Dacorum Community Safety Partnership

Overview report of the Domestic Homicide Review into the death of Peter, June 2018

Confidential

Independent Report Writer: Elizabeth Hanlon

Review completed: August 2020

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1. Timescales

1.1 This overview report has been commissioned by a Community Safety Partnership concerning the death of Peter which occurred in June 2018. Peter was identified as having been killed by his sibling Simon.

1.2 It is important to understand what happened in this case at the time, to examine the professionals' perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

1.3 The death of any person in circumstances such as examined herein is a tragedy. Family members and friends of both the victim and the offender were contacted during this review and a request was made to speak to them regarding the family dynamics. The family and friends of Peter were provided with the Home Office leaflet for families and were informed that they could be represented by a specialist advocate from AAFDA (Advocacy After Fatal Domestic Abuse). This offer was declined by Peter's and Simon's family and friends.

1.4 Extended family members were provided with a copy of the Terms of Reference and invited to contribute and comment. The extended family of both Peter and Simon declined to be a part of the review process and it was identified that they had not been in touch with either party since they were young children and that they did not have a relationship with either of the brothers. At the conclusion of the review process, Peter and Simon's cousin was contacted regarding reviewing the overview report and its recommendations and speaking to the report writer but unfortunately, no response was received.

1.5 Identified friends of both Peter and Simon were spoken to by the Chair and Report writer and provided valuable information into the family dynamics and the brothers' relationship. The panel would like to extend their thanks for their time.

1.6 The panel wish to send their condolences to the family and friends of Peter. Pseudonyms for both the victim and the perpetrator have been used throughout this report to maintain anonymity.

1.7 The Home Office were notified by a Community Safety Partnership (CSP) of their intention to carry out a Domestic Homicide review. The Coroner was also notified that a Domestic Homicide Review was taking place.

1.8 The Domestic Homicide Review was started in 2018 when the first meeting took place and concluded in August 2020. The panel met on four occasions, where they identified the key learnings, set the terms of reference, examined the IMR and agency information and scrutinised the overview report and its recommendations.

1.9 The reason for the delay in completing the review was due to the fact that the sentencing of Simon did not take place for several months after the death of Peter. The panel had made the decision that they wished the independent report writer to try to speak to Simon to try and identify any additional learnings that the agencies had not identified. Simon unfortunately declined to become involved in the review process.

1.10 The Senior Investigating Officer and the Crown Prosecution Service were spoken to by the report writer and the chair and although they stated that they were happy for the review to continue they felt that it was not appropriate for Simon to be interviewed until after he had been sentenced.

1.11 The findings of each Individual Management Review (IMR) are confidential. At the beginning of the meetings of the review panel, attendees were asked to sign a confidentiality agreement. The information supplied throughout the review process was only available to those participating in the review and their line managers.

1.12 The victim in this case was a white male aged 55 years at the time of his death. The perpetrator was the victim's brother and also a white male aged 53 years.

2. Reasons for conducting the review

2.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9(3)(a). Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The Act states that a DHR should be a review:

Of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or a member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

2.2 The purpose of a Domestic Homicide Review (DHR) is to:

A. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
B. Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;
C. Apply these lessons to service responses including changes to policies and procedures as appropriate; and
D. Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

3. Objectives of the review

3.1 One of the purposes of a Domestic Homicide Review (DHR) is to give an accurate as possible account of what originally transpired in an agency's response to Peter, to evaluate it fairly, and if necessary, to identify any improvements for future practice.

3.2 The GPs provided information surrounding Peter's Rheumatoid and Orthopaedic pain, however they were not aware of any family circumstance surrounding Peter and Simon nor had any concerns surrounding the family dynamics. Simon was not registered with a GP.

3.3 This overall report is based on the relevant information obtained from the Police IMR and also information from friends of both Peter and Simon. The IMR report was written by a professional who was independent from any involvement with the victim, family, friends or the perpetrators. Should actions be necessary by any of the agencies, the maintenance of, and strategic ownership of any action plan will be the overall responsibility of the Community Safety Partnership (CSP). It is essential that any resulting ownership and recommended activity is addressed accordingly.

3.4 Whilst key issues have been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of this overview report are shared by the membership of the review panel, commissioning officers and members of the Community Safety Partnership. The associated reports from agencies will not be individually published.

4. Terms of Reference

In conducting the Domestic Homicide Review into the death of Peter, the Panel shall have regard to:

4.1 Scope

4.1.1 This review is commissioned by Hertfordshire Domestic Abuse Partnership (HDAP) in partnership with the Community Safety Partnership as a result of the death of Peter in 2018.

4.1.2 The review will focus on events from January 2012 until Peter's death. This date was chosen by the review panel because in January 2012 Peter and Simon's mother died and this appeared to have started the breakup of the family.

4.1.3 If it becomes apparent to the Independent Chair that the timescale in relation to some aspects of the review should be extended this will be discussed with and agreed by the review panel and informed to the chair of the Hertfordshire Domestic Abuse Partnership Board (HDAPB).

4.1.4 The results of the review, including the panel's findings and recommendations will be shared with Peter's family.

4.2 Purpose

4.2.1 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Establish how effective agencies were in identifying both Peter's and Simon's health and social care needs and providing support.
- Establish the appropriateness of single and inter-agency responses to Peter and Simon until Peter'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.
- State clearly, where apparent, when the death was deemed to be preventable and the rationale behind this.

