excess of £18,000.00. It is not clear as to the nature of the debts, but an Experian credit check conducted at the point of presentation confirmed personal debts of £10,962 for Adult A and £8,253 for Adult B. Housing records indicate the family remained in temporary or private accommodation until November 2012.
- 6.4 On 05/05/11, Herts Partnership University NHS Foundation Trust received a referral from Adult\_A’s GP following a diagnosis of mixed anxiety and depressive disorder. She had a triage appointment on 20/05/11 where she explained she was suffering from fibromyalgia and much of her depression emanated from this condition due to her being in constant pain. She agreed to be referred for a psychological assessment for her depression.
- 6.5 On 05/07/11, Adult A had an initial assessment with a Cognitive Behavioural Therapist (CBT). During the assessment, she reported symptoms of low moods triggered by her physical health problems. She described feeling down each day and felt that there was no point in living as her pain affected every part of her daily life. She stated her children were her protective factor and her goal was to reduce her issues with anger management caused by her physical situation. She described how she often became

frustrated when she could not do the things she wanted to do and reported shouting at her children if they were doing things slowly. Adult A told the therapist she wanted to change her moods and decrease her feelings of anger and frustration.

- 6.6 On 13/07/11, she had her first and last session with a CBT therapist. She was very tearful at this session because her paternal grandmother, the person who had brought her up, had died. With her agreement, it was decided to defer the CBT for a couple of months to enable Adult A to receive bereavement counselling. Adult A was advised she could return to CBT at a later date. This arrangement was followed up with a letter, which was also copied to her GP. Adult A was advised to make a further appointment with the CBT therapist, when she was ready to resume her therapy. No further contact was made with the service provider.
- 6.7 On 24/08/12, Adult A and Adult B made an application to Dacorum Borough Council Housing Team for council accommodation, stating they were declaring themselves as homeless as they could no longer afford private accommodation due to significant rental increases. The housing application recorded them as having two children; there was no mention of their eldest child who would have been 23 years old at this stage.
- 6.8 On 19/11/12, Adult A and her family became tenants in the council accommodation where they remained until the time of the murder. Initially they received £110 per week housing benefit but in October 2018 this reduced to £12 per week due to Adult B gaining full time employment. The couple were up to date with rent payments.
- 6.9 The original housing application showed Adult A and Adult B as having different surnames but on other occasions within housing records Adult A was also referred to as having the same surname as Adult B. Although they presented as a married couple, in 2014, Adult A clarified her surname as being the one she originally provided. She declared that she had been married previously and never divorced her first husband. No other details are recorded by any agency with regards to her having been married before.
- 6.10 In 2013, Adult A and B applied to Hertfordshire Children's Services to become foster carers. They took part in an assessment process in accordance with National guidelines. The assessment process involves the completion of mandatory checks including disclosure and barring service, accommodation, financial,

employment and provision of personal references in addition to home visits and interviews with approved social workers to assess suitability.

- 6.11 On 27/04/14 the foster panel approved their application which was ratified by the agency decision maker on 31/04/14. Adult A was the primary carer and Adult B the secondary carer, as he was in and out of employment. Between 2014 and 2019, the couple fostered eleven babies. At the time of her death, Adult A was fostering a three-month-old baby who had been placed with her since birth.
- 6.12 As part of the process to assess Adult A and B's suitability to become foster parents, some useful information was gathered with regards to their background and recorded on assessment Form F (an assessment using Form F is primarily about identifying whether an applicant or applicants are suitable to be approved as foster carers).
- 6.13 Adult A informed the fostering service she married Adult B within six months of meeting him. This contradicts the information she provided to the DBC housing agency, when she reported never having married Adult B because she had not divorced her first husband. No other information is available to assist with clarifying whether Adult A and Adult B were married.
- 6.14 Between November 2013 and November 2018, Adult A and her family collectively lodged 78 separate reports of ASB to Hertfordshire Constabulary and 50 complaints to the housing department about their next-door neighbours. These were invariably the same complaint made to both organisations. Adult A reported most incidents to both organisations, albeit other incidents were reported by her children. The behaviour reported included the persistent smell/smoking of cannabis, excessive noise/loud music, the use of abusive language and racist comments.
- 6.15 In January 2019, the police were initially called to the home address of Adult A to take a missing person's report. This quickly developed into a murder enquiry and Adult B was arrested and subsequently convicted of the murder of Adult A. It is believed the 3-month-old foster child was present in the house at the time the murder occurred and may have been taken to the deposition site where Adult B disposed of Adult A's body. The police took the baby into police protection, and another placement was found by children's social care.

6.16 In terms of employment, records show that between 2007 and 2009, Adult A trained and worked as a beauty therapist. Adult B held a variety of different roles including working as a handyman, and decorator. For the months preceding the incident, Adult B was employed by a company contracted to Dacorum Borough Council and worked as a parking enforcement officer.

