Bristol Domestic Homicide Review

Executive Summary of the Overview Report

Into the homicide of Holly in January 2014

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Tribute from Holly's Mother

Holly was joyful and intelligent.
She bubbled over with energy,
She was funny and at times hilarious.
She was a loving caring mother.

One of her closest friends had this to say;
"Her loyalty and integrity, her kindness and generosity, her dedication to and wilful self-sacrifice for her friends, family and her son, made her a uniquely admirable and truly rare person."

There are still no words to describe our pain at the loss of Holly.

But I am grateful to be able to portray some of her loveliness here.

1. Introduction

1.1. This Domestic Homicide Review examines the circumstances surrounding the death of Holly (pseudonym), a single mother, who was 22 years of age and was living in Bristol.

1.2. Holly left home on the South coast and moved to Bristol, living in squats, until April 2012 when she moved into a rented two-bedroomed flat, just prior to giving birth to her son Michael (pseudonym).

1.3. Michael's father stayed for a short time after the birth but the relationship did not last and he left Holly to return to a previous girlfriend in Leicester, Nevertheless he told Holly that he still wanted to share the care of Michael and they arranged for him to return and live with Holly for two weeks out of every month for the first year of the baby's life. Michael's father then kept Michael in Leicester, alleging Michael was at risk with Holly.

1.4. The perpetrator Arturo (pseudonym), a Mexican national, arrived in the UK at the end of December 2012 on a 6-month visitor's visa. Sometime in June/July 2013 he met Holly, in the "Bear Pit", a pedestrian area in central Bristol. By the end of June 2013 Arturo had overstayed his visa period. In September 2013, Holly invited him to stay at her flat and they soon started a relationship. Friends and neighbours became aware that Arturo was, on occasions, violent to Holly, but this was never reported to the authorities or support agencies. In late December 2013 Holly was in the early stages of pregnancy and Arturo was believed to be the father. During the first week of January 2014 Holly was unhappy with their relationship, and contacted a clinic to enquire about having an abortion,

1.5. On the 7th January 2014 Holly went to visit a friend and told her, she was going to ask Arturo to leave her flat, as their relationship was volatile and she wanted to end it. During the evening she received a number of abusive text messages from Arturo. Her friend invited her to stay with her for the night, but she declined. She went home at about 12.30am and her last contact with her friend was at 3.20am, when her friend had texted, asking if she was OK.

1.6. At about 6am a neighbour described hearing a loud bang.

1.7. At 10.30am on 8th January, Arturo contacted one of his friends and said he had "hung" (Spanish for strangulation) Holly. Friends went to the flat at midday, at about

the same time as the police, who were responding to a 999 call from Arturo. In that call he stated that his girlfriend was dead and that he had choked her.

1.8. Holly was confirmed as dead and a post-mortem examination established that she had died as a result of blunt force trauma to the face. She had multiple fractures; there were also signs of strangulation and evidence of sexual assault. It was confirmed that she was in the early stages of pregnancy.

1.9. Following his arrest Arturo was interviewed and made no comment, other than to confirm that words written on the headboard of Holly's bed were in his writing and they had not been there the previous day, but were present following Holly's death. Translated from Spanish the words read "Die Whore". His blood alcohol reading was over 330 micro grammes of alcohol per 100 millilitres of blood (drink-drive limit is 80). He had consumed alcohol post offence. No drugs were detected, although he later indicated he had taken Ketamine.

1.10. He later pleaded guilty to Holly's murder and was sentenced in accordance with Section 5 Schedule 21 of the Criminal Justice Act 2003, murder involving sexual conduct, and received a sentence of life imprisonment with a tariff of 31 years, which was reduced by five years for the early guilty plea. He will be deported upon his release.

2. The Review Process

2.1. This summary outlines the process undertaken by the Bristol Domestic Homicide Review Panel in reviewing the death of Holly.

2.2. The Domestic Homicide Review (DHR) was recommended and commissioned by the Bristol Community Safety Partnership in line with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011 on 6th June 2014.

2.3. The Home Office was informed of the intention to conduct a DHR on 12th June 2014.

2.4. The process began on the 22nd July 2014 with an initial Review Panel meeting of all agencies that potentially had contact with the victim Holly, perpetrator Arturo prior to the point of Holly's death, and concluded on 14th January 2015.