4.2.2 The Review will exclude consideration of who was culpable for the death.

4.3 Key Lines of Enquiry

4.3.1 **Information:** How was information about Peter and Simon's health and social care needs received and addressed by each agency and how was this information shared between agencies?

4.3.2 **Assessments and diagnosis**:

- Were there any recent changes in Peter's or Simon's physical or mental health and well-being that may have affected Simon's behaviour?
- Could the physical or mental health and well-being of Peter and Simon have compounded any safeguarding concerns or considerations or masked evidence of domestic abuse and/or coercive control? Did this result in specific or increased risk and missed opportunities for agencies to probe and respond effectively?
- Is there any clear information in relation to domestic abuse and/or coercive control and its impact? Were any carer's/agency assessments completed?
- Was there any indication or sign of any cultural perceptions or beliefs that were relevant? Did these bring with them any implications on the relationship and behaviours?
- Were there any barriers to seeking support? What were they? How can these be overcome?

4.3.3 **Contact and support from agencies:**

- What was the nature and extent of the contact each agency had with Peter and Simon?
- What support did they receive and from whom; individually and as a family?
- Were there any indicators or history of domestic abuse and/or coercive control? If so, were these indicators fully realised and how were they responded to? Was the immediate and wider impact of domestic abuse on Peter fully considered by agencies involved?
- Was there any collaboration and coordination between any agencies in working with Peter and Simon; individually and as a family? What was the nature of this collaboration and coordination, and which agencies were involved with whom and how?
- Were there any issues of intersectionality identified and how were they dealt with by agencies? Did the interventions of agencies demonstrate competent strategies and practice of intersectionality in their responses?
- What lessons can be learnt in respect of domestic abuse and/or coercive control, how it can affect adults, and how agencies should respond to any impact?

4.3.4 **Any additional information considered relevant:** If any additional information becomes available that informs the review this should be discussed and agreed by the independent chair and the review panel.

- The panel shall also request access to any parallel reviews taking place by individual agencies regarding their involvement with either Peter or Simon.
- The Panel shall seek Information in respect of the background and any previous convictions of Simon and whether or not they had ever been subject to Multi Agency

Public Protection (MAPPA) Arrangements or Domestic Violence Perpetrator Programs (DVPP).

- The Overview Report shall be written by the nominated Review Panel Report Author who shall, subject to the agreement of the Panel Chair, submit a draft to the Panel for its consideration. The Report shall set out the extent, from the findings of the review, whether there are improvements that could be made in the way in which relevant agencies and organisations can work individually or together to safeguard future potential victims. The Panel shall also consider whether further information should be made available in the public domain for the benefit of family or friends who have concerns relating to potential abusive relationships.

4.3.5 Subject to the point above the Panel will identify any changes in policies and procedures arising from the lessons learnt, make recommendations and will, through an agreed Action Plan, establish timescales for their implementation and identify what is likely to change as a result.

5. Contributors to the review

5.1 Scoping letters were sent out to GP services, Hertfordshire Constabulary, Hertfordshire County Council, Children's Services and Adult Services, Dacorum Borough Council, Refuge Hertfordshire IDVA service, Hertfordshire Partnership Foundation Trust (mental health services), National Probation Services, BeNCH, Squire Estates and Citizens Advice Bureau and as a result of the information received, agencies were asked to submit chronologies.

5.2 An Individual Management Review (IMR) was only requested from Hertfordshire Constabulary in this case as they were the only agency that had any significant contact with Peter and Simon. The Police IMR writer was identified as being independent to the investigation itself and was not involved with the investigation nor supervised people who did. It was identified that the IMR writer had experience in writing IMR reports and therefore no additional support or guidance was requested. The IMR was quality assured by a supervisor and was signed off by management prior to being presented to the panel.

5.3 This IMR was prepared by David York an accredited Review Officer with the Bedfordshire, Cambridgeshire and Hertfordshire Major Crime Unit (BCH MCU). He is a retired Detective Sergeant with over 27 years' experience as a Detective in a 31 year career, followed by over two years as a Review Officer.

6. The Review Panel Members

Name	Position and Organisation
Scott Crudgington	Chief Executive, Stevenage Borough Council
Elizabeth Hanlon	Independent Report Writer
Keith Dodd	Head of Adult Safeguarding, Adult Care Services, Hertfordshire County Council
Tracey Cooper	Associate Director Adult Safeguarding, East and North Herts and Herts Valleys Clinical Commissioning Groups
Amy Dalton	Community Safety Lead Officer, Dacorum Borough Council
Naomi Bignell	Named Nurse, Hertfordshire Community NHS Trust
Tracy Pemberton	Detective Chief Inspector, Hertfordshire Constabulary (until January 2019)
Stephen O'Keeffe	Detective Chief Inspector, Hertfordshire Constabulary (after January 2019)
Sarah Taylor	Development Manager, Hertfordshire County Council
Karen Hastings	Consultant Social Worker (Adult Safeguarding)/AMHP, Hertfordshire Partnership Foundation NHS Trust
Susan Pleasants	Victim Team Manager, Hertfordshire Probation Service
Mari Edwards	Specialist domestic abuse services provider and independent member, Refuge
Louise Coulson	Senior Operations Manager, Refuge
Bonita Sparkes	Clinical Nurse specialist safeguarding Adults, West Herts Hospital Trust

7. Chair and Overview Report Writer

7.1 Hertfordshire County Council set up a process when Domestic Homicide Reviews were first implemented whereby Chief Executives from different Districts of Hertfordshire would chair the Domestic Homicide Review that occurred within other districts of Hertfordshire. The Chief Executives are chosen based on their independence of the other district. The independent chair appointed on behalf of the Community Safety Partnership was Scott Crudgington, who was the Chief Executive for Stevenage Borough Council. Scott is independent of all the agencies involved within the review and also has no affiliation to the other Council.