## 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 - The professionals involved did not recognise the subtle signs of coercive controlling behaviour that was present.

7.2 There is no information recorded in any of the participating agency files or as a result of interviews with the professionals who came in to contact with Adult A or B to indicate that there were any issues known to professionals relating to domestic abuse prior to her murder.

7.3 Based on the evidence available to the review, however, Adult A had been subjected to years of domestic abuse at the hands of Adult B. It appears that the abuse involved both coercive and controlling behaviour. Even though Adult A had a significant amount of contact with professionals from the Police, Children's Services and Housing, none of the professionals involved became aware of the abuse suffered by Adult A which ended in tragedy.

7.4 The policies and procedures within Hertfordshire are believed to be fit for purpose, once professionals become aware of incidents of domestic abuse. However, it is clear, from this case, that none of the professionals involved were aware of the abuse and this begs the question as to whether or not the relevant assessment processes in existence allow for more generalised questions around coercive control to be asked and whether professionals have received sufficient training on this subject to look for the signs of this type of abuse. This is relevant when considering the imminent introduction of the new Domestic Abuse Bill and may provide an opportunity for HDAP to review the training arrangements on this subject and this forms the basis of a recommendation.

7.5 As part of the review process, it has been identified that there were some subtle signs to indicate Adult A was subjected to coercive controlling behaviour at the hands of Adult B. This included the fact that Adult B was invariably present in the background when professionals visited, which may have prevented Adult A from having the opportunity to disclose the abuse, the fact she was reliant on Adult B for household chores and for transportation. It is possible this was a practical need but may also have been indicative of Adult B's controlling nature.

7.6 It is only as a result of information gathered as part of the murder investigation did the reality of the situation fully come to light. There were numerous opportunities for professionals involved in this case to explore the prospect of domestic abuse in general terms, but no-one asked the question. Professionals will need to adopt a more proactive creative approach on this subject going forwards.

Key Issue Two - The lack of understanding of the effects of trauma and the potential impact on a domestic relationship.

7.7 Although there is no evidence to suggest that any of the participating agencies had any cause to suspect domestic abuse featured in the relationship between Adult A and Adult B, had professionals (from social care in particular) had a better understanding of the impact of trauma on interpersonal relationships, they may have been in a position to identify a need for support for the couple.

7.8 The IMR author for Children's Services has recorded in her report that there were aspects of the assessment process which were worthy of further exploration, particularly the trauma suffered by both in Colombia and how this might have impacted on their relationship and other aspects as well.

7.9 Independent research has found a link between post-traumatic stress disorder (PTSD) and domestic abuse. Intimate partner violence has been found among people who have experienced certain traumatic events or have PTSD.

7.10 Separate from PTSD, a connection has been found between the experience of certain traumatic events and domestic abuse. Studies have found that women who experienced sexual, emotional or physical abuse in childhood were more likely to experience violence in intimate relationships than those without a history of childhood trauma.

7.11 It has also been found that people with PTSD are more likely to be aggressive and engage in intimate partner abuse than people without a PTSD diagnosis. The connection between PTSD and violence has been found for both men and women with the disorder.<sup>1</sup>

7.12 There is little doubt that the trauma suffered by both Adult A and Adult B would have impacted on their relationship. A more enhanced knowledge of the effects of trauma amongst professionals may have resulted in higher levels of professional curiosity around potential domestic abuse.

Key Issue 3 - The lack of understanding of cultural issues and how that may impact on a domestic relationship

7.13 One aspect of the terms of reference was to consider whether there were any cultural aspects which may have impacted on the dynamics of the relationship between Adult A and B who were both immigrants from Colombia. The review has identified there are significant cultural issues which may have been a contributory factor when considering the significant level of domestic abuse that Adult A was subjected to. Although professionals were aware of their background and culture, there appears to have been little or no consideration given to the potential risk for domestic abuse within the dynamics of the relationship. The ongoing work of HDAP has recognised that domestic abuse within BAME communities is significantly underreported and more work needs to be done with regards to overcoming the understanding of cultural issues and overcoming barriers.

Key issue 4 – To encourage under reporting of domestic abuse by minority ethnic and migrant groups.