2.5. Holly's family and Arturo's solicitor were contacted at the start of the Review. Holly's mother said she would be the family contact with the Review and wanted to be involved with the Review. She asked that the Panel consider two particular issues;

a) When Arturo, a Mexican national, overstayed his 6-month visa period, what attempts were made to trace him and send him back to Mexico?

b) What grounds did "Leicester Social Services" have for stopping Holly having joint custody of Michael. Their decision directly influenced Holly's life choices. That is, Holly's mother believes that if "Leicester Social Services" had allowed Holly to have Michael at home, she would not have allowed Arturo to stay at her flat.

2.6. Arturo was interviewed during the Review and confirmed that he had not been in contact with any statutory organisation whilst in the UK, because of his immigration status as an "overstayer". He confirmed that on entry to the UK, at Heathrow Airport, he had been questioned at length about his reasons for visiting the UK. He commented on the thoroughness of the then Border Agency personnel.

2.7. Holly's mother was informed about the specialist support she could receive from the charity, Advocacy After Fatal Domestic Abuse (AAFDA) and a leaflet was left with her. She confirmed she was receiving close support from the police family liaison officer and from the Homicide Support Service; nevertheless she took the opportunity to seek the assistance and support of AAFDA.

2.8. On 11th November 2014 Holly's mother and brothers accompanied by her advocate from AAFDA were informed of the outcome of the Review and given sections of the draft Overview Report relating to lessons learnt, recommendations and conclusions.

2.9. The agencies participating in the Review are:-

- Avon and Somerset Constabulary*
- Avon and Somerset Probation Trust
- Compass Centre*
- Border Force*
- Bristol City Council Safeguarding Adults
- Bristol City Council Children & Young People's Services*
- Bristol City Council Public Health
- Bristol MARAC
- Immigration Enforcement Directorate*
- Leicestershire Police
- Leicester Social Care and Safeguarding Service*
- Mexican Ministry for Foreign Affairs*
- NHS Bristol Clinical Commissioning Group*
- NHS England
- Next Link Domestic Abuse Service
- North Bristol Hospital NHS Trust
- Reeds Solicitors*
- University Hospital Bristol NHS Foundation Trust*
- University Hospitals of Leicester NHS Trust

Those that have completed an Individual Management Review (IMR) or Report are marked above with an *.

2.10. Agencies were asked to give chronological accounts of their contacts with the victim and/or perpetrator prior to the homicide. Where agencies had no involvement or insignificant involvement, they informed the Review accordingly. In line with the Terms of Reference, the DHR has covered in detail the period from December 2012 and the death of Holly on 8th January 2014, as well as events prior to 1st December 2012, which are relevant to violence, domestic abuse or to Holly's custody of her son.

2.11. Of the sixteen agencies contacted about this Review, six responded that they had had no contact with the victim or perpetrator.

2.12. Eight agencies completed either an Independent Management Review (IMR) or a report with information indicating some level of involvement with Holly or Arturo. Additionally two organisations have responded: the Mexican Ministry for Foreign Affairs, has confirmed that Arturo was a Mexican citizen, but was not known to any official body in Mexico; and the Immigration Enforcement Directorate, has stated whilst they had no direct contact with Arturo, they did have a computer record of his entry as a visitor into the UK, on 25th December 2012.

2.12.1. Avon and Somerset Constabulary

The police IMR reviews the few contacts the police had with Holly. In 2011 she was arrested twice for two minor thefts of food and on a third occasion the police were called to a disturbance between Holly and a male friend outside a supermarket in central Bristol. There was a CCTV recording of the incident and the police were satisfied with the couple's explanation that it was no more than a verbal argument.

In August 2013 at the request of Leicestershire Police, a welfare check was made at Holly's address in Bristol after Michael's father made allegations of child neglect by Holly. Michael who was then 16 months old, was at his father's in Leicester at the time. The officer reported back that he had found nothing to concern him at the address.

These incidents were dealt with appropriately and had no bearing on the circumstances surrounding Holly's death.