7.2 The independent report writer for this latest review is Elizabeth Hanlon, who is independent of the Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective from Hertfordshire Constabulary, having retired six years ago, who has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership Reviews and Serious Case Reviews. She has written several Domestic Homicide Reviews for Hertfordshire and Essex County Council. She has received training in the writing of DHRs and has completed the Home Office online training. She also attends the yearly Domestic Abuse conferences held in Hertfordshire and holds regular meetings with the chair of the Domestic Abuse Partnership Board in Hertfordshire to share learnings across boards. She is also the current independent chair for the Hertfordshire Safeguarding Adults Board. This is an independent role and as such she has no affiliation to any of the agencies involved in the review. The role of the chair of the Safeguarding adults Board is to gain assurance that agencies are safeguarding adults with care and support needs within Hertfordshire and to hold these agencies to account. As such the chair must remain independent on all occasions and must act as an independent scrutineer.

8. Parallel Reviews

8.1 There were no parallel reviews taking place.

9 Equality and Diversity

9.1 The Panel considered the nine protected Characteristics under the Equality Act 2010, (age, disability, gender reassignment, race religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity). They sought to establish if they were applicable to the circumstances of the case and had any relevance in terms of the provision of services by agencies or had in any way acted as a barrier.

10. Dissemination

10.1 The Panel shall, once it has agreed the final report, submit it to the Community Safety Partnership for its consideration. The Partnership will be requested to consider the content of the report, the recommendations and the associated Action Plan. If the Partnership is satisfied with the report, it shall be requested to:

A. Submit the report to the Home Office;

B. Consider whether, prior to the Home Office response, there are issues that should be brought to the immediate attention of Hertfordshire Strategic Domestic Abuse Partnership Board;
C. Consider which agencies, organisations or individuals should receive a copy of the report and the degree to which its findings should be made public, following the approval of the report by the Home Office.
D. 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;

Dacorum Community Safety Partnership.
Hertfordshire Domestic Abuse Strategic Partnership.
Hertfordshire County Council.
Hertfordshire Constabulary.
Dacorum Borough Council.
Hertfordshire Partnership University NHS Foundation Trust.
Herts Valleys West Hertfordshire, Clinical Commissioning Groups.
Refuge (providers of Hertfordshire IDVA Service).
West Hertfordshire NHS Trust.

E. In accordance with Home Office guidance all agencies and the family and friends of Peter and Simon 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.

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

10.2 Due to the pandemic the overview report was only presented to the CSP in August 2020 which has caused a delay in its submission to the Home Office.

11. Background information (the facts)

Case background

11.1 Police attended an address in Hertfordshire in 2018 following a report of a concern for welfare. They were greeted by Simon who told the officers that he had killed his brother Peter and that the body was in the garden shed. The body of Peter was

discovered, and Simon was arrested for murder. The cause of death was blunt trauma to the head and the scene appeared to have been within the house.

11.2 The victim, Peter, aged 55 years, lived alone in the family home. His mother died in 2012 and his father died in 2015. He had one brother Simon aged 53 years who lived alone at a separate address. There are no other known close family members. Peter owned a dog that had previously belonged to his father.

11.3 Peter belonged to the local lawn tennis club which is located at the bottom of his road. He had been a member for over 40 years. His friends all appear to be from the club. They describe him as a quiet and polite man who you could "set your watch by". He would attend the club at least three times a week where he would play tennis and socialise in the bar.

11.4 Friends, work colleagues and neighbours of both Peter and Simon have all mentioned an estrangement between the brothers after their mother died in December 2012; she was apparently in the end stage of a terminal illness around Christmas time. Simon is understood to have refused to cancel a holiday to South Africa and unfortunately his mother died whilst he was out of the country. This upset Peter and Simon's father who reportedly threw Simon out of the family house which he continued to share with Peter.

11.5 When Peter and Simon's father died in 2015, Simon became aware that he had been disinherited with Peter becoming the sole benefactor of his father's estate. Peter had been living with and caring for his father for the years preceding his father's death.

11.6 It is this inheritance issue which is believed to be at the heart of the motive for the dispute between the two brothers and ultimately the motive for the attacks and subsequently the killing of Peter by Simon. Simon would not accept that the final will of his father had left him nothing and took it upon himself to try to recover what he thought he was entitled to.

11.7 Simon pleaded guilty to the murder of Peter and sentenced to life imprisonment with a tariff of 18 years. A coroner's inquest was opened and closed.

12. Chronology

Police Involvement

12.1 In April 2016 Hertfordshire Constabulary control room received what is described as an "abandoned 999 call" shown as being from a mobile number linked to Peter's address. The call taker recorded that there was no disturbance heard, but there were a series of tones heard indicating that numbers were being pressed on the phone after it had connected. Policy was complied with and the call taker called the number back and the original caller gave his details as Peter. He explained that he had been leaning on his phone and that it was an accidental call and no further action was taken.

