HERTFORDSHIRE
domestic abuse
PARTNERSHIP

Domestic Homicide Review

Dacorum Community Safety Partnership

Overview report into the death of Adult A, January 2019

Author: Tracy Hawkings B.Ed.
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

SUMMARY OF CONTENTS

Section No	Subject	Page Number
	Preface	
	List of Abbreviations	
1	Introduction	
2	Timescales	
3	Confidentiality	
4	Terms of Reference	
5	Methodology	
6	Involvement of family, friends, neighbours and wider community	
7	Contributors to the Review	
8	Review Panel Members	
9	Chair and Author of the Report	
10	Parallel Reviews	
11	Equality and Diversity	
12	Dissemination	
13	Background Information	
14	Chronology	
15	Overview	
16	Analysis	
17	Conclusions	
18	Lessons to be Learnt	
19	Recommendations	
Appendix 1	Details of agencies contacted for the Review and summary of involvement. (Including glossary of terms).	
Appendix 2	Summary of Responses to additional Questions set by Review Panel.	

PREFACE

I would like to begin this report by expressing my sincere sympathies, and that of the Panel, to the family and friends of Adult A. I am sorry for their loss and hope that in some way this report provides an insight to her life and a voice to Adult A's story.

"She was always inspired, passionate and driven, never taking no for an answer, always getting into people's hearts with love kindness and good humour. She always accepted the opportunity to help others, making everyone else her top priority. She would not hesitate to put herself in the face of danger, no fear, no doubt, always speaking her mind out loud, always genuine, always real".[1]

I would like to thank the Panel and those that provided chronologies and Individual Management Reviews (IMR) for their time and co-operation.

[1] BBC Interview with eldest child of Adult A on 13 September 2019, who is reading an extract from victim personal statement.

LIST OF ABBREVIATIONS

Abbreviated Term	Full Term
ASB	Anti-Social Behaviour
ASBAM	Anti-Social Behaviour Action Meeting
CBT	Cognitive Behaviour Therapy
CSC	Children’s Social Care
DASH	Domestic Abuse Stalking and Honour-Based
DCSP	Dacorum Community Safety Partnership
DHR	Domestic Homicide Review
HCC	Hertfordshire County Council
HCS	Hertfordshire Children’s Service
HDAP	Hertfordshire Domestic Abuse Partnership
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
JSNA	Joint Strategic Needs Assessment
LAWRS	Latin American Women’s Rights Service
PTSD	Post-Traumatic Stress Disorder
VS	Victim Support

1.0 INTRODUCTION

1.1 This is the report of a Domestic Homicide Review (DHR) undertaken by Dacorum Community Safety Partnership (DCSP). It examines agency responses and support given to Adult A, a resident of Hemel Hempstead prior to her murder in January 2019.

1.2 The primary purpose of a DHR is to enable learning where a person has died as a result of domestic abuse. In order 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.

1.3 This report will consider the contact that agencies had with Adult A between the dates 1st May 2009 and the date of her homicide in January 2019. These dates provide an overview of the period Adult A and her family were resident in the Dacorum area and engaged with the agencies that feature in this report.

1.4 In addition to agency involvement, the review has also sought to examine the past to identify any relevant background or specific risks to Adult A and whether there were opportunities to provide further support to her. 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.

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

2.0 TIMESCALES

2.1 The DCSP commissioned this review on 23rd January 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 Hertfordshire Domestic Abuse Partnership (HDAP) in partnership with the Dacorum Community Safety Partnership. The Home Office were informed of the review on 25th January 2019.

2.3 This review commenced on 29th January 2019. The Home Office Statutory Guidance advises that where practically possible the DHR 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. The Review was unable to be completed in the six-month time frame due to the on-going criminal proceedings which did not conclude until the end of July 2019. This caused a delay in the Independent Chair and Report Author making contact with the family of Adult A, to establish if they wanted to take part in the review, and in seeking support from other external

organisations. A further delay was caused by the suspension of DHRs in Hertfordshire due to the COVID-19 pandemic.

2.4 Both the Independent Chair and Overview Report Author were formally appointed at the first Panel meeting on 25th February 2019. During this initial meeting, the draft terms of reference were discussed and subsequently agreed.

2.5 The family of Adult A were contacted after the criminal proceedings had concluded and invited to actively contribute to the review.

2.6 The Panel met on six occasions, as follows:

- February 2019
- June 2019
- September 2019
- December 2019
- February 2020
- April 2020

2.7 Following the last formal Panel meeting in April 2020, the Overview Report Author and Chair finalised this overview report. Contact with Panel members was maintained in the intervening months and the report was completed in December 2020.

2.8 The report was then heard at the next meeting of DCSP's Responsible Authorities Group in March 2021. Further amendments were requested at this meeting and were subsequently made, and a version of this report was submitted to the Home Office Quality Assurance Panel, who quality assure all DHRs conducted in England and Wales, in June 2021.

2.9 The report was returned to DCSP in December 2021 and a great deal of further analysis was duly required. It was noted that the changes requested were similar to other Hertfordshire DHRs submitted before it which had been returned by the Home Office Quality Assurance Panel, and whilst time was taken was taken to ensure the analysis was strengthened, work to implement learning and ensure recommendations were acted upon continued. This is evidenced by the action plan associated with this review, which has remained under constant review.

2.10 It is notable that this review has been delayed at various points throughout the process. The review was initially delayed because the Review Panel felt it was important to seek expert advice on cultural issues, effects of trauma and coercive control. For this reason, advice was sought from the following organisations:

- Latin American Women's Rights Service (LAWRS), an advocacy Service to support Latin American Migrant Women affected by domestic abuse
- The For Baby's Sake Trust (previously the Stefanou Foundation), a charity set up to break the inter-generational cycle of domestic abuse, specialising in the effects of trauma in childhood.

- Refuge, a charity providing specialist support for women and children experiencing domestic violence. Refuge has also provided Hertfordshire's Independent Domestic Violence Advocacy (IDVA) service since 2016.
- Their comments have been incorporated into the body of this report.

2.11 Following the last Panel meeting in April 2020, many Panel members struggled with capacity due to the COVID-19 pandemic and the need to develop new and innovative ways to support victims and survivors of domestic abuse during this time. Panel members requested additional time to review reports during the various 'waves' of the pandemic, which were granted to ensure all agencies had the opportunity to provide feedback.

2.12 Further delays were then caused by reasonable requests for changes to the report by both the Panel and the DCSP.

2.13 Since the Home Office Quality Assurance Panel returned their feedback on this report in December 2021, there has been a dramatic increase in the number of DHRs being conducted in Hertfordshire, and the number of domestic homicides notified to the Home Office by Hertfordshire's 10 CSPs has doubled. This has also impacted the time it takes for members of DHR Panels to review and provide feedback on reports whilst they try to prioritise the completion of any actions allocated to them as the result of a DHR.

2.14 An amended version of the overview report was submitted to the Home Office in November 2022. The Home Office Quality Assurance Panel approved the draft fit for publication on [XXXXX].

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.

3.2 Before the report is published, DCSP will circulate the final version to all members of the review Panel for sign off within their respective organisations.

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. It has not been possible to engage with family members and therefore the use of pseudonyms has not been discussed with them. The pseudonyms agreed with the Panel are as follows:

- 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.

TERMS OF REFERENCE

4.1 The 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.

4.2 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.

4.3 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.

5.0 METHODOLOGY

5.1 The methods for conducting DHRs are prescribed by the Home Office Guidelines.[2] These guidelines state: -

> *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 DCSP took the decision to commission the review on 23rd January 2019. Those involved in making the decision were the Chair of HDAP, the Chair of the DCSP, the Chair of the DHR sub-group and representatives from Hertfordshire Constabulary, Hertfordshire County Council (Local Authority) and the county's two Clinical Commissioning Groups.

5.3 Following the decision to undertake the review, all agencies were asked to check their records and identify any interaction with either Adult A or Adult B. The responses were compiled in a composite chronology for the Chair and Panel to review. Details of the agencies contacted and their involvement are recorded in Appendix One of this report.

5.4 Where it was established that there had been contact with Adult A or Adult B, the Partnership ensured that all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become Panel members. Agencies that were deemed to have relevant contact were then asked to provide an IMR.

5.5 The following agencies supplied IMRs:

- Hertfordshire Constabulary – IMR and two additional reports relating to Anti-Social Behaviour (ASB) incidents with the neighbour.
- Hertfordshire County Council - Fostering and Adoption Service – IMR
- Dacorum Borough Council – Housing and Community Safety Team - IMR

5.6 There were two specific areas for Hertfordshire Constabulary and Hertfordshire Children's Services to consider as part of their agency review, which involved the management of a long term and on-going neighbour dispute (Police) and professional contact through Adult A's work as a foster carer (HCS).

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.

---

[2] 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' (Home Office, 2016)

Where changes were required, then each IMR also identified how those changes would be implemented.

5.8 Each agency's IMR covered details of their interaction with Adult A and Adult B, 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, the IMR author from Hertfordshire Children's Service interviewed several staff who had interaction with the family. In addition, members of Hertfordshire Constabulary were interviewed in connection with the ASB incidents involving the neighbours of Adult A and her family.

5.9 The findings from the IMR reports were endorsed and quality assured by senior officers within the respective organisations who commissioned the report and 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 IMR authors provided additional information to clarify issues raised individually and collectively within their IMRs. Contact was made directly with those agencies outside of the formal Panel meetings. This included contact with the Hertfordshire Constabulary and Dacorum Borough Council, in relation to the ASB incidents, and contact with Hertfordshire Children's Service, in relation to the fostering arrangements and assessment process.

5.11 Following a Panel meeting held on 25th September 2019, additional questions were sent to the IMR authors in respect of policies and procedures. The questions and summary of responses can be found in Appendix Two.

5.12 The Panel has also consulted with external agencies seeking expert advice. A representative from an independent advocacy and advisory service called Latin American Women's Rights Service (LAWRS) was consulted to seek their expert view on the Colombian Culture and domestic abuse. In addition, a representative from the "For Baby's Sake Trust" (Stefanou Foundation) was consulted to advise on the effects of trauma and a representative from Refuge was consulted to advise on coercive controlling behaviour.

5.13 The family of Adult A have not met with the DHR Chair or Report Author. The information provided by the family referred to in this report has been obtained through access to information held by the police and media interviews which are in the public domain.

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

6.1 On 29th September 2019, the review Panel Chair wrote to the three adult children of Adult A, making them aware of the review and inviting them to take part. They were provided with the Home Office Leaflet 'domestic homicide information leaflet for family members'. The letter was distributed by advocates from Victim Support (VS) and subsequent contact was maintained with the family by a case worker from the Domestic Homicide Support Team within Victim Support.

Initially, the eldest child of the couple indicated an interest in taking part in the review but later changed their mind due to ill-health.

6.2 In addition, a letter and leaflet translated into Spanish was sent to Adult B to invite him to speak with the Chair. The letter was sent after the criminal proceedings and appeal period had concluded. There was no response received from Adult B and no further attempts were made to contact him thereafter.

6.3 Members of the family have engaged with a case worker from the homicide team within VS, who communicated with them on numerous occasions between February 2019 and March 2020. The VS advocate was contacted by the DHR Report Author who confirmed the family were visited on seven occasions and contacted by telephone in excess of 60 occasions in addition to sending texts and e mails. The family were also supported by the Police Family Liaison Officer throughout the criminal investigation and judicial proceedings. All three children are now resident abroad and no longer engage with their case worker. They have not responded to any form of communication since March 2020.

6.4 During the homicide investigations, witness statements were taken from friends and colleagues of the couple and the information contained within is referred to in this report.

7.0 CONTRIBUTORS TO THE REVIEW

7.1 The contributors to the DHR, and the nature of their contributions, are detailed here.

Agency	Contribution
Hertfordshire Constabulary	IMR and two reports regarding ASB incidents with neighbours
Hertfordshire County Council, Children's Services –	IMR
Dacorum Borough Council	IMR
Metropolitan Police	Information
Lincolnshire Police	Information
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 (provided by Refuge)	Information
Herts Community NHS Trust	Information
LAWRS	Information

For Baby's Sake Trust	Information

7.2 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. In hindsight, they should have been given the opportunity to contribute to the DHR to provide an even clearer picture of what life was like for Adult A. Unfortunately, at the time this review was conducted, this was not recognised by the Chair or Panel, and for this they extend their deepest apologies to those close to Adult A.

7.3 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.