The Police had only one contact with Arturo, when on 23rd April 2013 a Bristol Police Community Support Officer (PCSO) gave him "advice" about begging and moved him on from the area. This was prior to Arturo's visa period running out. The officer took his details and submitted an intelligence report, in accordance with the police procedures in place at that time.

2.12.2. Home Office - Border Force

On his arrival at Heathrow Airport on 25th December 2012, Arturo was questioned at length about the reasons for his visit to the UK. As Arturo admitted he had not made any definite plans about his stay, merely that he would be looking for hostels to stay in, as he backpacked around the country, the initial Border Agency officer referred the case to a

higher grade officer. After a search of his baggage revealed a guide book, some camping equipment and sufficient money he was eventually allowed leave to enter the UK. All procedures were correctly carried out.

2.12.3. Bristol City Council Children & Young People's Services

In November 2012, Holly, who was five months pregnant and homeless, sought help to secure accommodation, after being placed in emergency accommodation she was allocated a two bedroomed flat in Bristol. In accordance with the Bristol City Council Expected Baby Protocol (2011) a social worker carried out an assessment on Holly prior to the birth of Michael. The social worker did not consider that an ongoing service was required to enable Holly to be able to meet the needs of the unborn child once it was born.
In August 2013 Bristol Children and Young People's service were informed by Leicester Social Care and Safeguarding Service that they were making enquiries into concerns that Holly's 16-month-old son Michael was at risk. However as Michael was then living in Leicester with his father, there was no requirement for Bristol Children and Young People's Service to take any action. They asked to be notified if Michael returned to Holly in Bristol.

2.12.4. Compass Centre

The Compass Centre provides help and support for homeless people in the centre of Bristol, managed by St. Mungo's Broadway.
The Centre had no record of any contact with Holly and the only contact with Arturo was on one occasion when he visited the Centre to find out if there was any help available for him to return to Mexico. He had an appointment to return to the Centre the week after the homicide.

2.12.5. Leicester Social Care and Safeguarding Service

In August 2013 Michael's father took him to a GP practice in Leicester. He explained that he had shared custody of Michael on alternate weeks. He told the GP that Holly had declined to have Michael vaccinated and that he was concerned that he had recurring head lice and had noticed lice in Michael's eyelashes. The GP referred these and other safeguarding issues to the Leicester duty social work team.
Leicestershire Social Services, in liaison with health services and the police, investigated and assessed there were no concerns about the father's care of Michael. It was also assessed that there was no reason why Holly should not have contact with Michael, but that there would be concerns if Michael was returned to her care.

On 25th September 2013 a social worker wrote to Holly and Michael's father, informing them that there would be no further involvement with the family and advising them that they should take independent legal advice regarding custody of Michael. Holly, who had employed a solicitor, contacted a duty social worker on 28th November 2013 asking for information about the social work involvement and access to records which she indicated would assist her in resolving contact issues. Information about access to records was sent to her by post. There was no further contact.

2.12.6. NHS Bristol Clinical Commissioning Group

Arturo had no contacts with any medical service during his time in the UK up until the time of the homicide. Holly's medical history was limited to Michael's birth and later about contraceptive issues.

2.12.7. Reeds Solicitors

Holly sought the professional help of a solicitor to assist her in regaining joint custody of her son, Michael. The solicitors, who have provided the Review with copies of their papers relating to Holly, were unaware of her relationship with Arturo.

2.12.8. University Hospital NHS Trust

When Holly first contacted the Community Midwife Team in November 2011, she was homeless. A Community Midwife assisted in her in making contact with the Bristol Children and Young People's Service where she received help to obtain a flat. Holly had a home birth without complications on 14th April 2012. The last Health Visit was in February 2013 with a 12 month review planned in February 2014.

2.12.9. General information

The information from Holly and Arturo's friends show that Holly made no secret that Arturo was violent to her; yet neither she nor their friends or neighbours considered contacting either the police or any of the support agencies available in the Bristol area for help. The information was only provided to the police during their investigation into Holly's murder.

3. Terms of Reference

3.1. The purpose of the Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

3.2. Overview and Accountability:

3.2.1. The decision for Bristol to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Bristol Community Safety Partnership on the 4th June 2014 and the Home Office informed on 17th June 2014.