12.2 In March 2017 Peter contacted Hertfordshire Constabulary by calling 999. He told the call taker that he had just been assaulted by his brother Simon about 15 minutes earlier.

12.3 The call taker complied with policy and went through a prescribed question set pro forma with Peter, recording the responses on the incident log. This process is completed to ensure all relevant information is gathered and to assess the risk and appropriate response by Police. It was established that Peter was not seriously injured and was not in any further immediate danger as Simon had left.

12.4 It was alleged that Simon had assaulted Peter by punching him about 30 times causing scratches and bruising.

12.5 Peter stated that the dispute was over the fact that he had inherited the house and their late father's estate and that Simon was left nothing. He stated that Simon blamed Peter for their father's death.

12.6 Peter stated that Simon had said he wanted Peter out of the house and that he would return the next day and if he had to, he would "kill" Peter. Peter said he believed this threat.

12.7 It was alleged that although this was the first time Simon had assaulted Peter, he had been around and shouted at Peter a few days earlier. The escalation in behaviour was noted but had not been reported before.

12.8 Peter was given basic safeguarding advice to lock all doors and dial 999 again by the call taker in the event that he felt in further danger. Simon's location or address were not known to Peter.

12.9 An officer visited Peter's house in the early hours of 25th March where Peter was seen, and a witness statement was taken, and his injuries were photographed for evidence.

12.10 A DASH booklet (Domestic Abuse, Stalking & Harassment & Honour Based Abuse) was completed effectively and submitted in accordance with policy by the attending officer; the risk level was assessed as "medium" with a score of 9. This is below the level to indicate where a Multi-Agency Risk Assessment Conference (MARAC) may be required (that is, 14 ticks from the 26 questions asked).

12.11 The incident was reviewed; the risk was assessed as "medium". It was decided that further efforts would be made in the morning to continue enquiries. A crime report was raised and allocated for further investigation.

12.12 In March 2017 Simon was arrested at his home address and taken to a Police Station. He was interviewed about the allegations. He admitted he had attended his brother's home address but said he had gone there to get evidence to support his theory that Peter had falsified their father's new will before his death. He said that they had

"tussled" and that Peter had approached him first. He denied assaulting Peter by punching him "30 times", adding that there would surely have been more injuries than those evident if that allegation were true. He also denied making any threats to kill Peter.

12.13 A decision was made by a supervisor to take no further action against Simon and he was released without charge. The rationale for this decision was recorded on the Custody Record. The rationale is in summary that it is one person's word against another concerning the facts and causes of the altercation and there would be insufficient evidence to present to CPS (Crown Prosecution Service) or to prosecute. Peter was informed of this decision prior to the release of Simon.

12.14 The incident was classified as a "non-intimate" case of interfamilial Domestic Abuse. This led to the investigation being completed by Local Policing staff rather than the specialist team, DAISU (Domestic Abuse Investigation and Safeguarding Unit). The crime report was reviewed by the Victim Support Team (VST) and DAISU Business Support Assistant (BSA) prior to filing. The investigating officer was informed that the case history would be reviewed in accordance with policy to ascertain if the case met the threshold for a MARAC and the result was that it did not. It was identified by the review panel as good practice regarding the identification of a non-intimate relationship still falling within the guideline of a domestic abuse incident. It is not, however understood what level of support or signposting was offered to Peter subsequently.

12.15 In September 2017 Hertfordshire Police control room received a further "abandoned 999 call" from the same mobile number linked to Peter. There was again no disturbance heard, and again a series of tones indicating numbers were being pressed after the call had connected. Again, policy was complied with and the caller was contacted by control room staff, he identified himself as Peter; he explained that it was another accidental call made while he had been "wiping down his dog". No further action was taken.

Friends

12.16 Several friends of Peter and Simon were spoken to throughout the review process. There were no identified close family members, however a cousin of Peter and Simon were informed of the review and asked if they wished to contribute but they did not feel that they had any relevant information to be able to contribute. The parents of Peter and Simon were described as being very strict and controlling, although the father more than the mother. Both the boys were required to save a third of their money, give a third to their parents and they were allowed to spend a third. This was instilled in both boys and started at a very early age and continued throughout their adulthood.

12.17 There was a very strict regime within the family where both Peter and Simon were expected to be home at a certain time for their dinner, which would be placed on the table at that time and if they weren't there it would be thrown away. One friend of

Peter's, who had been a friend since they were 13 years old, described phoning the family home and asking to speak to Peter. It was Peter's father who answered the phone and stated that there wasn't a Peter living at the address and that he needed to use his full name. On all future occasions the friend would have to ask for Mr. Peter and give his surname and also introduce himself with his full name as calling. This is the only way Peter's father would allow him to talk to Peter.

12.18 Friends of Peter stated that he had been a good tennis player and that he had played from an early age. They were unable to recall any occasions when any family members would turn up at the tennis club to watch Peter play any matches. He always appeared to be on his own. Peter was described by friends as being a very quiet man who was a stickler for the rules. Peter was described as socialising at the tennis club a few times a week and that he also played snooker once a week. It appeared that he had a few friends at the tennis club but that he did not socialise out of that arena. They had tried to persuade him to go on holiday with the tennis club on several occasions but that he had always refused. They stated that Peter never went on holiday and only went away with his parents before his mother became ill and that was always in England.