8.0 THE REVIEW PANEL MEMBERS

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

Name	Job title	Agency	Panel role
Amanda Foley	Chief Executive Officer	St Albans City and District Council	Independent Chair
Dawn Bailey	Lead Nurse Safeguarding Adults	West Herts Hospital Trust	Panel member
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 Foundation Trust (mental health)	Panel member
Sarah Taylor	Development Manager for Domestic Abuse	Hertfordshire County Council	Local Authority Representative

Name	Job title	Agency	Panel role
Stephen O'Keeffe	Detective Chief Inspector	Hertfordshire Constabulary	Police Representative
Claudia Megele	Head of Quality Assurance and Practice	Children's Services, Hertfordshire County Council	Panel member
Katie Fulton	Development Manager for Domestic Abuse	Hertfordshire County Council	Panel member
Joe Guiton	Team Leader	Community Safety and Children's Services, Dacorum Borough Council	Panel member
Tracy Hawkings	Independent Consultant	N/A	Overview Report Author

8.2 The Panel met on four 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 on this report are the collective responsibility of the DCSP and the HDAP.

8.3 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.

9.0 CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 DCSP appointed Amanda Foley as the Chair of the DHR and Tracy Hawkings as the Overview Report Writer on 25th February 2019.

9.2 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.

9.3 At the time this review was conducted, DHRs were reciprocally chaired by the Chief Executive Officers (CEOs) and Managing Directors of Hertfordshire's ten District and Borough Councils, the boundaries of which correspond to Hertfordshire's ten CSPs. Under this arrangement, a CEO outside of the District or Borough in which the victim was resident at the time of their death would Chair the review. The Hertfordshire Domestic Abuse Partnership has since commissioned an Approved List of independent domestic abuse specialists for the Chairing and Authoring of reviews. This arrangement came into effect in April 2020.

9.4 Prior to this review, Amanda received training from Advocacy After Fatal Domestic Abuse (AAFDA), an organisation that specialises in the conduct of domestic homicide and supporting those bereaved by it, regarding DHRs and their conduct.

9.5 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.

9.6 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.

9.7 Tracy has completed both modules of the Home Office online 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.

10.0 PARALLEL REVIEWS

10.1 An inquest was opened and adjourned by Her Majesty's Coroner in Hertfordshire. Following the conclusion of the criminal trial, the coroner decided not to hold a formal inquest, accepting the findings of the criminal court. The inquest was closed on 24th September 2019.

10.2 As part of the DHR, Hertfordshire Constabulary conducted an internal review into the management of ASB incidents which took place between Adult A and her family and a next-door neighbour. There are some learning points for the police which sit outside of this review.

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 and gender
- Sexual orientation

11.2 At the time of the homicide, Adult A was aged 50 and Adult B was aged 56. Both were born in Columbia, immigrating to the UK in March 2009.

11.3 Most of the interactions with professionals in this case were with Adult A and there is not much information held on Adult B, but nonetheless, a number of possible equality and diversity issues have been identified.

11.4 In identifying the relevant equality and diversity issues retrospectively for Adult A and Adult B, the Review Panel noted that:

- Adult A was of Colombian descent and her first language was Spanish.
- She was aged 50 at the time of her homicide.
- She had been in a relationship with Adult B since 1988 and they had three children together. They were also foster parents and looked after eleven children between 2014 and 2019.
- There is conflicting information as to whether or not the couple were married, but they did initially present to professionals as a married couple.
- Adult A was likely disabled, despite not being formally assessed as such by agencies.
- Due to Adult A's probable disability, Adult B likely had to act as her carer at various points from 2009 onwards.

11.5 Each of the relevant protected characteristics will now be discussed in turn.

11.6 Disability resulting from fibromyalgia

11.6.1 In 2009, Adult A was diagnosed with fibromyalgia. Fibromyalgia is a medical condition characterised by chronic widespread pain and a heightened pain response to pressure. Typical symptoms include excessive tiredness, restless leg syndrome, bowel and bladder

problems and sensitivity to noise or light. It is often associated with anxiety, depression and post- traumatic stress disorder.[3]

11.6.2 In 2011, Adult A was subsequently diagnosed with anxiety and depression caused as a result of the pain she suffered with fibromyalgia. She was referred for psychological therapy. It does not appear, from medical notes or any other information available to agencies, that she was registered with a disability. According to the Equality Act (2010):

> A person (P) has a disability if—
>
> (a) P has a physical or mental impairment, and
>
> (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.[4]

11.6.3 Adult A was in a lot of pain due to fibromyalgia. In a medical assessment conducted by Children's Services in 2014 to assess whether Adult A's condition would affect her ability to foster children, Adult A is described by the assessor as a:

> 46-year-old female with significant pain and mobility issues caused by fibromyalgia these are unlikely to resolve. Unfortunately, advice was not taken from the pain clinic to attend physiotherapy and she is dependent on her husband from a practical point of view with regards to cooking, mobility and even going out of the home. The panel should be aware that on her own she would not be physically able to support a child. As she requires so much support there might be a conflict of care priorities in the household if fostering children.

11.6.4 It is clear from this assessment that the symptoms of fibromyalgia had a significant effect on Adult A's ability to do normal activities. The effects also appear to have been long lasting, given she was diagnosed in 2009 and was still struggling with pain and mobility issues in 2014. The Panel therefore believe that Adult A likely had a disability, even though this was not formally determined.

11.6.5 The Panel also identified that Adult A could have been considered as an adult at risk according to organisational criteria based on national guidelines. According to Section 42 the Care Act (2014), a local authority must act when it has 'reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

1) has needs for **care and support** (whether or not the authority is meeting any of those needs),
2) is experiencing, or is at risk of, **abuse or neglect**, and
3) as a result of those needs is **unable to protect himself or herself** against the abuse or neglect or the risk of it.'[5]

---

[3] NHS, 'Fibromyalgia', < https://www.nhs.uk/conditions/fibromyalgia/>

[4] Equality Act 2010, Part 2, Chapter 1, Section 6: 'Disability'

[5] Care Act 2014, Section 42

11.6.6 To identify whether Adult A was eligible for a referral to adult safeguarding, it is useful to breakdown what each of the above three points may present.

11.6.7 <u>1) Care and support needs</u>

11.6.7.1 Care and support needs can include:

- elderly and frail due to ill health, physical disability or cognitive impairment
- has a learning disability
- has a physical disability and/or sensory impairment
- has mental health needs including dementia or a personality disorder
- has a long term illness/condition
- has needs because of a dependency on drugs or alcohol

11.6.7.2 If Adult A was disabled due to Fibromyalgia, she would be considered to have a care and support need. This is especially evident in the notes from the medical assessment conducted by Children's Services, which record her being completely reliant on Adult B for her care.

11.6.8 <u>2) Experience, or risk of, abuse or neglect</u>

11.6.8.1 The Care and Support Statutory Guidance defines ten types of abuse.[6] These are:

- Physical abuse
- Domestic violence or abuse
- Sexual abuse
- Psychological or emotional abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational or institutional abuse
- Neglect or acts of omission
- Self-neglect

11.6.8.2 Whilst we now know that Adult A was a victim of domestic abuse, including coercive control and economic abuse, this was not identified by agencies.

11.6.8.3 As research has shown that disabled women are twice as likely to be a victim of domestic abuse, safeguarding professionals need to enquire about domestic abuse more routinely to be able to identify those at risk.[7] The fact that 0 out of 925 referrals of disabled victims

---

6 Care and Support Statutory Guidance, November 2022

7 Crime Survey for England and Wales 2015. In the year to March 2015 the Crime Survey reported women (16%) and men (8.8%) with a long standing illness or disability were more likely to experience some form of domestic abuse than women (6.8%) and men (3.2%) with no long standing illness or disability.

to domestic abuse services were from adult safeguarding is 2015-16 also highlights the need for more routine enquiry.[8]

11.6.9 3) Inability to protect self, due to care and support needs

11.6.9.1 SafeLives, a national domestic abuse charity, have reviewed numerous studies and statistics on domestic abuse and disability as part of their 'Spotlights' series.[9] The following findings from their spotlight report make clear that victims of domestic abuse with a disability will face additional barriers to safety:

- Disabled victims typically endure abuse for an average of 3.3 years before accessing support, compared to 2.3 years for non-disabled victims. This suggests that disabled victims are often not being identified
- Even after receiving support, disabled victims were 8% more likely than non-disabled victims to continue to experience abuse
- For a disabled person, the abuse they experience is often directly linked to their impairments and perpetrated by the individuals they are most dependent on for care, such as intimate partners and family members

Although there was an assessment made by Children's social care in 2014 which noted that the victim was registered disabled and she was "dependent on her husband from a practical point of view with regards to cooking, mobility and even going out of the home… she would not be physically able to support a child" a referral to Adults Social Care was not considered at this point, therefore, consent was also not discussed with the victim.

11.7 Race

11.7.1 Race includes—

a) colour;

b) nationality;

c) ethnic or national origins.

11.7.2 Adult A was born in Columbia, immigrating to the UK from Spain in March 2009. Adult B is also of Colombian descent. This report will describe Adult A and Adult B as being from an ethnic minority group. The UK government 'use 'ethnic minorities' to refer to all ethnic groups except the white British group'.[10]

11.7.3 In relation to race, the panel considered:

---

8 Disabled Survivors Too: Disabled people and domestic abuse (SafeLives, 2017)
9 Spotlight #2: Disabled people and domestic abuse (SafeLives, 2017)
10 Writing about ethnicity (gov.uk)

- Specific barriers faced by victims from ethnic minority groups
- Any barriers faced due to English not being Adult A or B's first language
- Influence of Columbian culture and Adult A and B's lives.

11.7.4 Each of these points will now be discussed further.

11.7.5 **Barriers for ethnic minorities**

11.7.5.1 Whilst there is no information to suggest that Adult A or B were directly discriminated against due to their ethnicity, it is known that ethnic minority victims face additional barriers to disclosing domestic abuse and seeking support.

11.7.5.2 There are a number of reasons for this, including a fear of racism from public agencies which, sadly, is regularly reported in the media. One of example of this includes the Baroness Casey Review, and subsequent media coverage, which identified systematic racism and misogyny in the Metropolitan Police.[11] Similarly, a recent independent culture review of the London Fire Brigade identified the service as institutionally misogynist and racist.

11.7.5.3 Unfortunately, numerous victims of domestic abuse have also experienced racism first hand. A report by Revive (2020) identified that whilst higher proportions of ethnic minority women suffer domestic abuse, they routinely 'face racism from public agencies'.[12] In addition to this, the report highlights a lack of understanding by many statutory and voluntary agencies about the "specific ethnic, religious and cultural concerns" of ethnic minority women fleeing domestic abuse, with cultural identity, language and religious beliefs often being overlooked. In practice, this might mean ethnic minority victims face:

- Limited access to translators
- Cultural background not being considered or misunderstood
- Religious practices and rituals not being acknowledged
- Assumptions being made based on the survivor's age and ethnicity
- Prejudices around marital backgrounds
- Insufficient support around socio-economic factors, particularly to overcome poverty

11.7.5.4 The information outlined above may have had very real implications for Adult A. She may have felt that she could not trust agencies enough to disclose domestic abuse to them, or that support simply was not available to meet her needs. Likewise, professionals may have

[11] The Baroness Casey Review | Metropolitan Police
[12] Impact of racism on domestic abuse survivors (Revive, 2020)

been less likely to identify Adult A as a victim of domestic abuse due to uninformed or prejudiced assumptions being made about her and her life based on her ethnicity.

11.7.5.5 In terms of the area where Adult A lived, 80.9% (n=902,006) of the population in Hertfordshire are from a white British background and only 19.2% from all other ethnic groups combined.[13] In Dacorum, where Adult A resided at the time she was killed, the proportion of the population from an ethnic minority group is even lower, standing at 14%. Given the general lack of diversity in the community where Adult A lived, this may have contributed to a general feeling of isolation or of support not being available for her.

11.7.5.6 Referrals to Hertfordshire's domestic abuse services, such as the IDVA service, are predominantly for those from a white British background, suggesting that victims of domestic abuse from ethnic minorities (excluding white minorities) are either not being identified and referred by professionals or not self-referring, perhaps due fear, a lack of trust or feeling services are not for them.

11.7.6 **Language**

11.7.6.1 Whilst language is not a classed as a protected characteristic its own right, it is relevant to consider under the equality and diversity section of this review. This is because not speaking English as a first language can create further barriers to seeking and receiving support.