3.2.2. The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. In this case, the Review was adjourned until after the conclusion of the criminal proceedings, so that the views of the perpetrator and witnesses could be sought.

3.2.3. This Domestic Homicide Review which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

3.3. The Domestic Homicide Review will consider:

3.3.1. Each agency's involvement with the following from 1st December 2012 until the death of Holly on 8th January 2014, as well as events prior to 1st December 2012, which are relevant to violence, domestic abuse or to Holly's life choices.

a) Holly (pseudonym) 22 years of age at time of her death.
b) Arturo (pseudonym) 27 years of age at date of incident.
c) Holly's son Michael (pseudonym) 2 years of age.

3.3.2. Whether there was any previous history of abusive behaviour towards the deceased or her son and whether this was known to any agencies.

3.3.3. Whether family or friends want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide.

3.3.4. Whether, in relation to the family, friends and neighbours there were any barriers experienced in reporting abuse.

3.3.5. Could improvement in any of the following have led to a different outcome for Holly considering:

a) Communication and information-sharing between services
b) Information-sharing between services with regard to the safeguarding of adults and children.
c) Communication within services.
d) Communication to the general public and non-specialist services about the role of the police and the availability of specialist support services in Bristol.

3.3.6. Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards
b) Domestic Abuse policy, procedures and protocols

3.3.7. The response of the relevant agencies to any referrals relating to Holly concerning domestic abuse or other significant harm from 1st December 2012. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim or perpetrator.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.
d) The quality of any risk assessments undertaken by each agency in respect of Holly, her son or the perpetrator.

3.3.8. Whether thresholds for intervention were appropriately calibrated and applied correctly, in this case.

3.3.9. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

3.3.10. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

3.3.11. Whether any training or awareness-raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

3.3.12. Whether decisions made relating to Holly's access to her son were made in an appropriate manner and in accordance with set polices and practice.

3.3.13. Whether decisions made at the time of the perpetrator's entry into the UK were consistent with the then Border Agency's set procedures and protocols and whether correct procedures were carried out in trying to trace him after he had overstayed his visit to the UK.

3.3.14. The review will consider any other information that is found to be relevant.

4. Key Issues

4.1. The DHR provided an opportunity to analyse information obtained from agencies, the perpetrator, the victim's mother, brothers, friends and neighbours.

4.2. Holly's mother asked the Review to consider issues which have been included in the Review's Terms of Reference and which are detailed in paragraph 2.5 of this summary.

4.3. The Review also considered whether any of the nine protected characteristics of the Equality Act influenced decisions made by organisations in their contacts with either Holly or Arturo. The Review Panel is satisfied that there were no equality issues in the limited contacts agencies had with them, but notes that Arturo, on religious/moral grounds, has said he was deeply upset that Holly was considering an abortion.

4.4. There were no agencies with any knowledge of Holly's relationship with Arturo. The few contacts that organisations had with Holly were in the main historical or in relation to her contact with her son. Arturo's only contact with any statutory body was when he has warned about begging, but this took place prior to his meeting Holly and before his visa ran out.

4.5. The Review is satisfied that Arturo was correctly allowed into the UK, after the proper checks and enquiries had been completed. After Arturo's immigration status had changed when he overstayed his visa period in July 2014, the Immigration Enforcement had no referrals regarding him and as the UK currently does not conduct exit checks of people leaving the country, had no way of knowing he was still in the UK.

Note (Arturo informed the Review that he never made contact with any official body or organisation in the UK as he was an "overstayer" and did not want to be caught.)

4.6. The concerns raised by Michael's father about the quality of care being provided to Michael by Holly were investigated by Leicester Social Care and Safeguarding Service and in September 2013 they wrote to the boy's father and Holly, stating there would be no further involvement with the family. Holly was therefore aware that she was not being prevented from taking steps to re-establish joint custody of Michael. The Review is therefore satisfied that, although there are lessons to be

learnt, the actions of Leicester Social Care and Safeguarding Service are unlikely to have influenced Holly's decision to let Arturo live at her flat.

4.7. The key issues in this Review are that while several of Holly and Arturo's friends and some of her neighbours knew Arturo was being violent to her, no-one, including Holly herself, reported it to the police or sought help from any support service, general or specialist. Since the homicide, several of their friends have admitted they did not think of reporting the abuse as they thought Holly would do so if she wished. None knew about the availability of specialist support services in Bristol or what they do.