12.19 A friend of Peter's also described the family dynamics, stating that the family fell apart when the brothers' mother died. It appeared that she was the peace maker within the family. Simon was never forgiven for going on holiday at the time of his mother's death and that his father would have nothing to do with him due to this. This fact caused a rift between the brothers which deepened following the death of their father and the fact that all the inheritance had been left to Peter. Simon had not been allowed to attend the funeral of his mother which had caused a great deal of upset. Several of Peter's friends stated that Peter was very upset about the rift with his brother and that he wanted to patch things up and was considering giving some of the family money to Simon. This never happened as unfortunately Peter died before this could happen.

12.20 Friends of Peter were aware of the fight that had taken place between Peter and Simon in March 2017. They described Peter as being of slim build and very quiet where Simon was very stocky and used to go to the gym a lot and had a stronger personality. Peter had spoken to friends about getting a restraining order out on Simon after the fight, however agencies have been unable to find any record of this. The family solicitor was contacted however was unable to provide any further information to the panel. The panel also made contact with the courts within their area and established that an injunction had not been taken out.

12.21 The report writer also spoke to a friend of Simon's who had known him since school. He also described the family dynamics as being strained. He described the fact that Peter was close to his father and that Simon was closer to his mother. He believed that Simon looked after his mother and was one of the main carers when she was ill with cancer. It appears that the relationship that Simon had with his father was more difficult and that they 'rubbed each other up the wrong way'. When the mother died the relationship between Simon and his father deteriorated even further. Simon had gone on holiday at the time of his mother's death, although it appears that Simon had

checked with his mother's GP prior to going who had stated that her death wasn't imminent. When Simon returned from his holiday his relationship with his father and brother was very strained as they blamed him for leaving his mother and he was sent a letter asking him to leave the family home. He was also told that he could not attend his mother's funeral which apparently really upset him.

12.22 When Peter and Simon's father became ill, it appears that Simon found out about it from someone else and that he wasn't told by Peter. When their father came out of hospital Simon's friend believed that Simon tried to visit on several occasions but was turned away by Peter. Simon had concerns regarding the way Peter was looking after their father and they had several arguments about it.

12.23 After the death of their father Simon and Peter's relationship suffered further. Simon went to see Peter on several occasions to discuss the will as he believed that Peter had forged the will and that he was keeping all the money to himself. He stated that Simon had started drinking a lot and was having trouble sleeping. He stated that Simon was getting more and more frustrated about the money and the fact that he believed that he had been conned out of his inheritance by Peter.

12.24 Simon's previous employers were also spoken to. They described Simon as having worked for the company for numerous years, that he had always been reliable and hard working. He was an ideal worker who never argued or disagreed with anyone and would always volunteer to work extra hours. They stated that he always had two holidays a year at exactly the same time and that he always went abroad on his own. The company were aware of the break down in his family's relationship although he didn't talk a great deal about it. He tended to keep himself to himself. All employees are encouraged to have lunch together in the staff canteen and socialise, however Simon would never do that. He would always have his lunch separately and go to his own car and have a 30-minute sleep.

12.25 The Operations manager did however state that he noticed a change in Simon over the previous couple of years leading up to the murder of his brother. He described an incident at work where a young female member of staff had reversed her car into Simon's accidently. Simon is described as getting very angry and trying to force the woman to give him money for the damage. The HR department needed to step in and told Simon to go through his insurance company but the week afterwards he showed up at work with the damage mended. He was then seen by another member of staff to place a nail under the woman's tyre which looked like the intention to cause her to drive over it. Simon was placed on probation after this incident. The manager appeared to be very surprised about the incident and stated that they had never had any issues with Simon previously and that they felt it was completely out of character. The manager also stated that he had noticed a change in Simon's behaviour over time, he noticed that he appeared to be preoccupied and that he had caught him talking to himself on several occasions, however they had no concerns regarding his mental health as such.

12.26 The HR manager mentioned that Simon had come into work at 7am the day after the murder and that he had been acting the same as he usually did. On the Monday morning he had given them a new address, which was his family home address, stating that 'that's my new address'.

13. Analysis

13.1 Both the friends of Peter and Simon describe the family dynamics before the death of their mother and then subsequently their father. It appears that their father was very strict with both the sons and that he expected the rules of the house to be upheld. The mother appeared to be the peace maker within the family and when she died their father became more authoritarian and controlling.

13.2 It does appear that the mother's death was a catalyst for the relationship between the brothers deteriorating and that Simon was never forgiven by his father for going on holiday. Simon moved out of the family home into a small bedsit where it appears, he became more isolated. Work colleagues described Simon's car being full of his property as his bedsit wasn't big enough to accommodate all his belongings.

13.3 The panel have discussed the relationship between the brothers and whether they believed that this relationship fitted into coercion and control. The criminal offence of coercive control under S76 Serious Crime Act 2015 was operative from the 29th December 2015.

- Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
- Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The full definition is contained within Appendix B.

13.4 When Simon and Peter's mother died, Simon was forced to leave the family home which would appear to fall within the confines of controlling behaviour. This behaviour was however exhibited by the father within the family against one of the siblings and it appears that this behaviour extended across the whole family. It was considered whether the level of coercion and control had extended throughout the family and continued after both parents had died, resulting as a norm within the siblings' lives. Peter remained at the home address; however, the level of contact between the two brothers remained minimal. As described by Peter's friends, Peter felt torn over the fact that his brother had been written out of the will, but he also struggled with going against his father's wishes. It appears that prior to his father's death Peter was told by his father that the family money was for him and was not to be shared with his brother.