11.7.6.2 Adult A's first language was Spanish. She was able to communicate with professionals in English and it was she who usually took the lead when conversing. There was a reference to the couple's command of English noted in the "Skills to foster feedback" form (September 2013), where the facilitator raised a query around the extent to which the couple understood the content of the material and were able to participate. The housing department have reported she was hesitant at first when they initially had dealings with her in 2012 but her English became much improved over time.

11.7.6.3 The Panel identified there may have been barriers to accessing services in relation to inequality. Firstly, the couple's understanding of what services were available to them may have been affected by their level of understanding of the English language. It does not appear from the information provided that any consideration was given to the use of an interpreter.

11.7.7 **Columbian culture**

11.7.8 One aspect of the terms of reference was to consider whether there were any cultural aspects which may have impacted on the dynamics of domestic abuse perpetrated by Adult B. The Report Author has conducted extensive research into Columbian Culture and believes there are cultural factors which are relevant when considering this aspect of the terms of reference.

---

[13] Diversity profile for Hertfordshire

11.7.9 Between 1964 and 2016 there was a civil war in Colombia which led to an entrenched ideology in relation to violence and aggression, and there was a significant 'increase in homicides and assaults' as a result. (Archer & Gartner, 1976 & 1984).[14],[15] The civil war left Colombia with a culture of violence, where violence and aggression were used as a primary intervention when dealing with conflict.

11.7.10 The Colombian police were heavily involved in the civil unrest, which is relevant in this case as Adult B was a police officer prior to leaving the Country. Over several decades, policing in Colombia has been extremely controversial, with police officers fearing attack from angry residents, and residents claiming retaliation for police brutality. It is clear that in order to function and operate within such a culture of violence and aggression the police culture itself has moved towards a stance of fueling conflict, whether proactively or reactively (Alves, 2019).[16]

11.7.11 When considering the issue of domestic abuse in Colombia, research has shown that Colombia is a patriarchal society, where women are expected to look after the home and children. Gender roles are traditional, where men occupy a dominant role within the household as breadwinner and disciplinarian and assume responsibility for maintaining family pride and position within the community. Domestic abuse is about power and control, and so therefore men can use domestic abuse to ensure that a woman is kept in a traditional gender role, within a patriarchal society.

11.7.12 Cases of domestic abuse in Colombia are rife, with 'one woman on average killed every three days, and 55 cases of sexual violence reported daily' (National Institute of Legal Medicine and Forensic Sciences). It is further reported that Colombian women rarely report incidents of domestic abuse or sexual violence for fear of retribution or reprisals.

11.7.13 In terms of Colombian migrants living in the United Kingdom, research has suggested 'that changes indicate transformations in gender practices rather than ideologies which are more resistant' (Maclaine, 2010).[17] The majority of Colombian men are perceived as machistas, who adhere 'to the norms and ideals of machismo. Machismo refers to a cult of exaggerated masculinity involving the assertion of power and control over women, and over other men' (Chant & Craske 2003).[18]

11.7.14 With regards to employment, Colombian male migrants tend to take on more low status working roles, previously carried out by women, and classed as more 'feminized' jobs. This leads to a form of disempowerment. Within the household, some Colombian men have 'also resented having to do housework, resulting in tensions in the home which sometimes leads to domestic violence' (McIlwaine, 2010). This fact is relevant in this case as it is

[14] Dane Archer and Rosemary Gartner, 'Violent acts and violent times: A comparative approach to postwar homicide', *American Sociological Review*, 41 (1976), 937-963

[15] Dane Archer and Rosemary Gartner, *Violence and crime in a cross-national perspective* (New Haven, CT: Yale University Press, 1984)

[16] Jaime Amparo Alves, 'Refusing to Be Governed: Urban Policing, Gang Violence, and the Politics of Evilness in an Afro-Colombian Shantytown', 42 (2019), 21-36

[17] Cathy McIlwaine, 'Migrant machismos: exploring gender ideologies and practices among Latin American migrants in London from a multi-scalar perspective', *Gender, Place and Culture,* 17 (2010), 281-300

[18] Sylvia Chant, *Gender in Latin America,* (New Brunswish: Rutgers University Press, 2003)

known Adult B did take on a number of low paid jobs and did not have the employment status that he held in Colombia.

11.7.15 The DHR Panel has recognised that cultural issues may have influenced and affected Adult B's treatment of Adult A. There is the history of violence which is endemic in Colombia due to the civil wars; the attitudes and mindset displayed by Colombian men towards women; Adult B's status as a police officer which enabled him to operate within a culture of violence and intimidation; and the fact he may have felt disempowered when moving to England having to take low paid casual jobs and assisting with household chores.

11.8 Gender

11.8.1 Sex and gender should always be a consideration in DHRs. Sex is considered a risk factor as the overwhelming majority of victims of domestic abuse are female with the perpetrators being overwhelmingly male. Research has also shown that the majority of intimate partner homicides are disproportionately perpetrated by men on women. In 2019, 74% of the victims of domestic homicides were female.[19]

11.9 Religion

11.9.1 Catholicism is the main religion of Colombia, but the Panel have been unable to determine if either Adult A or Adult B were practising Catholics.

11.10 Socioeconomic status

11.10.1 In 2012, when the couple applied for local authority housing, they disclosed they had debts of £18,000 and could no longer afford to privately rent a property. This was not explored by the housing team in detail because 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.

11.11 Status as a foster carer

11.11.1 Another possible barrier to Adult A seeking support could have been her role and status as a foster carer. She may have been concerned about losing her approval to be a foster carer, if it became known she was the victim of domestic abuse perpetrated by Adult B. The Panel are confident, however, that had Adult A disclosed abuse to the professionals with whom she came in to contact, she would have received support.

11.12 Summary

11.12.1 The Panel identified that although there was no evidence that Adult A was directly discriminated against by an agency or individual based on the nine protected characteristics, there has to be some acknowledgement of the fact that, in addition to the

[19] 'Domestic abuse victim characteristics, England and Wales: year ending March 2019' (Office for National Statistics, 2019)

usual obstacles to separating from or fleeing a perpetrator of domestic abuse, Adult A could have faced additional barriers because of her culture and background.

12.0 DISSEMINATION

12.1 This version of the overview report is for discussion by the Review Panel. Circulation is restricted to staff directly involved in the review and the managers within the following organisations:

- Family Members
- Dacorum Community Safety Partnership
- Hertfordshire Domestic Abuse Partnership
- Hertfordshire County Council
- Hertfordshire Partnership Foundation Trust
- Hertfordshire Constabulary
- Dacorum District Council
- Hertfordshire Partnership University NHS Foundation Trust
- IDVA Service

12.2 In accordance with Home Office guidance, all agencies and the family of Adult A 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 specific organisations. The overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.3 The content of the overview report has been suitably anonymised to protect the identity of the female 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.

12.4 The family of Adult A will be provided with the final version of the overview report prior to publication and be given the time and space to read the report in their own time. It must be noted, however, that at the present time, the family have disengaged from contact with their case worker. The Review Panel will make further attempts to re-establish contact with them.

13.0 BACKGROUND INFORMATION (THE FACTS)

13.1 Both Adult A and Adult B, are of South American descent originating from Colombia. Both were born in the 1960’s with Adult A being five years younger than Adult B. They both experienced trauma whilst in Colombia.

13.2 Adult A had a difficult childhood. Her mother died when she was a baby and she was brought up initially by her father and grandmother. When Adult A was aged seven, her father remarried and she went to live with him, her stepmother and two step siblings.

13.3 Adult A was neglected and emotionally abused by her stepmother, who would make her undertake excessive chores and often withheld food from her for several days at a time. Her father worked away a lot and was therefore unaware of the abuse Adult A suffered at the hands of her stepmother. She eventually confided in a cousin and her grandmother intervened, taking Adult A back to live with her. Her relationship with her father, stepmother and step siblings became strained as a result.[20]

13.4 Adult A described Colombia as a very dangerous place and when growing up she was exposed to gang violence, drugs and murders. Adult A's step-sibling was murdered when aged 15 years old.

13.5 Adult A met Adult B when she was aged 19. At the time, Adult B was a serving police officer. She reported not being sure about him at first, but he later impressed her with his romanticism. The relationship became serious and they married in 1988 after dating for six months. At the time of their marriage, Adult A was aged twenty and Adult B was aged twenty-five. By 1993, they had three children. This information was given as part of the assessment process for Adult A and B to become foster carers, but their marital status was later contradicted by Adult A in her dealings with the housing department.

13.6 Adult A described an incident where her two youngest children and mother-in-law were kidnapped and held hostage by 'corrupt policemen' who were looking for Adult B, who was working away at the time. They were eventually released unharmed, but what followed was an eighteen-month period of restlessness and uncertainty for the family, who were in constant fear for their lives.

13.7 The kidnap was the precursor event which led to the family seeking asylum in the United Kingdom in 1998. They initially settled in the London Borough of Barnet and in 2005 they applied for and were granted British Citizenship. In 2007 the family moved to Spain to live and work but returned to England in 2009. Initially they moved back to London, but after a few months relocated and settled in Hemel Hempstead in Hertfordshire.

13.8 At the time of her death, Adult A was resident in a Dacorum Borough Council owned property in Hemel Hempstead with Adult B, her youngest child (aged 26), and a 3-month-old foster child who had been placed with them since birth. The family had lived at this location since November 2012.

13.9 There are no recorded incidents of domestic abuse between Adult A and Adult B. However, during the post-incident murder investigation, witness statements were taken from immediate family, friends and colleagues of the couple and a very different picture emerged which demonstrated that Adult A had suffered years of physical and emotional abuse at the hands of Adult B. The domestic abuse appears to have been more prevalent

[20] Source – Fostering service assessment Form F

when they lived in Colombia but did continue following their migration to England. This information has been provided by the police, and the Panel have obtained their prior permission before making reference to the information in this report.

13.10 Adult A was described by her eldest child as a strong willed, active and determined woman. She was completely devoted to bringing up her own children and in later years immersed herself in providing a loving caring home for the foster children who were placed with her. Adult A was extremely proud of her fostering work. Adult A held a driving licence, but she was heavily reliant on Adult B for transportation to do activities such as shopping or attendance at meetings with social care and the fostering service. The reason given for this was that she was not a confident driver. Adult B was described as hard working but not aspirational, and he was usually happy to go along with what Adult A said with regards to domestic matters.

13.11 Adult B has also been described by his children as an intimidating controlling man who was in a position of power because of the status he previously held as a Police Officer in Colombia. He had access to firearms which he kept at home (in Colombia), and his family described "things getting very ugly" when he was around. They referred to Adult A frequently having to climb out of the window of their home to escape his aggressive behaviour. Adult A was subjected to years of humiliation, physical and emotional abuse from Adult B, much of which was witnessed by their children.

13.12 There is reference made to Adult B having several extra-marital affairs, but he would deflect his conduct and behaviour by frequently accusing Adult A of being unfaithful to him. The family of Adult A stated she found her voice in the UK, and in the months prior to her death had reached the stage where she wanted to be liberated from him. In late 2018, Adult A informed Adult B that their relationship was over, and this heightened tensions within the household.

13.13 Additional evidence was taken from three witnesses, all of whom had conversed with Adult A or Adult B either pre- or post-separation. The witnesses included a neighbour, a friend of the family who knew both Adult A and Adult B well and a work colleague of Adult B.

13.14 The neighbour did not have any interaction with the couple in all the time they lived at the address. She described Adult B frequently having male friends to the house during the summer months and they sit in the garden all day drinking alcohol. The neighbour also stated she frequently heard the male shouting at his wife. Sometimes she would argue back, but more often than not it was the male doing the shouting. The neighbour could not understand what was being said as they spoke in Spanish but could tell by the tone of voice that the male was asserting his authority.

13.15 Adult A disclosed details to the family friend of the abuse she had suffered at the hands of Adult B and stated that he had tried to kill her when they lived in Colombia. She had hoped his behaviour would change when they moved to England and they could have a fresh start and although the physical abuse decreased, the emotional abuse continued. She stated

she stayed with him for the sake of their children, but as they were now grown up and independent, she wanted to leave him and have a life of her own. Adult A told the friend that Adult B frequently accused her of having affairs and would try to control her by withholding finances, a form of economic abuse, or hacking into her Facebook account to monitor her movements.