5. Effective Practice/Lessons to be learnt

5.1. Only the following agencies that had contacts with Holly or Arturo have identified lessons they have learnt during the Review.

5.2. Avon and Somerset Constabulary

5.2.1. In partnership with all agencies and services, there is a need to work together to raise awareness of domestic abuse and to encourage domestic abuse reporting, particularly third- party reporting.

5.3. Bristol Children's Social Care

5.3.1. The response to the initial contact with Holly in 2011 could have been quicker. Nevertheless relevant professionals were communicated with and an assessment of the unborn child's needs was completed, culminating in Holly being provided with a two-bedroomed flat. A clear and reasonable decision regarding ceasing Social Work involvement was made after this was achieved.

5.3.2. The outcome of the contact in August 2013 between the Social Work assessment Team and Leicester Social Care and Safeguarding Service was appropriate given the issues and concerns raised. The situation clearly placed the child within the care of his father, who was residing in Leicester. Therefore it was appropriate that the concerns raised by the father were addressed.

5.4. Bristol Clinical Commissioning Group

5.4.1. Records indicate that the threshold to trigger a safeguarding children's alert was applied correctly.

5.4.2. Individuals appeared to be dealt with without judgement or discrimination based on their life choices throughout the records.

5.4.3. The records show effective consultation with Safeguarding Specialist Nurses.

5.5. Leicester Social Care and Safeguarding Service

5.5.1. There were aspects of work and assessment undertaken by children's services in Leicester which could have been developed further in order to ensure that Michael's needs were being met.

5.5.2. There were also missed opportunities to identify with Holly, through the process of assessment about her home circumstances, any concerns that she may have had about her relationship with Arturo; although it is questionable whether she would have taken up such opportunities to share any concerns she may have had at this time.

5.5.3. Social work case notes do indicate that Holly was clearly and understandably troubled and upset that Michael was not returning to her care and planned to challenge this through independent legal advice. Again, however, it is difficult to determine what impact Michael's remaining in Leicester or the involvement of children's services in both Leicester and Bristol had on Arturo, or on Holly's relationship with Arturo - for example, whether this resulted in increased stress for either or both of them, thereby increasing tensions in their relationship or acted as a catalyst for abusive behaviour by Arturo.

5.6. University Hospitals Bristol NHS Foundation Trust.

5.6.1. The Community Midwife demonstrated good practice in relation to domestic abuse by discussing this with Holly at booking, and documenting this in notes. Appropriate referrals were made in pregnancy and when Holly did not attend appointments, these were all followed up.

5.6.2. In the Accident and Emergency Department (A & E) of the Bristol Royal Infirmary there is no documentary evidence that when Holly was admitted pregnant and with a head injury she was asked about domestic abuse, or whether this was considered, as would be expected practice. The Accident and Emergency Department did not formally inform the Maternity service of Holly's admission, despite her being 37 weeks pregnant.

5.6.3. The drug liaison midwife assumed Holly had changed Community Midwifery team when she moved house and when sharing the information about her A & E admission just left a message on an answerphone.

5.6.4. The Accident and Emergency department in the Children's Hospital made appropriate safeguarding assessments and shared relevant information with the health visitor and GP.

5.7. All Bristol-based Organisations

5.7.1. There is a general lack of awareness amongst the general public on what they can do if they become aware of incidents of domestic abuse involving other people.

5.7.2. There is a reluctance to contact the police about domestic abuse/violence involving friends or neighbours, this was particularly apparent in this review by people living in rented accommodation, by homeless people and by people in other “hard to reach/hear” groups.

5.7.3. There is widespread fear of being considered to be interfering in someone’s private life if they, as a third party, contact the authorities, support agencies or even by asking the suspected victim if she/he needs help about domestic abuse.

5.7.4. There is a widespread lack of knowledge about the availability of domestic abuse support services and how they are able to assist victims.

6. Conclusions

6.1. In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Holly, her son, and Arturo in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of domestic abuse victims in Bristol in the future?
- Was Holly's death predictable?
- Could Holly's homicide have been prevented?

