Dacorum Community Safety Partnership

Executive Summary for 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. The Review Process

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 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.

1.3 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.

1.4 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.

1.5 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.

1.6 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 a white male aged 53 years.

Objectives of the review

1.7 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.

1.8 The GPs provided information surrounding Peter's Rheumatoid and Orthopedic 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.

1.9 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.

1.10 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. The overview was not presented to the CSP until August 2020 due to the pandemic, this has caused a lateness in the submission to the Home Office.

2. Terms of Reference

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

2.1 Scope

2.1.1 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.

2.1.2 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.

2.1.3 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).

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

2.2 Purpose

2.2.1 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.

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

2.3 Key Lines of Enquiry

2.3.1 **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?

2.3.2 **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?

2.3.3 **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?

2.3.4 **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.

2.3.5 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.

3. Contributors to the review

3.1 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.

3.2 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.

4. 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

5. Chair and Overview Report Writer

5.1 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.

5.2 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.

6. Background information (the facts)

Case background

6.1 Police attended an address in 2018 following a report of a concern for welfare. They 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.

6.2 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.

6.3 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.

6.4 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.

6.5 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.

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

<u>Friends</u>

6.7 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 but 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.

6.8 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.

6.9 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.

6.10 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 contacted the courts within their area and established that an injunction had not been taken out.

7. Police Involvement

7.1 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. A call back was made, and Peter explained that he had been leaning on his phone and that it was an accidental call and no further action was taken.

7.2 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. It was established that Peter was not seriously injured and was not in any further immediate danger as Simon had left. It was alleged that Simon had assaulted Peter by punching him about 30 times causing scratches and bruising.

7.3 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. 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.

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

7.5 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.

7.6 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.

7.7 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.

7.8 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.

7.9 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. The number was contacted by control room staff, the caller 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.

8. Analysis

8.1 The panel have discussed the relationship between the brothers and whether they believed that this relationship fitted into coercion and control under S76 Serious Crime Act 2015.

8.2 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.

8.3 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.

8.4 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.

8.5 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.

8.6 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. At the conclusion of the investigation into the March 2017 assault, Peter was given rudimentary safeguarding advice.

8.7 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.

8.8 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.

8.9 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.

8.10 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.

8.11 During the review it was highlighted that leisure centers 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.

8.12 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.

9. Conclusion

9.1 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.

9.2 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.

9.3 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.

9.4 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.

9.5 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.

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

9.7 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.

9.8 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.

9.9 Agencies identified that as Peter was not signposted to any support agencies and due to this 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.

9.10 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.

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

9.11 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).

10. 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.