13.16 The friend described spending some time with Adult A in Spain in August 2018. It was during this time that Adult A confided in her that she had made the decision to leave Adult B, as she was deeply unhappy. Adult A described the treatment she received at the hands of Adult B which included threats, intimidation, possessiveness, economic abuse (through restricting access to economic resources) and accusing her of having affairs to deflect his own infidelity. The witness received frequent calls from Adult B during this period, and described him as appearing paranoid and insecure worrying about his wife and the status of their relationship.

13.17 In December 2018, Adult A confided in her friend that she had found a buyer for the family property in Spain and when sold, her share of the equity would give her the financial independence to leave Adult B and have a life of her own, highlighting the central nature of economic resources to Adult A's decision making.

13.18 A former work colleague of Adult B described him as a lovely man who was always happy and cheerful in the workplace. He presented as a man who was devoted to his wife and would often show his work colleagues pictures of her because she looked so attractive. As time went on, they noticed a change in his personality and he started to disclose problems within the relationship. He thought his wife was having an affair and was going to leave him and he was distressed by this. He disclosed the fact that Adult A was starting to spend more and more time at their property in Spain and only returned home to look after a foster child who was placed with them in late 2018. During the week before the murder, Adult B had informed his work colleague that a family meeting had been called for the following Monday. He stated he did not know what it was about but thought Adult A was going to tell him the marriage was finally over and that she was going to leave him.[21] It is now known, Adult B murdered Adult A over the weekend preceding the planned family meeting.

13.19 In January 2019, during the late evening, a family member of Adult A contacted the police to report her as a missing person. Her children had been trying to contact her throughout the day without success and became increasingly concerned by Adult B's general demeanour and comments he had made inferring she had left the home and might not be coming back. In addition, they knew Adult A would never have left home without taking her 3-month-old foster baby with her.

---

[21] Para 13.11 to 13.19 – Source – statements taken by the police for criminal investigation.

13.20 On police attendance at the home address, Adult B informed them that Adult A had left the family home that morning following a domestic argument, during which, he claimed, she had assaulted him causing him to sustain some superficial facial injuries. The argument is believed to have been in connection with the couple's separation.

13.21 During the early hours of the following day, the Police reattended the address and arrested Adult B on suspicion of murder. He was taken into police custody and later interviewed. He maintained his initial account that Adult A had left the family home following a domestic argument.

13.22 Subsequent enquiries located witnesses who saw a male, later identified as Adult B, on Northchurch Common, Berkhamsted digging a hole and setting fire to something. It was here that later, the partially burnt body of Adult A was found, hidden in a suitcase buried in a shallow grave. The forensic post-mortem examination did not reveal a cause of death as the body of Adult A was so badly burnt, but there were signs of blunt trauma injuries to her neck which would be consistent with strangulation.

13.23 Three days after Adult A had been reported missing, Adult B was charged with her murder. In July 2019 following a trial at St Albans Crown Court, he was found guilty of murder and received life imprisonment. He is to serve a minimum term of 19 years imprisonment. He did not appeal the conviction or sentence.

13.24 A Coroner's inquest was opened but adjourned pending criminal proceedings. The Coroner later accepted the findings of the criminal court and did not hold an inquest.

14.0 CHRONOLOGY

14.1 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.

14.2 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.

14.3 On 18 May 2009, the family relocated from London to Hemel Hempstead with two of their three children. A credit check undertaken as part of the housing application process identified combined debts exceeding £18,000. From September 2009, the family resided in private rented accommodation at a monthly rent of £925. On 26 July 2012, the landlord issued notice of a rent increase to £1,350 per month with effect from 2 September 2012. Both adults were unemployed and in receipt of housing benefit, with the local housing allowance for a three-bedroom property capped at £1,000 per month, rendering the tenancy unaffordable. As a result, the family was placed in temporary accommodation by

Dacorum Borough Council from 2 September 2012. 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.

14.4 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.

14.5 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.

14.6 On 13/07/11, she had her first and last session with a CBT therapist. She was very tearful at this session due to the fact that 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.

14.7 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.

14.8 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.

14.9 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.

14.10 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.

14.11 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.

14.12 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). This is detailed above, between paragraphs 13.1 and 13.8.

14.13 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.

14.14 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 the majority of 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.

14.15 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.

14.16 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.

15.0 OVERVIEW

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

15.2 Adult A and her family sought asylum in England. They initially settled in the London Borough of Barnet. There is no information available to the review author in relation to this period. The panel did request information from Barnet but were informed no records were held.

15.3 Between 2007 and 2009, the family moved from Barnet and relocated to Spain. It is recorded in their housing application that they applied for asylum with the Spanish Authorities. There is no information available as to whether this was granted or the reasons why they moved back to England in 2009.

15.4 Dacorum Borough Council (Housing)

15.4.1 The family briefly returned to the London Borough of Barnet before settling in Hemel Hempstead in May 2009. They resided in private rented accommodation until 2012 when they presented to Dacorum Borough Council as potentially being homeless, reporting they could no longer afford to pay for private accommodation. Finance checks revealed they had in excess of £18,000 worth of debt, though the source of this debt. It was not explored by the housing team whether the debt was coerced by Adult B and was part of a wider pattern of economic abuse, because it was not relevant to the need to house and both adults held broadly comparable levels of debt in their own names. Their application was accepted and in November 2012, they were placed at the address which was to become their long-term home.

15.4.2 The homelessness assessment asks specific questions about availability of accommodation anywhere in the world including whether any property is owned. Neither Adult A or Adult B admitted to ownership of any properties and signed a declaration to that effect. As part of the homicide investigation, it became known, the couple owned a property in Spain. If they had disclosed the fact they owned a property abroad at the time of declaring themselves as homeless, enquiries would have been made with the relevant authorities via the embassy. This is not an enquiry that is completed as a matter of course due to the time taken for such enquiries to be resolved and the inevitable delay caused to homelessness applications. Had the assessment revealed the couple owned a property, it

may have affected the outcome of their application, but various factors would have been considered before a final decision was made.

15.4.3 When the initial housing application was made, Adult A gave a different surname to Adult B. They presented as a married couple and there are several entries on the housing records which recorded them as having the same surname. On 17/03/14, there is an entry on the housing records changing Adult A's surname back to the original name she gave when they first presented to the housing team. This was on the basis that she informed them she had never married Adult B, because she had been married before and not divorced her first husband. She produced her passport which clarified her surname to be different to that of Adult B. This was not challenged by the housing team. It would not have affected their status as tenants.

15.5 General Practitioners

15.5.1 The relevant information from health services is in relation to Adult A's diagnosis of Fibromyalgia and an associated diagnosis of anxiety and depression due to the fact she was in so much pain with the condition. Adult A was referred for CBT therapy but unfortunately only attended one session due to the fact she was so distressed by the recent death of her grandmother. The therapist felt it would be more appropriate for her to attend bereavement counselling and return to CBT at a later date. Adult A's GP was notified in writing that the CBT sessions had been interrupted.

15.6 Hertfordshire Children's Services

15.6.1 In 2013, Adult A and B applied to become foster carers with Hertfordshire Children's Services with Adult A being the primary carer. Their application was approved in 2014, and they fostered 11 babies between 2014 and 2019. Adult A in particular had significant contact with social workers during this time. She had a supervising social worker visit her on a monthly basis to support her as a foster carer. A children's social worker also visited the home on a monthly basis to check on the children placed in her care and monitor the stability of the placement. Furthermore, an Independent Review Officer visited the home each time a new placement started. Over and above this, Adult A and B would have to present to a fostering panel at the time of their initial approval, annual reviews or upon applications for change of approval.

15.6.2 There is nothing documented in the case files or via the IMR author's interviews with children's social workers, independent reviewing officers, practitioners and supervising social workers to indicate that there were any issues relating to domestic abuse for Adult A and her family. Professionals described Adult A as a positive, energic and happy person who enjoyed fostering and working with children. There were no observations from practitioners that Adult A felt scared, intimidated, or fearful of Adult B. Regarding the overall management of the case, audit activity confirmed that fostering procedures were followed in accordance with Fostering Regulations and Hertfordshire's Fostering Procedures.

15.6.3 Regular reviews were undertaken on the 29/11/14, (6-month review), 29/10/15 (change of approval review to allow the couple to foster 2 children) 09/06/17 and 29/03/18. The couple also progressed to Level 2 foster carers in February 2017, which would be a competency-based assessment signed off by the Service Manager.

15.6.4 The following dates were noted as unannounced visits: August 2015, January 2016, September 2016, November 2017 and March 2018. Unannounced visits should be made twice a year, and the records show there are two unannounced visits missing. The write up of the unannounced visits were brief in detail and the Form focuses on the child, meaning there were no observations of the presentation and demeanour of the carer(s) noted.

15.6.5 In the Form F assessment undertaken in 2014 to determine Adult A and B's suitability to become foster carers, the trauma of what the family experienced in Colombia was discussed and recorded but needed further analysis. For example, Adult A had lost her mother as a baby, suffered neglect from her stepmother, had fragmented relationships with her father and step siblings, and one of her step siblings was murdered at the age of 15. Two of her children were held hostage whilst she was visiting her husband, who at the time was a police officer in another city. In addition, Adult A's diagnosis of fibromyalgia and its impact on those caring for or support her may have benefited from further consideration.

15.6.6 The assessment could have also been strengthened by considering the couple's relationship. There is a section within Assessment Form F where practitioners are asked to record the detail of the relationships within a household. For example, the couple married six months after meeting and had their first child a year later. They had been together for a significant length of time (25 years) and they still described their relationship as one of doing everything together. This could have been indicative of a positive attachment as a couple and a reflection of the additional support Adult A needed from Adult B. Alternatively, further enquiry may have revealed that Adult B was controlling Adult A and did not permit her to do anything without him.

15.6.7 The IMR author questioned how the dynamics of their relationship might have changed as Adult A's health improved. At the time of the initial health check, Adult A was described as being reliant on her husband for housework, cooking, mobility at times, and going out due to the fact she suffered with fibromyalgia. This aspect may have benefited from further questioning and probing as part of the assessment process.

15.6.8 In addition, Adult B was a police officer when in Colombia, with a certain professional identity and status. This changed significantly when he came to the UK and undertook a number of different roles from handy man and decorator to parking enforcement officer. This may have had a significant impact both on the family's finances and the couple's emotional life together.

15.6.9 During the IMR process, several children's social workers, independent reviewing officers, practitioners and supervising social workers involved with the family were interviewed. They consistently described the foster carers as happy, relaxed and positive care givers to all foster children, and therefore assessments of relationship dynamics were seen as positive. Children were described as thriving in the care of the foster parents. This demonstrates that in terms of their behaviour, the couple displayed consistent positive behaviour during 2014 – 2019 and if Adult B was abusing Adult, he was able to hide this effectively from the professionals involved in the case.

15.6.10 When professionals visited their home, Adult B was always moving around the house to complete tasks such as cooking and cleaning therefore observations of their interactions together as a couple were rather limited, but when they spoke about each other they always did so in a positive light (as reported in interviews with social workers). The professionals interviewed did not view Adult B's behaviour as avoidance of professionals as he always greeted them and spent varying amounts of time contributing to the meeting or review. Professionals noted that he did for the most part fulfil the requirement of a three-monthly supervision session with the Supervising Social Worker. However, Adult B busying himself with other tasks may have benefited from further analysis and discussion during supervision between the Supervising Social Worker and her team manager with the purpose of identifying possible domestic abuse. Adult B did not always fully engage in the process.

15.6.11 During the audit process it was noted that there were some gaps in supervision between the period of March 14- Sept 18. Additionally, supervisions between manager and Supervising Social Worker had limited recording. Supervisions between Supervising Social Worker and carer tended to focus primarily on the child in placement rather than discuss the carers and their competence, and more broadly speaking, what life was like for them as carers and as couple and individuals

15.6.12 The family and couple consistently presented positively to professionals there was an assumption based on their positive demeanour that all was fine and well. As foster carers, Adult A and B, did not experience any placement breakdowns and all placements progressed smoothly, and this may have reinforced a view that all was well within the household.

15.7 Herts Police and Dacorum Borough Council

15.7.1 Adult A and her family had extensive contact with members of Hertfordshire Constabulary and Dacorum Borough Council ASB Team between 2013 and 2018. This was as a result of a significant number of anti-social behaviour incidents involving their next-door neighbours. The incidents are documented within Police systems and the shared SafetyNet system, which is a web-based platform designed for neighbourhood teams to record and manage ASB incidents, allowing partner agencies to view, record and share information in relation to any on-going cases. ASB incidents may relate to a specific location or to an individual or group of individuals, and SafetyNet is designed to enable information to be

actively and proactively shared to facilitate a multi-agency problem-solving response through tasking and action plans. In November 2019, the new iteration of SafetyNet went live and is called SafetyNet+. This is the system being used by the constabulary now to support partnership-oriented problem solving.