6.2. The IMRs have been open, honest and thorough. The organisations have used their participation in the Review to consider their policies and practices and where appropriate identify and address lessons learnt from their contacts with Holly in line with the Terms of Reference (ToR).

6.3. The Panel however has recognised that there were very few agency contacts with either Holly or Arturo and none relevant to the homicide. The fact that neither Holly nor any of their friends and neighbours, who were aware of the ongoing abuse, contacted any statutory body or voluntary support agency for help, is highlighted as the key lesson to be addressed by the organisations contributing to this Review.

6.4. The Review Panel is satisfied that the agreed recommendations address the needs identified from the lessons learnt. Provided those recommendations are fully and promptly implemented, they will improve the safety of victims of domestic abuse, but particularly those living in rented accommodation or who are homeless in Bristol in the future.

6.5. The Review Panel, in considering all of the information provided, believes that Holly's death was not predictable. None of her friends or neighbours appeared to consider the dangers and no agency had been informed about Holly's situation.

6.6. Could Holly's death have been prevented? The Review Panel believes that if Holly or any of the people who knew of Arturo's violence to Holly, had informed the Police, Housing or one of the many support agencies of their concerns then positive action may have been taken to stop the abuse. As Arturo was an "over-stayer" in this country, he could have been detained prior to removal to his country of origin, Mexico.

7. Recommendations

7.1. National Recommendations

7.1.1. That the Home Secretary completes the introduction of the exit checks programme in relation to people leaving the UK and that intelligence gathered as a result is passed to Immigration Enforcement to tackle those who overstay their leave.

7.2. Cross-Agency Recommendations

7.2.1. That the Bristol Domestic and Sexual Abuse Strategy Group organizes a domestic abuse awareness campaign focused on third-party reporting from all communities, but particularly from people less able to easily access mainstream services.

7.2.2. All partner agencies of the Bristol Domestic and Sexual Abuse Strategy Group and the DHR Panel will take action to pro-actively raise awareness of domestic and sexual abuse amongst their staff and service users and promote a third party reporting campaign.

7.2.3. The Bristol Domestic and Sexual Abuse Strategy Group will remind agencies of the importance of domestic and sexual abuse training for staff and to offer help in designing training to those organisations.

7.3. Individual Agency Recommendations

7.3.1. Avon and Somerset constabulary

- Force processes need to be examined to ensure that front-line officers are able to accurately identify foreign nationals and conduct relevant checks, and that any intelligence gathered is routinely shared with the Immigration Enforcement Department and other relevant agencies
- That Avon and Somerset Constabulary continues to raise the profile of domestic abuse and encourages all victims, friends, family and neighbours to seek advice and support. Methods of anonymous reporting to be publicised to increase intelligence where members of the public do not wish to come forward directly when they are

aware of domestic abuse. This, in turn, will provide more opportunities for third-party reporting of incidents and intelligence from a wide range of agencies and organisations, including, as an example in this case, abortion clinics and midwifery services

- That where third-party intelligence is captured in respect of potential domestic abuse, that it is disseminated to neighbourhood policing teams and to the Safeguarding Co-ordination Units who will assess and develop a safety plan. Where appropriate, as part of a considered safety plan the relevant information is shared sensitively with immediate neighbours to establish a 'cocoon watch' to look out for the welfare of the victim and immediately report any signs of disturbance. This 'cocoon watch' must be fully briefed and supported by the local policing team to ensure they are familiar with how and whom to report concerns to.

7.3.2. Leicester Social Care and Safeguarding Service

- IMR findings to be cascaded where relevant with Child in Need Service heads of service and service managers, via senior management meetings.
- IMR findings to be cascaded where relevant to Child in Need team managers and social workers, via team meetings or briefing session
- Within this process, the need to seek and evidence decision-making, inter-agency discussion, and third-party or triangulating information (e.g. health information which corroborates or reduces concern about a child) should be reinforced to social work staff. Relevant procedures e.g. Leicester Safeguarding Children's Board (LSCB) procedures should also be highlighted. The need to ensure that an inter-agency perspective is maintained throughout an assessment or intervention should be highlighted.
- Within this process, the importance of completing timely, thorough and holistic social work assessments which take fully into account the overall needs of each child, the overall circumstances of each carer or parent, and any relevant environmental issues or issues for the wider family should be reinforced. In particular, reminders should be offered about promoting and ensuring effective cross-boundary working. Again, relevant procedures e.g. LSCB procedures should be highlighted. Dissemination of IMR findings should comment on the need to ensure that contact or

residence issues or disputes do not falsely obscure or hinder focus on children's day-to-day and safeguarding needs.