13.5 There is, however, nothing to suggest that Simon was using coercive and controlling behaviour towards Peter, or Peter towards Simon. There does not appear to be a

continuous level of violence against Peter by Simon nor did the initial assault of Peter have a substantial adverse effect on his life. The panel does not believe that there were elements of coercion and control within the relationship between Peter and Simon; however, they all agreed that this appeared to be consistent within the family dynamics which ultimately had an impact on the brothers' relationship following the death of both their parents.

13.6 The police dealt with the offence of assault by Simon on Peter within the guidelines of domestic abuse although controlling and coercive behaviour was not highlighted by the officers attending the incident within the DASH report it was recognised that the incident did not fall within the definition at that time. The police did however recognise the fact that it was a domestic abuse situation between the two brothers which fitted the definition of domestic abuse.

13.7 Hertfordshire Police officers and staff are trained in recognising the indicators and dealing with instances of Domestic Abuse and Coercive Control. All officers receive training in legislative and procedural changes, and these are delivered and reinforced on regular staff training days.

13.8 There are policies and processes in place to manage Domestic Abuse cases. These are published on the Hertfordshire Police Intranet and there is guidance on the forms and templates that are used routinely by officers to complete mandatory paperwork in Domestic Abuse cases.

13.9 In this case it is apparent that Police were sensitive to the needs of Peter; officers and staff responded appropriately and promptly. There were no additional unrecorded concerns about Simon. The management and supervision of this case was evident and appropriate to the circumstances. Supervisory reviews were accompanied by realistic decisions and backed by appropriate rationale and all within policy.

13.10 The assessments for the March 2017 assault case were, at the time for that case, appropriate. There were no additional indicators within the circumstances of that case that would have given any idea that Peter was at risk of being murdered by his brother. There were no other reported incidents between the two parties in the 14 months between the assault and the murder.

13.11 Simon stated in his Police interview for the murder allegation that he had acted on impulse in killing his brother. Notwithstanding the fact he had broken into the house to challenge his brother, such impulsive behaviour and the ensuing result would have been difficult to reasonably predict in the pre-cursor events leading to the events of that morning.

13.12 There was no other agency involvement or information sharing in regard to the March 2017 assault case. The victim was not subject of a MARAC, the assault offence was not sufficiently serious to reach the threshold to warrant any further referral or action. Neither party had come to the notice of Police for anything relating to Domestic Abuse previously.

13.13 At the conclusion of the investigation into the March 2017 assault, Peter was given rudimentary safeguarding advice, such as using his mobile phone to dial 999 if there should be further problems and locking his doors as a preventative measure. Peter was deemed to have the capacity and means to look out for his own needs and at this stage no further direction to support was necessary. He owned a mobile phone, was able to ensure his home was secure and was able to identify when or if he needed to seek further help and knew how to do so. There were no other means of support identified as required in this case, such as deployment of an alarm or removal to a refuge.

13.14 The DAISU risk assessments are graduated and appropriate responses are in place where risks are assessed to be greater. For example, vulnerabilities due to age, mental capacity, infirmity would all have an impact on the assessment. DAISU specialist officers would deal with High Risk cases and some Medium risk cases with extenuating circumstances. Where a risk is assessed as High, a MARAC would be convened and there would be an inter-agency approach.

13.15 This was a domestic abuse case as Peter and Simon were brothers, however this is not an intimate relationship and they did not live in the same dwelling. Non-intimate domestic abuse cases are dealt with by Local Policing Units, although the risk levels are reviewed by DAISU staff. If the risk is deemed as “High” DAISU staff would be allocated the case.

13.16 Simon had no previous convictions or arrests recorded and there were no other allegations of violence against him. He was not subject to MAPPA or known to Police.

13.17 The two “abandoned” 999 calls were considered relevant for inclusion in the Police’s IMR as it was possible that these had been made by Peter in relation to issues with his brother. It should be stressed that there is no evidence of this, it is probable that it is simply a coincidence that Peter accidentally called 999 twice. In each case Peter was contacted back by Police staff and gave plausible explanations for the 999 calls; these were deemed as satisfactory to the control room staff and there was no cause for concern in the end. Current and contemporaneous policy was complied with in each case. In between these two calls Peter had reported Simon for the assault so it is not believed that he would have called 999 and then not felt confident to tell the call taker that he was in any need of assistance.

13.18 Friends of both Peter and Simon were spoken to about any previous incidents between the brothers and none of them were aware of any other incidents apart from the fight between them when the police were called. Both sets of friends were very shocked by the murder of Peter by Simon. They were all aware of the ‘bad blood’ between them but all agreed that there were no signs to indicate the level of violence that took place.

13.19 The review has considered the events that occurred, the decisions made, and subsequent action taken. In this case, given the circumstances it is considered that the

response to these events, the policy and process were adhered to effectively and appropriately.

13.20 National research in the most recent Home Office study (2016) on DHRs and the Sharing Together against Domestic Abuse (London Metropolitan University 2016) report, both identified Adult Familial Homicide as less common than Intimate Partner Homicide.