15.7.2 Both agencies responded to the reports and although there are some points of learning identified for the police in their internal review, they are not relevant to this process. Both agencies tried a number of different tactics in an attempt to resolve the issue.

15.7.3 The Police response included high visibility patrols in the area, a "safer streets" operation, personal visits to Adult A and the neighbour, criminal prosecution which led to a restraining order being put in place, and a warning signal was placed on Adult A's home which would attract a speedy response in the event of a call. There was liaison with the ASB Team which initiated follow up action.

15.7.4 The same housing officer was engaged with the family for the majority of their tenancy. He worked with the anti-social team and their response included personal visits to Adult A's home, the installation of sound equipment to try to gather evidence to corroborate her complaints of excessive noise and the offer of supporting a move for the family.

15.7.5 Both agencies acknowledge that although they were aware that Adult A was a foster parent, at no time did either agency consider notifying Children's Services. Whilst this is not an area directly linked to this DHR, it must be acknowledged that there was the potential for better communication with the fostering service by both the police and ASB Team.

15.7.6 The sharing of information between the police and ASB Team was good and over 162 entries were recorded on to the SafetyNet system. The police have acknowledged in their internal review that not all police action was recorded on to the system. For example, the system records that only 8 personal contacts were made with Adult A or her family, when in reality, numerous personal visits were made by the police or police community safety officers, and a lot of time, resources and effort was dedicated by Hertfordshire Constabulary in trying to support Adult A.

15.8 Friends and Family

15.8.1 This review has raised the subject of "bystander intervention". A recent report published by Public Health England states "We are all bystanders, all the time. We witness events unfolding around us constantly. Sometimes we recognise events as being problematic. When this happens, we might decide to do or say something, becoming an active bystander (either in the moment or at a later stage), or to do nothing and remain a passive

bystander. There are many factors that will influence why we decide to intervene or not."[22]

15.8.2 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 reinforced within a community or group, then the boundaries of what is considered acceptable behaviour will shift.".[23]

15.9 Independent view from LAWRS of professional involvement with Adult A.

15.9.1 The Panel consulted with experts from LAWRS, who were given access to a draft copy of the DHR report and asked to comment on any cultural issues which might be relevant and to comment on the interaction that Adult A and B had with professionals in this case. A conference call was held between two representatives from LAWRS and the Report Author and the below is a summary.

15.9.2 The representatives from LAWRS believe the points around culture and domestic abuse (coercive control) need to be considered as two separate issues. Although there are cultural issues to consider (which are captured in section eleven), this case is not typical because both Adult A and B had a significant amount of contact with statutory agencies, including the police and social care. This demonstrates that Adult A, in particular, was not fearful of professional agencies and was confident to engage with them. LAWRS are of the view that Adult A would not have engaged with agencies at all, if the cultural blockers applied in this case.

15.9.3 The professional view of LAWRS is that this case is centred around the coercive controlling behaviour of Adult B. Such behaviour is not unique to the Colombian culture and is present in all cultures and nationalities.

15.9.4 The signs of coercive control include:

- Adult A's disability/health and dependence on Adult B around mobility and domestic chores within the home.
- Adult B was at home a lot as his employment was sporadic and casual.

[22] Public Health England Report – "Bystander Interventions to Prevent Intimate Partner and Sexual Violence – Published December 2020.

[23] As Above

- Adult B was usually present when professionals called albeit in the background (he was still close enough to make his presence known).
- Adult B gave the impression of being a solicitous husband taking care of his wife.
- The couple were in debt and Adult A may have been subject of financial constraints.
- Adult B had extra marital affairs but made frequent accusations of infidelity against Adult A.
- The abuse of Adult A was constant throughout their relationship and so she was unlikely to reach out for help. This is a classic sign of someone who is subjected to coercive/control over a long period of time.
- The circumstances of her murder demonstrate a high degree of violence and attempts to cover up his actions.

15.9.5 The risk to Adult A was significantly heightened when she separated from Adult B. Research shows that 76% of murders happen at the point of separation and 80% of those within the first four months.[24]

15.9.6 LAWRS believe some of the classic signs of coercive control were present but could not have been easily identified by the professionals involved at the time of their interaction with the couple.

16.0 ANALYSIS

16.1 This part of the review will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or 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 part of the report will first consider key themes identified by the Panel during the review and following this, the Terms of Reference will be addressed.

16.3 Theme 1: Economic Abuse

16.3.1 Overview of economic abuse and its impact

16.3.1.1 It is clear that Adult A was a victim of economic abuse. Economic abuse is a legally recognised form of domestic abuse, and is defined in the Domestic Abuse Act (2021) in the following way:

> 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.

[24] Laura Richards, 'What is post-separation control?', on Coercive-control.com

16.3.1.2 Economic abuse, as with many other forms of domestic abuse, is highly prevalent. Surviving Economic Abuse estimate that one in six women in the UK has experienced economic abuse by a current or former partner. They explain that:

> *Economic abuse can include exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.*[25]

16.3.1.3 By restricting, exploiting, and sabotaging a victim's access to money or other resources, perpetrators limit the freedom of the person they are abusing. In turn, this forces victims to be more dependent on the person abusing them, meaning it is incredibly difficult for them to leave. If they can leave safely, victims often find it hard to rebuild their lives, as may not have the resources to do this. If their abuser got them into debt, this can also make achieving longer-term financial stability impossible due to poor credit scores or having to repay debts accrued in their name.

16.3.2 Experiences of economic abuse in Hertfordshire

16.3.2.1 In a recent consultation with 642 victims and survivors of domestic abuse in Hertfordshire, participants talked about the different ways their abusers found ways to curtail their economic freedoms. For many, this involved their ability to use their own economic resources being limited, as in the following example:

> *Yeah, she'd never let me buy stuff. She'd go mad at me if I ever did. Umm, even just like going shopping; I absolutely hated going food shopping with her she'd have to, you know, pick everything and it was the little things you know, that were taken out of my control*

16.3.2.2 This example shows how the perpetrator controlled how money was spent. Another survivor shared a similar experience, where their abuser had prevented them from shopping online.

> *There were points when she wouldn't let me do on-line shopping or anything like that.*

16.3.2.3 Participants also talked about the long-term impacts of economic abuse, as in the following examples.

> *He married me under false pretences, he lied about his finances, I discovered he was deeply in debt, and I paid it all off*

---

[25] What is economic abuse? - Surviving Economic Abuse

I was told that because I had money (on paper), I would have to pay to stay at a hotel or pay even more for a place in a women's refuge centre. They did not take into account that my payslip did not reflect my personal situation - that my ex-husband took most of my salary and had run me into debt applying for payday loans in my name

16.3.2.4 This makes clear that Adult A's experience of economic abuse is not unique, and that many others in Hertfordshire are not getting the right help, at the right time, when they are made a victim of economic abuse

16.3.3 Adult A as a victim of economic abuse

16.3.3.1 There were many signs that Adult A was a victim of economic abuse. These include:

Indicator	Analysis
In 2009, and again in 2012, Adult A and B disclosed debts of £18,000 when applying for local authority housing.	Sadly, perpetrators often intentionally create economic instability which they later exploit to reinforce coercive control. One of the ways they can do this is through generating debt. It is not known how the £18,000 of debt disclosed was generated, and who by.
In August 2018, whilst in Spain with a friend, Adult A talked about how Adult B controlled her by withholding finances.	Here, Adult A has disclosed economic abuse to her friend. In the recent consultation with Hertfordshire victims, it became apparent that victims, and those close to them, often do not realise that economic abuse is a form of domestic abuse, even though they know what is happening is not right. If members of the public are not aware of the signs of economic abuse and are also not aware that economic abuse is a form of domestic abuse, then both victims and those in their wider support network are unlikely to know where to get help from. A few months after this disclosure, Adult A talks to her friend about her plan to free herself from economic abuse, suggesting she didn't seek support or that support was not available. This indicates that more needs to be done both to increase awareness about economic abuse and to support those whom it is being perpetrated against.
In December 2018, Adult A told the same friend that she had found a buyer for her property in Spain, and that this would give her the financial	Adult A feeling she had to sell her house in Spain clearly illustrates that 'access to economic resources, including housing and welfare, is central to decision-making and safety planning for victim/survivors'.[26]

[26] 3_-wha-economic-abuse.pdf (dahalliance.org.uk)

independence she needed to leave Adult B.	Adult A clearly felt she needed to be economically safe to achieve physical safety, and sadly this is the case for many victims.

16.3.3.2 This review also identified that Adult A may not have disclosed domestic abuse to professionals due to a fear of having to give up fostering. Not only was this something she enjoyed doing, but it was also a source of income. This highlights the importance of routine enquiry about domestic abuse with foster carers, which will be discussed further in Section 16.5.

16.3.3.3 In a recent roundtable discussion with victims and survivors of economic abuse, conducted by the charity Surviving Economic Abuse (SEA), participants discussed the persistent nature of economic abuse. They spoke of how economic abuse would often continue post-separation, with their abusers finding new ways to manipulate their ability to acquire, use of maintain economic resources.

16.3.3.4 Even when economic abuse had ceased following separation, those participating in the roundtable told SEA how difficult it was for them to recover from the economic damage inflicted by their abuser. Participants explained how they found themselves with serious financial obligations, debts and poor credit ratings that had been created by their abuser. In turn, survivors' ability to become or remain self-sufficient is severely limited.

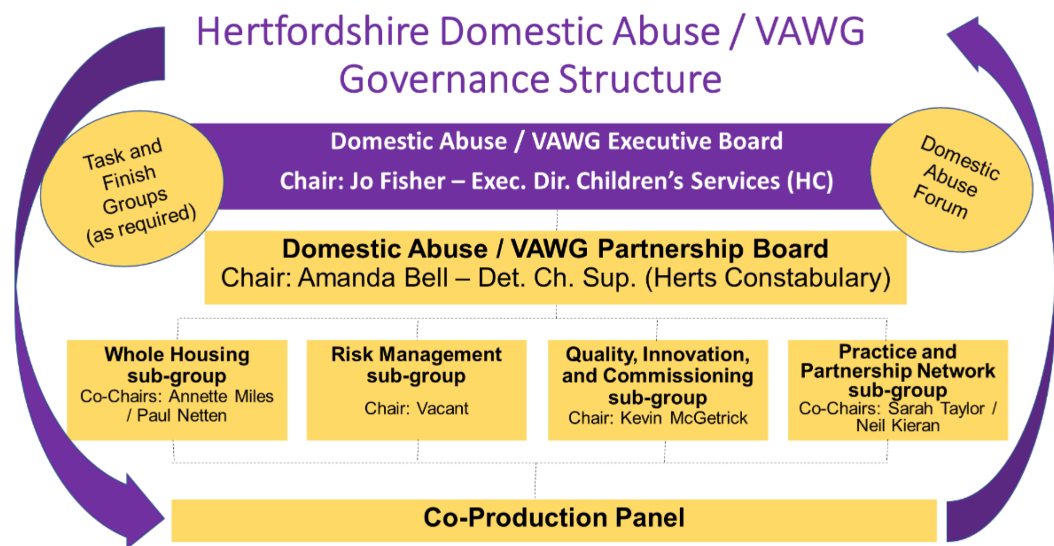
16.3.3.5 The key findings of SEA's roundtable match the experiences of victims and survivors of economic abuse in Hertfordshire, who are calling for greater support for economic abuse both pre- and post-separation.[27]

16.3.4 Response to Economic Abuse in Hertfordshire

16.3.4.1 To find out more about support available for victims and survivors of economic abuse in Hertfordshire, discussions were held with the Strategic Partnerships Team, a team based in HCC's department of Adult Care Services are responsible for developing, coordinating and monitoring the multi-agency Hertfordshire Domestic Abuse Strategy (2021-25).

16.3.4.2 They advised that the Hertfordshire Domestic Abuse Partnership's 'Quality, Innovation and Commissioning sub-group' (governance structure below), who are responsible for scoping the needs of victims and survivors of domestic abuse in Hertfordshire and designing services to meet this need, are currently developing services specifically for victims and survivors of economic abuse.