7.14 The children of Adult A and a family friend knew she was the victim of sustained and prolonged domestic abuse at the hands of Adult B which went unreported to statutory or voluntary agencies. There are many reasons why people do not report domestic abuse which include fear and intimidation of the perpetrator, culture, distrust of authorities, economic and social factors. The challenge for all professionals going forwards is to put measures in place to encourage people to come forwards and seek support for themselves or another, in an effort to reduce domestic abuse. Public Health England have stated “When we do decide to intervene, we are sending a clear message to the wrongdoer that their behaviour is socially unacceptable. Social norms determine the rules of behaviour for given social groups or social situations. So, if messages about certain behaviours being unacceptable are constantly sent and

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<sup>1</sup> Mathew Tull ‘The relationship between trauma and domestic abuse’, *Very Well Mind*, (2020) <<https://www.verywellmind.com/ptsd-and-domestic-violence-2797405>>

reinforced within a community or group, then the boundaries of what is considered acceptable behaviour will shift.”<sup>2</sup>

## 8.0 CONCLUSIONS

- 8.1 This is a tragic case where Adult A suffered years of domestic abuse at the hands of Adult B which culminated in her murder. She lost her life because she made the decision to gain her independence and leave the relationship, a decision which could not be accepted by Adult B and as a consequence he murdered her. Adult B was convicted of the murder of Adult A in July 2019.
- 8.2 The abuse was suffered in silence and although Adult A had significant contact with statutory agencies, none of the professionals involved in this case were aware of the abuse she suffered or identified any indicators of abuse.
- 8.3 There may have been more opportunities to identify the abuse if the professionals involved had a better understanding of the impact of trauma on the dynamics of a relationship, the signs of controlling coercive behaviour and in this case, the cultural issues associated with Colombia.
- 8.4 There were subtle signs of coercive control which should have been explored in more depth by the professionals involved. For example, the couple disclosed they were in debt to the housing team, Adult B was rarely in employment, and the couple were in receipt of benefits. The review discovered, Adult A was the victim of financial abuse, and this was one of the ways she was controlled by Adult B. Adult A was diagnosed with depression and the reason for this was not explored in any depth by her GP. They disclosed they had suffered significant trauma whilst in Colombia and the effects of this within an intimate relationship was not explored fully.
- 8.5 The Panel are of the view, however, that although there were signs of coercive control, they were not obvious at the time the couple interacted with professionals and have only been identified fully as a result of the criminal investigation and this review. Adult B was able to effectively hide the fact he was an abuser from professionals who were unable to react or offer support to Adult A as a result. This review therefore concentrates on the learning that has been identified in an effort to prevent future homicides.

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<sup>2</sup> Public Health England Report – “Bystander Interventions to Prevent Intimate Partner and Sexual Violence – Published December 2020.

- 8.6 The review has identified that both Adult A and Adult B suffered trauma whilst in Colombia. More information is known about the formative years of Adult A who was subjected to child abuse, bereavement and exposure to gangs and violence before she met Adult B. As a couple, they had two children kidnapped, due to corruption associated with Adult B's profession as a police officer. The family fled Colombia to escape threats, intimidation and violence. In addition, Adult A and her children were exposed to years of controlling coercive behaviour by Adult B. The abuse went unreported, most likely because the family feared Adult B. There were opportunities to explore this in more depth as part of the fostering assessment process and had it been, professionals may have identified the impact that unresolved trauma can have on a relationship.
- 8.7 There are some cultural issues which need to be considered in the context of this case:
- ◇ As a police officer in Colombia, Adult B would, at the very least, have been exposed to the culture of police aggression, violence, and brutality. He had members of his family kidnapped as a result of his profession and up until the time the family fled the country, they were subject to fear, threats and intimidation.
  - ◇ Adult B grew up in a society where there is a culture of violence towards women, and a patriarchal machismo mindset that would have influenced his conduct and patterns of behavior towards Adult A. This is evidenced by the information provided by his family, friends and work colleagues, who described him as "violent", "controlling", "jealous", and "cruel". Research has shown that unless interventions are put in place, attitudes and beliefs remain unchanged despite Colombian Nationals migrating to the United Kingdom.
  - ◇ Given the police culture, the culture of violence and culture of violence against women in Colombia and fear of reprisals, it is understandable that Adult A did not report incidents of domestic abuse to the professionals with whom she came in to contact.
  - ◇ In addition, there would have been wider implications for Adult A in doing so, as she would have faced the prospect of losing her status as a foster carer, a role which she enjoyed and was proud to do. On a practical level, she also faced the prospect of potentially losing her income and financial independence and this would have been a barrier for her and one reason which may have prevented her from leaving Adult B.
- 8.8 From the moment Adult A informed Adult B that she wanted their relationship to end, the risks to her personal safety were greatly increased and made her extremely vulnerable. It is tragic that in an effort to gain her freedom, she lost her life because Adult B made the decision to murder her. Research has shown, 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.<sup>3</sup> The professionals involved in this case were unaware of the impending separation of the couple and this appears to be the key motivating factor for the murder.