13.21 It does not appear that any agencies had any involvement with the family apart from the Police who attended the domestic incident between Peter and Simon in 2016. The incident was dealt with appropriately by the police as a medium risk domestic abuse incident. Simon was arrested by the police but later released with no further action due to insufficient evidence. It appears that the appropriate level of support and advice was offered to Peter. During the review it was highlighted that leisure centres within the area would not specifically be aware of how to raise awareness on all aspects of DA or how to signpost their customers for support. The Hertfordshire Domestic Abuse Partnership is currently rolling out the J9 project throughout Hertfordshire however, the CSP felt that this was a targeted piece of work that they would like to implement within their District.

13.22 In 2017 a domestic homicide occurred in Hertfordshire where a female committed suicide following emotional abuse from her partner. This was dealt with by the police and the offender was convicted of coercion and control. As a result of that case and the subsequent DHR a considerable amount of partnership work has taken place regarding agencies recognising coercion and control and their responses to it. All agencies' policies and procedures have been reviewed and amended to include the offence and all the agencies' training also now included this offence.

14. Conclusion

14.1 As identified within the review the relationship between Peter and Simon appeared to be strained following the death of their mother in 2012. Their father blamed Simon for being on holiday at the time of her death and never forgave him. This resulted in Simon being forced to leave the family home and move into a bedsit which was significantly different from the home he was used to.

14.2 When Peter and Simon's father died, he left the family house and all the money to Peter and Simon was written out of the will. Friends of both Peter and Simon stated that both sons found this very hard to deal with but in different ways. Simon appeared to blame Peter for what had happened and made allegations that he had changed the will either just prior to his father's death or afterwards. Simon also felt that his mother would have left him money when she died but that he didn't receive any. Simon had apparently contacted a solicitor in relation to fighting the will however, the panel were unable to find any further information surrounding this.

14.3 The panel had lengthy discussions regarding Coercion and Control within the Domestic Abuse Act. In March 2013, the government introduced a cross-government definition

of domestic violence and abuse, which was designed to ensure a common approach to tackling domestic violence and abuse by different agencies.

14.4 The panel felt that although it appeared that the parents, especially the father, of both Peter and Simon acted in a controlling manner within the family home there was no information to suggest that the relationship between Peter and Simon was the same. Friends felt that Peter was intimidated by his father even though his father had died and did not feel that he could go against his father's wishes.

14.5 The panel discussed the significance of this being a non-intimate domestic murder and wanted to know the extent of support/advice and signposting available in Hertfordshire for victims of domestic abuse within families where the victim and offender were non intimate. Safer Places identified that they had recently extended their criteria to cover such victims as they had identified an increase in familial abuse referrals. but it was acknowledged that not all agencies were aware of this. Refuge would also offer support to non-intimate victims of domestic violence.

14.6 Hertfordshire Domestic Abuse Partnership has a strategy 2016-2019 'Breaking the cycle' supported by the Police and Crime Commissioner and Hertfordshire County Council[1]. The strategy is signed up to by all Hertfordshire partners including Dacorum Borough Council.

14.7 The strategy clearly articulates the vision of the partnership for 'Women, children and men in Hertfordshire to be kept safe from domestic abuse and have opportunities leading to healthy and happy lives'. This vision is addressed under themes of Prevent, Protect and Provide. The strategic and Governance Structure demonstrates how the strategy connects to the local community and voluntary organisations.

14.8 The Hertfordshire Sunflower partnership is underpinned by the Hertfordshire Sunflower website, and the Hertfordshire Domestic Abuse Helpline charity. The website www.hertssunflower.org – is a 'one stop' shop of information about services and support available for victims, friends and families of victims, professionals and perpetrators of domestic abuse. The website has a directory of services and provides an online reporting facility, so that non-emergency incidents can be reported directly to the police or an independent domestic violence advisor (IDVA). These include victims of familial abuse but again the signposting for such victims is limited.

14.9 Peter told friends that he felt guilty about the situation and that he was contemplating giving money to Simon but that he was struggling to go against his father's wishes.

14.10 It has been identified that the siblings were raised in a strict home where their father ruled the house. When their mother died it appears that this became worse. It was at

[1] Hertfordshire partnership Domestic Abuse Strategy 2016-2019 '*Breaking the Cycle*': https://www.hertfordshire.gov.uk/media-library/documents/herts-sunflower/hertfordshire-domestic-abuse-strategy.pdf

this time that the animosity started between the siblings which didn't change until the time of Peter's death.

14.11 The only agency who had any dealings with the siblings were the police who dealt with the domestic incident 15 months before the murder. It was identified throughout the Police IMR that the incident was dealt with by the police in the appropriate manner and that they felt that there were no additional indications that the violence would escalate between the siblings. However, the initial report of assault on Peter by Simon was described by Peter to the police as a frenzied attack where 'Simon punched him over 30 times' and made threats to kill him. Within the Police's IMR they described interviewing Simon and that Simon made counter allegations in relation to Peter which is why it appears that no further action was taken against Simon. There were also no identified injuries on Peter for the police to use as corroboration to the assault. Even though the level of violence used against Peter by Simon appears to be a precursor to his murder the escalation of violence is something the panel felt was difficult for agencies to predict.

14.12 Agencies identified that as Peter was not signposted to any support agencies there might be a gap in gathering information if any additional incidents of assaults or threats to kill had taken place. Had Peter lost faith in the police because his reported assault by Simon was not prosecuted and therefore failed to report any additional instances between them and had no additional support? There does not appear to have been any additional support for Peter where he could perhaps speak about ongoing abuse from his brother, if that was in fact the case.