[27] SEA-Roundtable-Report-2018-1.pdf (survivingeconomicabuse.org)



16.3.4.3 Between July and September 2022, the group conducted a scoping exercise to identify what support is already available for victims of economic abuse. They found that financial support and advice was very difficult to access in general and even when support was available, the offer was not consistent across Hertfordshire. Support for victims of economic abuse is also something frontline domestic abuse practitioners have reported as difficult to source for the victims they support.

16.3.4.4 In response to these findings, and the fact that the Hertfordshire Domestic Abuse Pathways Project identified financial support as one of victims' primary needs, the sub-group are planning to commission 'One Stop Shops' across Hertfordshire.

16.3.4.5 These One Stop Shops will be places where victims and survivors of domestic abuse can have all their needs assessed and met in one place. As Hertfordshire is a large county, with ten district and borough (Tier 2) authorities, these One Stop Shops will operate on a 'double-district' basis. This is the way MARAC operates in Hertfordshire, and will help ensure step up and down pathways between services across all risk levels.

16.3.4.6 The sub-group aim to deliver a 'minimum service offer' in each One Stop Shop through the commissioning of community based domestic abuse outreach services. Specifically:

(1) Support for victims at standard/medium risk
(2) Legal support
(3) Therapeutic support
(4) Support around finances

16.3.4.7 The specification for the One Stop Shops will be developed and commissioned between January and June 2023. The subgroup hope services will be operational by January 2024.

16.3.4.8 The subgroup consists of the main commissioners of domestic abuse services in Hertfordshire, including the OPCC, the ICB and HCC, but workshops will be held with local services in each double-district area, including specialist domestic abuse services and by-and-for services, to ensure that existing services are brought together and that new services are commissioned according to the needs of victims and survivors in each part of the county.

16.3.4.9 Whilst this is a positive step-forward, it is recommended that survivors of domestic abuse help to design the One Stop Shops, as they will have the clearest idea of what support is needed and where. The One Stop Shops should also be subject to an evaluation, to ensure the support being provided in each area is helping victims and survivors achieve their outcomes.

16.3.4.10 In addition to this, it is recommended that a communications campaign be developed to raise awareness of domestic abuse both at a public and professional level, as this DHR has highlighted that economic abuse is not always identified as a form of domestic abuse.

16.4 Theme 2: Bystanders to domestic abuse

16.4.1 Both national and Hertfordshire-specific research has shown that victims are much more likely to disclose domestic abuse to those close to them before, or instead of, professionals. Likewise, victims' friends and family members may be the first to identify that their loved one is being abused.

16.4.2 Nationally, there has been a call for bystander interventions to provide those aware of domestic abuse with the tools to become active, rather than passive, bystanders, further to the successful implementation of 'bystander interventions' or 'bystander programmes' in the United States.[28][29] Such approaches are a form of primary prevention, meaning a behaviour is prevented before it ever occurs.

16.4.3 The priorities of Hertfordshire's Domestic Abuse Strategy (2022-2025) are each linked to a different form of prevention, as set out in Figure X below. The strategy's first priority, 'Act before someone is harmed', pertains to primary prevention. The objectives the Hertfordshire Domestic Abuse Partnership is striving to deliver under this priority are as follows:

---

[28] Evidence_review_bystander_intervention_to_prevent_sexual_and_domestic_violence_in_universities_11April2016.pdf (publishing.service.gov.uk)

[29] Ricardo, C., Eads, M. and Barker, G. (2011) Engaging Boys and Young Men in the Prevention of Sexual Violence [online]. Pretoria, South Africa: Sexual Violence Research Initiative and Promundo. Available from: www.svri.org/menandboys.pdf [Accessed 17 April 2015].

1. **A consistent approach to healthy relationships education** across education settings to develop a zero-tolerance culture amongst children and young people for harmful of abusive behaviour within intimate and family relationships
2. **Develop public awareness campaigns** using behavioural insights techniques to reduce public tolerance, including increased awareness and identification, of domestic abuse
3. **Increase our understanding of the risk and protective factors that exist in Hertfordshire**, including inequality, to develop and pilot prevention interventions

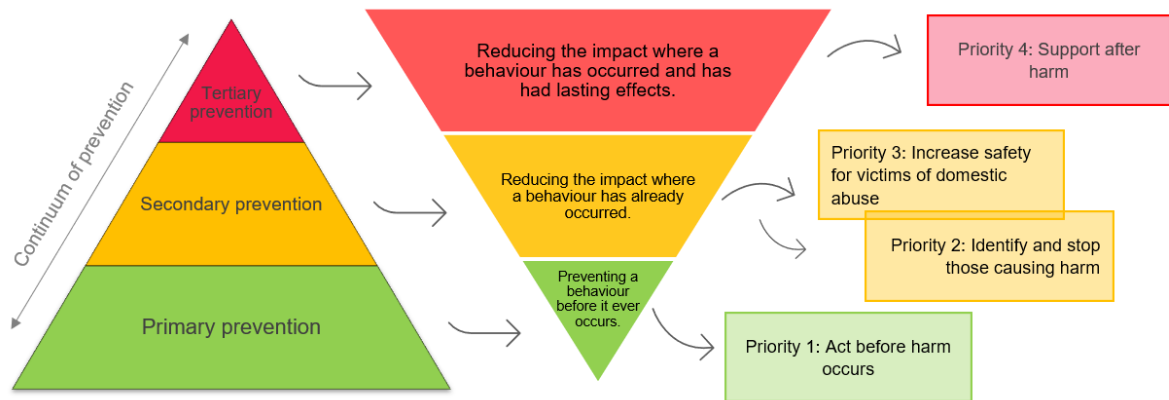


Figure 1 - Prevention in Hertfordshire's Domestic Abuse Strategy (2022-2025)

16.4.4 It is important to note that at the time of Adult A's murder, Hertfordshire had begun operating the 'J9' initiative. The initiative aims to raise awareness of domestic abuse and assist victims to access support safely by training professionals and members of the community to recognise domestic abuse and respond to victims. These are called 'Community Champions'. Once trained, businesses display the J9 logo in their window, letting people know they offer a safe place to access information and use a telephone to contact support services. More information about the J9 Initiative and Hertfordshire's wider Champions Network initiative, can be found at Appendix 3.

16.4.5 Further to this DHR and consultations with victims and survivors, it has been acknowledged that this initiative needs to be expanded and awareness of it increased. However, this initiative is focused on providing safe spaces for victims to disclose and does not provide bystanders of domestic abuse the information and resources they might need to go from inaction to action. It is widely accepted that there are four different stages that bystanders need to go through before taking action, as shown in Figure X.[30]

16.4.6 Hertfordshire's strategic priority to 'act before someone is harmed' appears to address stages one and two of the above model (1. Notice the event and 2. Interpret it as a problem), with objectives one and two setting out an ambition to develop campaigns and educational programmes that will raise public knowledge of domestic abuse. The third objective under Hertfordshire's priority to 'act before harm' alludes to prevention

[30] Berkowitz, A.D. (2009) Response Ability: A Complete Guide to Bystander Intervention. Chicago: Beck & Company.

interventions, but it is not clear what these are. A robust plan for the development of a bystander intervention programme in Hertfordshire is needed. Monitoring capacity needs to be built into any programmes developed, as some prevention efforts, however well-intentioned, can be harmful.[31]

16.4.7 In summary, the J9 initiative requires expansion so that victims across the county have equal access to a safe space, in a non-statutory setting, to disclose abuse and access

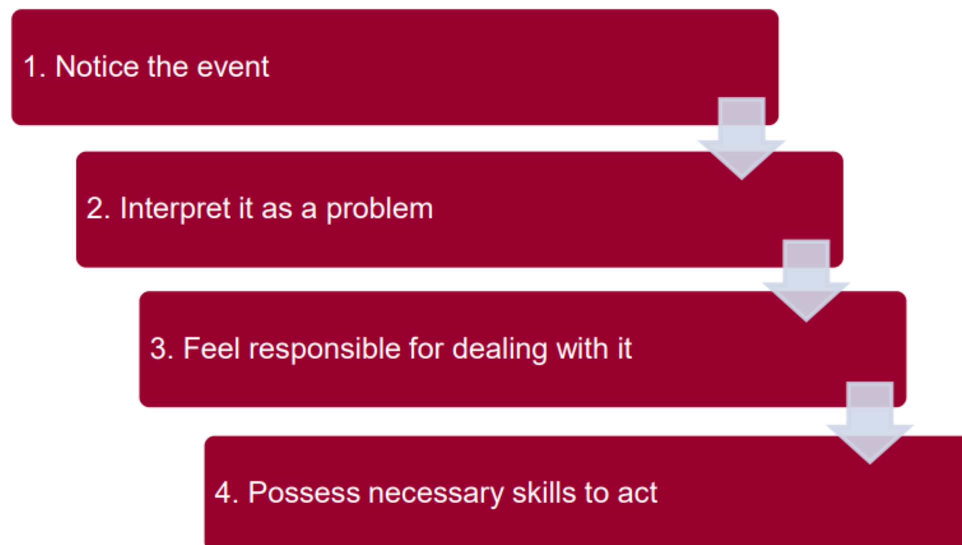


Figure 2 - Four stages to becoming a prosocial bystander (Figure taken from Public Health England, 2016, p.16)

support. The initiative also requires greater promotion, so that victims are aware that this support is available to them. This will require careful planning, with additional thought being given to reaching hard to reach groups. Alongside this, further work is needed in Hertfordshire to increase public awareness of domestic abuse, so that both victims and those close to them can recognise abuse. Finally, a robust plan for the development of bystander intervention(s) is required in Hertfordshire.

16.5 Theme 3: Risk to children in Adult A and B's care

16.5.1 The new Domestic Abuse Act (2021) states that when a child sees, hears, or experiences the effects of domestic abuse, and is related to the person being abused or the perpetrator, they are to be considered a victim of domestic abuse in their own right. This recognition of children as victims has been welcomed by organisations working to support both adult and child victims, given the prevalence and impact of domestic abuse on children and the lack of available support both for them and those looking after them. This part of the analysis will outline the scale of the issue so as to highlight and contextualise the real risk that the children fostered by Adult A and B faced.

16.5.2 National picture

[31] Hilton, N.Z. (2000) The role of attitudes and awareness in anti-violence education. Journal of Aggression, Maltreatment & Trauma [online]. 3 (1), pp. 221-238.

16.5.2.1 Research has shown that as many as one in five children under the age of 18 will have lived with domestic abuse at some point in their childhood. It is estimated that 120,000 children in the UK live in households where there is a high risk or serious harm or homicide, and sadly, this is the environment that the children Adult A fostered lived.

16.5.3 Local picture

16.5.3.1 Nationally, 51% of Child in Need assessments identified domestic abuse, but in Hertfordshire, this number is slightly higher at a rate of 55.5%. In 2019, it was estimated 245,413 of the Hertfordshire population were aged under 16 (20.6%). It is estimated that one in five children will witness domestic abuse. Based on this, and the figures above, we can estimate that roughly 49,082 Hertfordshire children in the current population have, or will, witness domestic abuse.

16.5.3.2 Since DHRs became statutory, there have been 32 DHRs in Hertfordshire. In 47% of these DHRs, there were children under the age of 18 residing with either the victim or perpetrator. In total, there have been 29 children in Hertfordshire who have lost a parent due to domestic homicide since the introduction of DHRs.

16.5.4 Impact

16.5.4.1 The impact of domestic abuse on children can be both severe and long lasting. There is a major overlap between direct harm to children and domestic abuse; in research conducted by SafeLives, 62% of children participating who had been exposed to domestic abuse were also directly harmed (including physical harm, emotional harm and neglect).[32] In almost all cases (91%), the harm was perpetrated by the same person abusing the adult victim. Additionally, children living with either a victim or perpetrator of domestic abuse are at greater risk of being killed by the perpetrator, especially following separation between the perpetrator and adult victim. Sadly, this was the very real risk faced by the three-month-old being fostered by Adult A and B at the time Adult B killed Adult A.

16.5.4.2 In addition to the risk of immediate harm, domestic abuse also inflicts long-term harm on children's lives. In the same study by SafeLives, over half of the participating children (52%) had behavioural problems, over a third (39%) had difficulties adjusting at school, and nearly two thirds (60%) felt responsible for negative events. Later in life, those who were victims of domestic abuse as children continue to feel the negative effects of this trauma, which frequently leads to mental health issues and maladaptive coping mechanisms, such as substance misuse. Unfortunately, the children fostered by Adult A and B will now have to deal with the long-term effects of any abuse they witnessed or experienced during the time in their care. Currently, limited support is available in Hertfordshire both to support children at the time of experiencing abuse, to reduce the risk of further harm, and to assist

[32] Final policy report In plain sight - effective help for children exposed to domestic abuse.pdf (safelives.org.uk)

with their recovery. Given the number of children this likely effects in Hertfordshire, this is concerning.