## 9.0 LESSONS TO BE LEARNED

9.1 There are lessons to be learnt by Hertfordshire Children’s Service with regards to:

- ◇ practitioners’ recording of the presentation and interaction between foster carers as well as hearing from both as individuals and how this is explored within practitioners’ own supervision.
- ◇ the need to conduct an audit of the standard and quality of unannounced visits.
- ◇ to develop refresher training for practitioners in relation to trauma and the impact on relationships.
- ◇ to exercise professional curiosity and ask sensitive but direct questions about domestic abuse in a safe environment.

9.2 There are lessons to be learnt by Dacorum Borough Council in relation to the need to develop existing shared information systems to record where foster children are placed and to raise awareness of housing providers to alert statutory agencies when concerns are identified.

9.3 There are lessons to be learnt for the HDAP to continue the work identified within the JSNA to develop an engagement and communication strategy to encourage the reporting of domestic abuse from minority ethnic groups and migrant communities. This will need to address potential language barriers and cultural issues.

9.4 There are lessons to be learnt with regards to raising the awareness of professionals around the impact of trauma on the dynamics of an inter-personal relationship and the effects of trauma and how it can manifest itself in medical conditions such as fibromyalgia or anxiety and depression.

9.5 There are lessons to be learnt for all professionals to explore the signs of coercive controlling behaviour in their interactions with people. There are some key indicators such as financial control, isolation, undermining, humiliation to name but a few, which could be explored in a general context.

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<sup>3</sup> Jane Monckton-Smith, ‘Intimate Partner Femicide: using Foucauldian analysis to track eight stage relationship progression to homicide’, *Violence Against Women*, 26 (2020), pp. 1267-1285.

- 9.6 There are lessons to be learnt with regards to raising community awareness about domestic abuse including coercive control. This is a key factor within the forthcoming domestic abuse bill and presents an opportunity for Hertfordshire HDAP to encourage all agencies - statutory, voluntary, private and public sector - to raise community awareness of this subject and to try and address the issue of “passive bystanders” not intervening when they become aware that domestic abuse is present in an intimate partner relationship.
- 9.7 There are lessons to be learnt with regards to raising the awareness of professionals of what local services or initiatives there are available, who can provide support for victims of domestic abuse or suffered trauma as a result of abuse.

## 10. RECOMMENDATIONS

Hertfordshire Children's Services (HCS)

### **Recommendation 1**

It is recommended that Hertfordshire Children's Services (HCS) introduce a requirement for practitioners to include within their home visit templates a section which records observations of the carers, their presentation, and their interaction with each other. Both carers should be seen individually, and the worker should have the opportunity to consider the nature/quality of the relationship within their own supervision. This measure should be introduced with immediate effect and then the subject of regular review.

### **Recommendation 2**

It is recommended that HCS carry out a Quality Assurance Audit of the quality of unannounced visit write-ups.

### **Recommendation 3**

It is recommended that HCS facilitate refresher training for all fostering social workers on trauma and its impact on attachment and relationships.

### **Recommendation 4**

It is recommended that Dacorum Borough Council work with Hertfordshire Children's Services to establish if there is a viable way to update existing shared information systems to record the fact that foster children are placed within local council housing or private accommodations (this could be expanded to include information on violent and sexual offenders).

### **Recommendation 5**

It is recommended that DBC raise awareness of all housing providers and the ASB team to recognise the significance of tenants who foster children. This should include information on the process for making a safeguarding referral where concerns are identified (this obviously requires notification and knowledge of the arrangement in the first instance – linked to recommendation 4).

HDAP

### **Recommendation 6**

It is recommended that the recommendation within the JSNA to develop an engagement and communication strategy to encourage the reporting of domestic abuse by minority ethnic and migrant communities is expedited and implemented throughout 2021/2022.

### **Recommendation 7**

It is recommended that HDAP introduce programmes of work supported by domestic abuse campaigns to encourage active community bystander programmes to be introduced across the County.

### **Recommendation 8**

It is recommended that HDAP encourage all agencies/organisations to introduce initiatives to raise community awareness about domestic abuse and how and where to seek support. This should include the provision of an information leaflet which provides professionals with details of all local service providers.

All Agencies

### **Recommendation 9**

All statutory agencies need to consider their internal arrangements for training provision around the subject of coercive control, the effects of trauma within an inter-personal relationship and the key changes being introduced within the Domestic Abuse Bill 2021. This recommendation needs to be adopted by Hertfordshire Constabulary, Hertfordshire Adult and Children's Social Care, Hertfordshire County Council Housing Teams and Hertfordshire CCG's.

### **Recommendation 10**

It is recommended all statutory agencies review their existing assessment processes to ensure they provide sufficient opportunity for the professional to address the subject of domestic abuse and the signs of coercive controlling behaviour. This should then be supported by training and the provision of information on the areas which need to be addressed during the assessment process. This recommendation needs to be adopted by Hertfordshire Constabulary, Hertfordshire Adult and Children's Social Care, Hertfordshire County Council Housing Teams and Hertfordshire CCG's.