14.13 The majority of guidance available is reflective towards intimate partner relationships. This included the DA tools used by agencies. The DASH risk assessment tool is geared up to intimate relationships and is not particularly relevant to parent/child abuse. Standing Together against domestic violence produced a briefing sheet in relation to Adult Family Violence (AFV). Within the briefing sheet it was identified that there was a dearth of research into AFV (Sharp-Jeff's and Kelly, 2016). The lack of research means that most of the existing practice guidance and tools in responding to domestic abuse are geared towards intimate partner violence and potentially unsuitable for dealing with AFV. Westmarland, 2015, emphasises the fact that whilst the practice guidance and tools are geared towards intimate partner violence, this has 'almost certainly contributed to its invisibility and the relative lack of research attention and therefore theoretical development.

14.14 The continued research showed that 26% of all domestic homicides involved adult family members. Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 114 were adult family homicides (28% of all domestic homicides).

15. Recommendations

1. All agencies to continue with the identified training surrounding Domestic Abuse and Coercion and Control. This to include the rolling out of the J9 project (appendix C) within Hertfordshire for all agencies, including non-professionals.

2. To ensure that clear pathways for victims of familial abuse within Hertfordshire are embedded into the future commissioning of domestic abuse services.

3. The CSP to carry out a leaflet drop providing information highlighting domestic abuse and the referral pathways to leisure facilities and community centres within their district.

Appendix A: Glossary

AAFDA - Advocacy After Fatal Domestic Abuse
A&E- Accident and Emergency
ATHENA – Police crime recording system
CRC- Community Rehabilitation Companies
CPS - Crown Prosecution Service
CSP - Community Safety Partnership
DASH - Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Identification Checklist
DASO- Domestic Abuse Safeguarding Officer
DV/1- Domestic Violence booklet
DVDS- Domestic Violence Disclosure Scheme
DHR - Domestic Homicide Review
DVPP – Domestic Violence Perpetrator Programme
FLO - Family Liaison Officer
GBH- Grievous Bodily Harm
GMPS - Government Protective Marking Scheme
IMR - Individual Management Reviews
IDVA – Independent Domestic Violence Adviser
MARAC - Multi-Agency Risk Assessment Conference
MAPPA - Multi-Agency Public Protection Arrangements
MOJ – Ministry of Justice
NPS- National Probation Service
OM- Offender Manager
OASys- Risk assessment used by the National Probation Service
PINS- Prison Intelligence Notification System
PNC- Police National Computer
RE- Routine Enquiry

RTK- Right To Know procedures
SED- Sentence End Date
SIO - Senior Investigating Officer
SMART - Specific, Measurable, Achievable, Realistic and Timely
TOR - Terms of Reference
VCS - Voluntary and Community Sector

Appendix B: Definition of the criminal offence of Coercive Control

The definition of the criminal offence of Coercive Control (Contrary to Sec 76 Serious Crime Act 2015).

"Section 76 of the Serious Crime Act 2015 creates an offence in relation to a person who repeatedly or continuously engages in behaviour towards another (this person being personally connected to them), that is controlling or coercive.

76(1) A person (A) commits an offence if -

- *(a) A repeatedly or continuously engages in behaviour towards another person (B) that is controlling or coercive,*
- *(b) at the time of the behaviour, A and B are personally connected,*
- *(c) the behaviour has a serious effect on B, and*
- *(d) A knows or ought to know that the behaviour will have a serious effect on B.*

76(2) A and B are 'personally connected' if -

- *(a) A is in an intimate personal relationship with B, or*
- *(b) A and B live together and -*
  - *(i) they are members of the same family, or*
  - *(ii) they have previously been in an intimate personal relationship with each other.*

76(3) But A does not commit an offence under this section if at the time of the behaviour in question -

- *(a) A has responsibility for B, for the purposes of Part 1 of the Children and Young Persons Act 1933 (see section 17 of that Act), and*
- *(b) B is under 16.*

76(4) A's behaviour has a 'serious effect' on B if -

(a) it causes B to fear, on at least two occasions, that violence will be used against B, or

(b) it causes B serious alarm or distress which has a substantial adverse effect on B's usual day-to-day activities.

76(5) For the purposes of subsection (1)(d) A 'ought to know' that which a reasonable person in possession of the same information would know.

76(6) For the purposes of subsection (2)(b)(i) A and B are members of the same family if -

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they are relatives;

(d) they have agreed to marry one another (whether or not the agreement has been terminated);

(e) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(f) they are both parents of the same child;

(g) they have, or have had, parental responsibility for the same child".

Appendix C - J9 Project

The J9 initiative was established with the primary aim to raise awareness of domestic abuse amongst local business and services in order to provide increased opportunity for those affected to gain timely help, support and access to services in a safe way.

It was developed in memory of Janine Mundy, a mother of two killed by her estranged husband in 2003 whilst he was on police bail. The J9 initiative was started by her family and the local police where she lived in Cambourne, Cornwall.

The initiative got its name from the way Janine used to sign her text messages 'J9'.

For the public: where the J9 logo is displayed in a premises it provides victims and survivors with the assurance that they can get help to access a safe place where they can seek information and the use of a telephone.

For Businesses and services: the initiative enables staff to become more aware and thus better able to respond, but also improves the capacity to provide the support and information needed in order to make more informed decisions about the support someone may wish to receive.