16.5.5 Barriers for parents and guardians

16.5.5.1 Given the number of children and young people who are victims of domestic abuse, and the serious impact this abuse has on their safety, health, and wellbeing, more needs to be done to identify domestic abuse and support all children at risk.

16.5.5.2 Efforts to identify domestic abuse at an earlier stage must take into consideration the unique set of barriers that those with children (whether they be biological, adopted or fostered) face when it comes to disclosing domestic abuse to professionals. For one, shame, fear and guilt, along with negative experiences of removal processes, significantly hinder mothers' decision to engage with services available to them. Added to this, perpetrators use both the threat of child removal, or the risk of direct harm to a child/children to keep mothers from reporting abuse or leaving abusive situations. This is a very real threat, evidenced by the fact that victims and their children are at significantly increased risk of homicide after leaving a partner.

16.5.5.3 As Adult A greatly enjoyed her role as a foster carer, she likely feared jeopardising this. A fear of children being removed from her care, combined with the stigma and shame victims often feel about domestic abuse, likely reduced how able she felt to disclose. As Children's Services did not enquire about domestic abuse, this likely reduced the probability of disclosure even further.

16.5.5.4 The combination of barriers faced by Adult A and lack of enquiry resulted in enormous safeguarding implications for the children placed in the care of Adult A and B. Nowhere is this more relevant than for the three-month old placed with them at the time Adult B killed Adult A, and who Adult B had with him when he was attempting to dispose of Adult A's body. Fortunately, Adult B did not physically harm this child, but there was a very real risk of this.

16.5.5.5 Given that children requiring foster care are more likely to have suffered abuse or neglect, and thus be vulnerable themselves, routine enquiry about domestic abuse is absolutely essential in these areas. This is key not only to mitigating the risk to children but also to those caring for them. Too often, parent and child are responded to separately where there are concerns or disclosures of domestic abuse. Research strongly suggests that the sort of response a family experiencing domestic abuse gets from professionals depends on the sector those professionals are working in. Marianne Hester (2011) describes the areas of domestic abuse, child protection work and child contact work as 'three planets', each 'with their own separate histories, culture, laws, and populations (sets of professionals)'. What this means is that each "planet" looks at the problem in a different way, and in turn their responses differ from one another's. Hester describes 'how, bouncing between these planets, are women and children who find inconsistency and contradictions; just the type of environment in which perpetrators can hide and abuse'

(Eaton-Harris, 2019). According to Hester, stopping families falling into this 'black hole' between planets:

> *Requires much closer and coherent practices across the three areas of work, with understanding of professional assumptions and practices and those of other professional groups. For children's services, it means taking into account not just that work on domestic violence requires intervention with victims, children and perpetrators, but that the most effective way of doing this is to* ***team up with practitioners on the 'domestic violence planet'****, who have extensive experience of work with both domestic victims and perpetrators****, and with practitioners on the 'child contact planet'*** *to integrate further a common response to women and children's safety.*

16.5.5.6 Existing multi-agency processes, such as MARACs and local safeguarding children's boards, tend to be situated 'within' planets rather than 'across' planets, meaning further work is needed to work out the best way to join up the approaches of the three planets when it comes to keeping victims of domestic abuse safe.

16.6 Addressing the Terms of Reference

16.6.1 This section of the analysis will now address the Terms of Reference use for this review.

ESTABLISH HOW EFFECTIVE AGENCIES WERE IN IDENTIFYING ADULT A'S HEALTH AND

Re-cap of relevant background information

16.6.3 In 2009, Adult A was diagnosed with fibromyalgia. Fibromyalgia is a medical condition characterised by chronic widespread pain and a heightened pain response to pressure. Typical symptoms include excessive tiredness, restless leg syndrome, bowel and bladder problems and sensitivity to noise or light. It is often associated with anxiety, depression and post- traumatic stress disorder.[33]

16.6.4 As a result of her condition, in 2010/11, Adult A experienced depression and anxiety and was referred for cognitive behavioural therapy. Unfortunately, the sessions were disrupted by the death of her grandmother, and it was recommended she receive bereavement counselling and return to CBT when she felt ready. A letter was sent to Adult A's GP notifying them that the CBT had been disrupted. There is nothing in the GP notes to suggest the GP surgery followed up on whether or not Adult A received bereavement counselling or ever returned to her CBT sessions.

16.6.5 At the time of her application and assessment to become a foster carer in 2013/14, she was prescribed amitriptyline and other medication which helped manage and treat nerve pain and neuralgia.

[33] NHS, 'Fibromyalgia', < https://www.nhs.uk/conditions/fibromyalgia/>

16.6.6 As part of the fostering assessment process, Adult A was required to undergo a medical assessment. This was initially undertaken by her GP on 17 December 2013. The GP described Adult A as having a condition that requires her to rely on her husband for a number of activities. The GP noted:

> "Has fairly consistent pain throughout the day which is worse with movement. She is not able to do her own housework and relies on her husband to do this. She can cook with her husband's help but cannot manage alone. She does not go out alone as she does not know when the pain will become more severe and can need help to walk at times".

16.6.7 Adult A was then assessed by the local authority medical advisor a second time on 26th February 2014. The following was recorded:

> "46-year-old female with significant pain and mobility issues caused by fibromyalgia these are unlikely to resolve. Unfortunately, advice was not taken from the pain clinic to attend physiotherapy, and she is dependent on her husband from a practical point of view with regards to cooking, mobility and even going out of the home. The panel should be aware that on her own she would not be physically able to support a child. As she requires so much support there might be a conflict of care priorities in the household if fostering children".

16.6.8 Adult A started to see a private physiotherapist which seemed to assist greatly. The couple described Adult A's health in more positive terms at the foster panel and Adult A articulated that her condition would not impact on her ability to foster. The panel recommended another medical review in six months.

16.6.9 A follow up medical review was conducted in November 2014 and there were significant improvements recorded with Adult A's health. There were no significant health concerns for Adult A following this period and by 2017, it is recorded her health had improved considerably and was no longer cause for concern.

Analysis

16.6.10 Earlier in this report, in Section 11 (Equality and Diversity), there is discussion as to whether Adult A could have been considered to have a disability as a result of fibromyalgia, and whether this, combined with what is known about the increased likelihood and risk of domestic abuse for people with a disability, meant she would have been eligible for a referral for support from adult safeguarding.

16.6.11 As the agencies Adult A was in contact with did not identify domestic abuse, it was unlikely that a referral to adult safeguarding would have been made. However, this has helped to highlight the need for increased awareness of the increased likelihood of domestic abuse where someone has a disability or long-term health condition and the vital importance of routine enquiry about domestic abuse, to improve identification.

17.0 CONCLUSIONS

17.1 This is a tragic case where Adult A suffered years of domestic abuse at the hands of Adult B which culminated in her murder. Adult B controlled Adult A for many years and when he thought he was going to lose that control, something he thought he was entitled to, he decided to kill her. Adult B was convicted of the murder of Adult A in July 2019.

17.2 The abuse was suffered in silence and although Adult A had significant contact with statutory agencies, none of the professionals involved in this case identified any indicators of abuse or made any enquiries, thus limiting the opportunity Adult A had to disclose.

17.3 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.

17.4 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.

17.5 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.

17.6 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.

17.7 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.

17.8 When Adult A told Adult B that she was wanted to separate from him, Adult B clearly took this as a threat to the control he believed had the right to. Outraged by the suggestion of separation, he decided to kill Adult A, taking her life so she had no opportunity to live free of the control he exerted over 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.[34] The professionals involved in this case were unaware of the impending separation of the couple, although without prior enquiry about domestic abuse, this information alone likely would not have highlighted the real threat Adult B posed.

18.0 LESSONS TO BE LEARNT

18.1 There are lessons to be learnt by Hertfordshire Children's Service with regards to:

[34] 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.

- 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.

18.2 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.

18.3 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.

18.4 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.

18.5 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.

18.6 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.

19.0 RECOMMENDATIONS

19.1 Hertfordshire Children's Services

<u>Recommendation 1</u>

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).

19.2 Hertfordshire Domestic Abuse Partnership

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

19.3 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 CCGs.

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 CCGs.

APPENDIX ONE – DETAILS OF AGENCIES CONTACTED AND SUMMARY OF INVOLVEMENT

Agencies Contacted	Involvement
Dacorum Borough Council	IMR – Housing and Community Safety Team.
Hertfordshire County Council Children's Services	IMR – Fostering and Adoption Team.
Hertfordshire Constabulary	IMR and two reports relating to ASB
Hertfordshire Partnership University NHS Foundation Trust	Information for Chronology
Herts Valleys and East and North Clinical Commissioning Groups	Information for Chronology
West Hertfordshire Hospital NHS Trust	Information for Chronology
East and North Herts Hospital NHS Trust	Information for Chronology
Highfield GP Surgery	Information for Chronology
Dacorum extended GP service	Information for Chronology
Metropolitan Police	Information for Chronology
Lincolnshire Police	Information for Chronology
Hampshire Police	Information for Chronology
LAWRS	Information for Chronology
For Baby's Sake Trust	Information for Chronology
Hertfordshire County Council – Adult Care Service	No contact
Barnett Borough Council	No Information
BeNCH – Community Rehabilitation Company	No Information
Refuge	No information but assisted with DHR
Spectrum CGL (Rehabilitation Centre)	No Information
Hertfordshire Community NHS Trust	No Information

APPENDIX TWO – ADDITIONAL QUESTIONS SET BY DHR PANEL FOR IMR AUTHORS

Additional questions for IMR authors Adult A with regards to policy, practice and procedures.

1. What inter- and intra-agency policies, procedures and practices were in place at the time of the agency involvement that are relevant to this case and action(s) taken?

Children's Social Care

- The involvement with the foster carers would have been underpinned by legislation which includes:
- Fostering Regulations (2011) which regulate how fostering services are delivered
- Children's Act 1989, primary legislation governing Looked After Children and Fostering services
- Care Standards Act 2000 which introduced national minimum standards for regulated services.
- Children's Act 2004 which introduced minimum fostering allowances.

*The above is not an exhaustive list.

Fostering practises would have also been governed by statutory guidance such as:

- Fostering Services National Minimum Standards (2011)
- Children's Act (1989) Guidance and Regulations and Fostering Services
- Assessment and Approval of foster carers (2013) which made amendments to the Children's Act 1989 and Fostering Services Regulations (2011). Amendments covered the assessment process, sharing information for the purposes of the assessment, the independent reviewing mechanism, reviews, changes to the terms of approval and termination of approval.

Dacorum Borough Council

The involvement with the family would have been underpinned by legislation which includes Part 6 and part 7 of the Housing Act 1996 and national MCHLG guidance, Allocations policy, Housing ASB Policy, Housing ASB procedure, Corporate ASB policy, DA and safeguarding policy, Information sharing protocol.

Hertfordshire Constabulary

The involvement with the family would have been underpinned by legislation which includes ASB Act, Crime and Policing Act 2014 consolidated and expanded law enforcement powers in addressing ASB.

Crime and Disorder Act 1998 – An Act to make provision for preventing Crime and Disorder; to create certain racially aggravated offences;

Force policy guideline on dealing with ASB – Sets out police response to dealing with ASB and how members of the public can report it.

2 What were the key aspects and expectations of these policies, procedures and practices – and who was responsible or accountable (role / agency) for what, when and at which stage?

Children's Social Care

The key aspects would have been to ensure that children living away from their birth families are safeguarded and given every opportunity to achieve in all aspects of their lives. That alternative carers are appropriately assessed and equipped with the necessary skills, knowledge and are supported to meet the needs of any child placed with them.

Accountabilities would have been shared between the child's social worker, the Foster Carers, the supervising social worker and the independent review officer. The fostering service would be responsible for the assessment and approval of the carers, and subsequent support, training, supervision and review. The child's social worker would be responsible for the child. The IRO would be primarily responsible for ensuring that care plans for children are legally compliant and in the child's best interest. Responsibilities remain with the different practitioners until the child leaves care at the age of 18.