- Within this process, reminders should be offered about the importance of ensuring that families are given appropriate information about social work processes, expected timescales for assessment, appropriate contact information and complaints and appeals information.

7.3.3. University Hospitals Bristol NHS Foundation Trust

- Emergency Department (ED) Bristol Royal Infirmary (BRI) Staff to consider domestic violence and safeguarding when patients attend the unit, and take the appropriate action.
- Adult Services to inform Maternity Services of any attendance of a pregnant woman to A and E or any admission to an Adult ward.
- Staff should not leave messages about patients and clinical information on answer phones but speak directly to colleagues or send written information if time allows.

7.3.4. Bristol Clinical Commissioning Group/NHS England

- Bristol NHS Provider services staff should consider asking people attending the service with symptoms or injuries which could indicate domestic or sexual abuse, whether they have been the victim of abuse

Note: Bristol Sexual Health HIT (Health Integration Team) is in the process of considering how to update primary care and specialist sexual health service providers training, to include identifying repeat requests for emergency contraception as a risk indicator for domestic/sexual abuse.

8. Appendix 1 Action Plan

Recommendation	Scope of recommendation ie local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
That the Home Secretary considers the introduction of an exit-checks programme in relation to people leaving the UK	National	The UK Government is committed to introducing exit checks. - The Government defines an “exit check” as a check that satisfies the Government to a reasonable degree that an individual has left the United Kingdom. - By April 2015 the UK will have exit checks on scheduled commercial international air, sea and rail routes. - Introducing exit checks will improve our ability to identify those who have left and, more importantly, those who have failed to leave the UK when they should have done so, and will	Home Office	April 2015 - exit checks on scheduled commercial, international air, sea and rail routes Staff briefing has been issued across the Home Office immigration commands confirming exit checks will go live from 8 April.	April 2015	

		bolster border security				
That the Bristol Domestic and Sexual Abuse Strategy Group organises a domestic abuse awareness campaign focused on third-party reporting from all communities, but particularly from people less able to easily access mainstream services.	Local Cross-Agency	Campaign to be developed alongside partner agencies and disseminated across the city.	Bristol Domestic and Sexual Abuse Strategy Group		Ongoing June 2015	
All partner agencies of the Bristol Domestic and Sexual Abuse Strategy Group and the DHR Panel will take action to pro-actively raise awareness of domestic and sexual abuse amongst their staff and service users and promote a third party reporting campaign.	Local Cross-Agency	Campaign messages and resources to be shared with partner agencies for use with their own staff and service users.	Bristol Domestic and Sexual Abuse Strategy Group		Ongoing June 2015	
The Bristol Domestic and Sexual Abuse Strategy Group will remind agencies of the importance of domestic and sexual abuse training for staff and to offer help in designing training to those organisations.	Local Cross-Agency	Bristol Domestic and Sexual abuse Strategy Group to develop offer for agencies to support development and improvement of training.	Bristol Domestic and Sexual Abuse Strategy Group		Ongoing June 2015	
Emergency Department (ED) Bristol Royal Infirmary (BRI) Staff to consider domestic violence and safeguarding when patients attend the unit.	Local	BRI ED staff to be reminded and it to be highlighted in training the importance of completing documentation and assessing any safeguarding/domestic abuse issues on a patient's	University Hospitals Bristol NHS Foundation Trust		February 2015	