Dacorum Borough Council

The Housing Act sets out the council's approach to discharging their duty and responsibilities in relation to homelessness. Responsibility of DBC Strategic Housing Team

Housing ASB Policy & Housing ASB procedure details the process by which the housing team investigate and address reports of low and medium ASB caused by tenants living in council homes. Responsibility of DBC Tenants and Leaseholders Team

Corporate ASB Policy. Details the process by which the corporate ASB team investigate and address high level ASB caused by council tenants, private owners and those renting in the private sector. Responsibility of DBC Residents services (since changed to Environmental and Community Protection.)

Safeguarding & Info sharing Policies – Set out the responsibilities of all departments within DBC in safeguarding residents and tenants. Responsibility of DBC Residents services (since changed to Community Safety Team).

Hertfordshire Constabulary

The criminal legislation sets out the details of offences linked to ASB and outlines preventative deterrents which can be considered by the Police or partners.

The responsibility for dealing with ASB falls primarily to the safer neighbourhood team who often work in conjunction with the Dacorum Borough council community safety or ASB Teams.

Information by either agency is recorded on to the safety net system which is is a web-based neighborhood and anti-social behaviour management system, designed to provide a 'one stop shop' storage facility for a variety of activities. SafetyNet was introduced in Hertfordshire in 2011 and is a tried and tested partnership system that enables the police and partner agencies to share ASB data in one location.

The system is used to create cases relating to new problems and record problem-solving activity. Information on SafetyNet is typically recorded in one of two forms; either under a Neighborhood Management System reference (appertaining to the location of a problem) or under an Individual Case Management reference (appertaining to an individual or group of individuals). A risk assessment is required when creating individual case management references which is subject of regular review and supervisory oversight.

3 Evidence clearly where, when and how these policies were followed and provide examination of whether and how any policy, procedure or practice was effective; including examples of good practice (including what worked well) and identification of whether the assessment indicates that any policy, procedure or practice needs review or change (including what didn't work well)? Provide an assessment of whether it was fit for purpose, and was it working as expected – e.g. strengths, opportunities for development?

Children's Social Care

Fostering procedures were followed in accordance with Fostering Regulations and Hertfordshire's Fostering Procedures. The application process was followed; on LCS (the information recording system used) the following documents were seen: Applicants registration of interest form, Skills to foster feedback, Form F, references x 5, (3 of which were interviewed) children's references, employment reference, letters of good conduct from Colombia, DBS and medical checks, pet assessment, safer caring policy, health and safety check, family profile, an ecomap and family tree. The Form F was reviewed by the practice educator and the student social worker was supported to complete the Form F by the practice educator. Correct procedures were also noted in terms of approval, Panel minutes were noted as well as ADM decision.

The Form F did have some strength; the sections were detailed and gave a rounded sense of the carer's skills and competence. The Form F could be strengthened by having analysis around trauma and the impact this had on the family, the couple's cultural views and norms. The Form F could also have had analysis regarding the impact of Adult A's health as the initial medical report describes Adult A as being reliant on her husband to assist with housework, cooking, mobility at times, and going out. However, these points and aspects were discussed at the fostering Panel.

Interviews undertaken with the author of the Form F highlights that she received weekly supervision which was supportive and provided direction on the case and the Form F assessment. However, it is important that such discussions and supervisions are recorded on the system.

Subsequent to their approval the auditor noted that regular reviews were undertaken. The couple also progressed to Level 2 foster carers in February 2017 which would be a competency-based assessment signed off by the Service Manager.

Where required appropriate risk assessments were completed i.e. holiday risk assessment. The auditor also noted a manager's file audit affording scrutiny and oversight.

Regular announced visits were undertaken; however, two unannounced visits are missing.

Due to the nature of how the visiting form is designed, there is an over emphasis on the child. There is no requirement to comment on the presentation and demeanour of the carer. This form has since been changed.

There was a lack of end of placement reports returned by the carers, which would have given them the opportunity to reflect on the placement, what went well, what they enjoyed, what was a challenge etc.

During the audit process it was noted that there were some gaps in supervision between the period of March 14 - Sept 18. Additionally, supervisions between manager and Supervising Social Worker had limited recording. Supervisions between Supervising Social Worker and carer tended to focus primarily on the child in placement rather than discuss the carers and their competence, and more broadly speaking, what life was like for them as carers and as a couple and individuals.

It is Hertfordshire's policy that joint supervisions with the secondary carer take place every quarter. However, Adult B did not always engage with this process as he often moved around the house or at times was away due to work commitments.

Dacorum Borough Council

Homeless approach was received, they accepted a duty in line with legislation and this was discharged to the council property they were offered. This worked as was expected.

The Housing ASB policy and procedures were followed. Risk assessments were carried out to identify if the case was a high risk due to vulnerabilities of the victim or the severity of the incidents. Where it was suspected the behaviour was hate related the case was referred to the corporate ASB Team. A home safety assessment referral was made to HCC in June 2015 in line with their procedures. Adult A did not notify them that any external agencies or support services were involved. Information was therefore only shared with the police. The case against her neighbour was also discussed at the ASB Action Meeting (ASBAM) where all agencies connected to ASB were in attendance. Mediation was offered to Adult A and her neighbours to try and resolve the complaints between them. Throughout this process Adult A was happy to contact them, allow access to the home and there were no signs of concern about her wellbeing or any domestic abuse in the household. The procedure in relation to the neighbour issues worked well. There was a potential for development as the case moved between the Housing Officer and the corporate ASB Team. While both teams have safeguarding training and follow the same

overarching information sharing and safeguarding procedure this could be an area for development. The Housing Officer was not aware they were fostering a child and this information could have ensured that a referral to social services would have been completed sooner. However, they were notified there was a visit with the police and social worker on 26.03.18 so there were connections between these agencies and the police had details of the case from emails and multiagency meetings and visits.

Hertfordshire Constabulary

Based on the entries recorded on SafetyNet, contact with Adult A and her family was almost exclusively reactive. Given the number of reports and the time span of the case, it is questionable whether police-initiated contact was timely and sufficient. However, there is reason to believe that contact was in fact more regular than is recorded on SafetyNet.

Based on the entries recorded on SafetyNet, the case received minimal direct supervisor scrutiny until May 2018. Notwithstanding there are at present no set guidelines stating to what extent and how often supervisors should review cases on SafetyNet, it is reasonable to conclude that the case lacked regular or proper management from a supervisor.

Accurate risk assessments were carried out on SafetyNet and appear in the main to have been timely, measured and appropriate.

Based on the SafetyNet entries appertaining to this case, it may have benefitted from greater long-term oversight by supervisors within the Dacorum Safer Neighbourhood Team. Had the detailed and directive supervisory reviews of August 2018 occurred in 2015, local officers responding to the problem may have done so with a better understanding of the long-term objective they were working towards and the tactical options available to them. Equally, individual officers who have owned this case or performed tasks in relation to it have seemingly not recorded all of their actions or contact with those concerned. In short, SafetyNet has been used primarily as a depositary for new allegations and less as a means of recording what the police have done to tackle those problems.

The response of the police and council to the problems reported arguably lacks clear direction or a robust approach. There is no readily identifiable application of the OSARA problem solving or National Decision-Making models. Equally, there appears to be only light and belated consideration of coercive powers contained within the ASB Crime and Policing Act (2014), which if applied, may have had a positive impact on the problem.

This review has emphasised a lack of training in the use of SafetyNet within the constabulary. Anecdotally and separate from this review supervisors, constables and PCSOs have spoken of a lack of confidence when using the system and sporadic learning. 'Training' apparently consists of self-generated shadowing of an experienced user, at a local level. Consequently, the use of SafetyNet within the force appears to be irregular and inconsistent. Equally there do not appear to be any clear guidelines or expectations around how and when SafetyNet will be used, when supervisors should review cases and what those reviews should look like.

There is no indication within the material contained within the SafetyNet cases that the Colombian heritage of Adult A and her family in any way impeded or influenced their willingness to report incidents to the police or local authority. Reference to their heritage is only made in relation to racist remarks made by the next-door neighbour. The frequency and persistency of reports to police and council officials, indicates that Adult A and her family believe/believed that the authorities would be receptive to their complaints and have the skills, powers and inclination to react appropriately.

4 Evidence any change or emergence of updated or new policy, procedure and practices now in place and provide assessment on the impact and difference any changed or new policy, procedure and practice now brings?

Children's Social Care

- Supervision with foster carers is now electronically recorded and is more detailed including a more comprehensive evaluation of the carer's needs and functioning.
- Home visit templates include observations of the carers, their presentation, their interaction with each other and demeanour.
- Joint supervisions need to clearly evidence contributions from both carers. Secondary carers should also be seen on their own for their own individual supervision.
- Practice guidance note to be issued regarding secondary carers and the importance of noting their involvement in supervision sessions and reviews.
- Refresher training for all fostering social workers on trauma and its impact on attachment and relationships.
- Audit schedule to be put in place to ensure that there is a regular audit on frequency and quality of supervision.
- Fostering Service have started a quality conversation process which is a reflective process that supports quality assurance and critical reflection.

Dacorum Borough Council

Any new legislation will lead to a review to any existing policy and procedure. They do this in line with appropriate legal advice and ensure it is reflective of the legislation.

ASB polices by both Housing and Corporate have now been combined into one joint policy that covers the responsibilities of DBC as a landlord and for Community Safety in Dacorum. This will ensure a more consistent approach across the organisation. Additionally, a restructure for the Housing service to continue managing high level cases will change the need for cases to be referred to a different team when they reach a certain threshold. This should improve the communication between these officers and prevent victims having to repeat details and be passed between teams.

Hertfordshire Constabulary

A new ASB management system (Safety net +) went live as of the end of November 2019 in Herts with enhanced automated case management and risk management functionality and access initially to council colleagues and wider partnerships in the future. This is not as a direct result of this case and was a piece of work already ongoing prior to the murder but does address the concerns raised in the ASB report raised by Police. The balance for the Report Writer is that this is an ancillary piece of work/consideration as the ASB reported is not shown as a contributory factor in the murder.

APPENDIX THREE – OVERVIEW OF THE HERTFORDSHIRE CHAMPIONS INITIATIVE (INCLUDING THE J9 INITIATIVE)

Hertfordshire's Sunflower Domestic Abuse Champions Network seeks to build, provide and empower a wealth of knowledge and awareness across the local area that could be cascaded and shared to increase capacity in early identification, intervention, guidance and support to improve the response to those affected by and experiencing domestic abuse.

Hertfordshire's Sunflower Domestic Abuse Champions Network has been implemented using a tiered approach:

(1) Strategic Champions: ambassadors and leader for domestic abuse policy and practice development within their organisation, influencing decisions and direction to ensure domestic abuse is fully understood and embedded throughout whilst supporting the local domestic abuse partnership Strategy and local priorities.

(2) Lead (Agency) Champions: frontline / work-based who can support the community champions and wider colleagues within their organisation and across the champions' network by giving enhanced practical help and support when needed.

(3) Community Champions (J9): A Community Champion can be anyone amongst local business and services who comes into contact with the public regardless of their job role. They receive training and resources to enable them to provide a 'safe haven' for victims to disclose and access information to assist decision-making and recognise and respond to victims and understand how to refer anyone to appropriate help and support. This is our 'help on the High Street' approach.

Anyone, especially those in a public facing job, who could help signpost victims of domestic abuse to sources of help and advice, are encouraged to become a Sunflower Domestic Abuse Champion.

The training provides opportunity to gain a better understanding of domestic abuse; to help recognise it, how to respond, and how to provide victims with a safe space where they can access support and advice.

Champions are enabled to provide needed support to colleagues within the workplace and beyond through enhanced practical help and support when needed. In return we provide access to resources, and further training and networking opportunities three times a year.

The scope of the network is intended to be far reaching and open to all sectors and partner agencies, local shops, businesses, and community settings. In its first 2-yrs of development the network had grown to include 400 individuals across the three tier approach.

An analysis of the network conducted in July 2022 indicated that there were 476 trained champions within the network, with a further 103 registered and awaiting to receive training. The network at that time was made up of more than 100 partner agencies and community-based businesses and local services throughout Hertfordshire. The table below provides an overview of the network across the three tiers:

Champion Network by DA Forum area	J9	Lead	Strategic	Total No.
North Herts & Stevenage	62	20	0	82
Watford & Three Rivers	69	13	0	82
St. Albans & Hertsmere	59	21	0	80
East Herts & Broxbourne	50	16	2	68
Dacorum	29	18	0	47
Welwyn Hatfield	16	15	0	31
Countywide	20	16	9	45
Unknown	13	28	0	41
	318	**147**	**11**	**476**