		admission				
Adult Services to inform Maternity Services of any attendance of a pregnant woman to A and E or any admission to an Adult ward.	Local	ED staff to be reminded and it to be highlighted in training	University Hospitals Bristol NHS Foundation Trust		February 15	
Staff should not leave messages about patients and clinical information on answer phones but speak directly to colleagues or send written information if time allows.	Local	Information and good practice to be re iterated via training.	University Hospitals Bristol NHS Foundation Trust		February 2015	
Force processes to be examined to ensure that front-line officers are able to accurately identify foreign nationals and conduct relevant checks, and that any intelligence gathered is routinely shared with HO Immigration and other relevant agencies	Local	ASC to liaise with HO Immigration and Enforcement to establish current or new protocols for information sharing of intelligence relating to foreign nationals New force crime recording system (NICHE) to ensure opportunities to capture nationalities and intelligence relating to foreign nationals	Avon and Somerset Constabulary		November 2014 April 2015	
That Avon and Somerset Constabulary continues to raise the profile of domestic abuse and encourages all victims, friends, family and neighbours to seek advice and support. Methods of anonymous reporting to be	Local	The DA lead for the Constabulary considers all possible methods of raising awareness and encouraging third party reporting including through media opportunities	Avon and Somerset Constabulary		Ongoing	

publicised to increase intelligence where members of the public do not wish to come forward directly when they are aware of domestic abuse. This, in turn, will provide more opportunities for third party reporting of incidents and intelligence from a wide range of agencies and organisations, including as an example in this case, abortion clinics and midwifery services		Local policing teams establish good partnership working with their communities and encourage third party reporting including through Crimestoppers			Ongoing	
That where third party intelligence is captured in respect of potential domestic abuse, that it is disseminated to neighbourhood policing teams and to the Safeguarding Co-ordination Units who will assess and develop a safety plan. Where appropriate, as part of a considered safety plan the relevant information is shared sensitively with immediate neighbours to establish a 'cocoon watch' to look out for the welfare of the victim and immediately report any signs of disturbance. This 'cocoon watch' must be fully briefed and supported by the local policing team to ensure they are familiar with how and who to report concerns to.	Local	Intelligence, SCUs and Integrated Victim Care assess and disseminate relevant safeguarding information to ensure the safety of known victims or potential victims where information is received via third party reporting. This can be achieved through the tasking process under the new force operating model. Intelligence should be shared with the Safeguarding Champions on the local policing teams as soon as possible for awareness and appropriate action including Cocoon watch if relevant Both actions to be implemented	Avon and Somerset Constabulary		July 2015	

		and driven by the force DA lead through the Gold Group				
IMR findings to be cascaded where relevant with Child in Need Service heads of service and service managers, via senior management meetings.	Leicester		Leicester Social Care and Safeguarding Service			
IMR findings to be cascaded where relevant to Child in Need team managers and social workers, via team meetings or briefing session.	Leicester		Leicester Social Care and Safeguarding Service			
Within this process, the need to seek and evidence decision-making, inter-agency discussion, and third-party or triangulating information (e.g. health information which corroborates or reduces concern about a child) should be reinforced to social work staff. Relevant procedures e.g. Leicester Safeguarding Children's Board (LSCB) procedures should also be highlighted. The need to ensure that an inter-agency perspective is maintained throughout an assessment or intervention should be highlighted	Leicester		Leicester Social Care and Safeguarding Service			
Within this process, the importance of completing timely, thorough and	Leicester		Leicester Social Care and			

holistic social work assessments which take fully into account the overall needs of each child, the overall circumstances of each carer or parent, and any relevant environmental issues or issues for the wider family should be reinforced. In particular, reminders should be offered about promoting and ensuring effective cross-boundary working. Again, relevant procedures e.g. LSCB procedures should be highlighted. Dissemination of IMR findings should comment on the need to ensure that contact or residence issues or disputes do not falsely obscure or hinder focus on children's day-to-day and safeguarding needs.			Safeguarding Service			
Within this process, reminders should be offered about the importance of ensuring that families are given appropriate information about social work processes, expected timescales for assessment, appropriate contact information and complaints and appeals information.	Leicester		Leicester Social Care and Safeguarding Service			
Bristol NHS Provider services staff should consider asking people attending the service with	Local	DHR Report to be taken and presented to the Bristol Safeguarding Adult Board	Health – BNSSSG AT NHSE SAB	DHR on Bristol SAB Agenda; Recommendation	March 2015	

symptoms or injuries which could indicate domestic or sexual abuse, whether they have been the victim of abuse		(SAB); Safeguarding Board asked to add this recommendation to their work plan;	Board Member	contained on SAB Work Plan		