Bristol Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death 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 willful 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 Preface

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). 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) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term “domestic abuse” is used in preference to “domestic violence”, as this term has been adopted by Bristol Community Safety Partnership after widespread consultation within the City and County of Bristol.

1.3 The purpose of a DHR is to:

- 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.
- 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 identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.4 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Holly (pseudonym) in Bristol on 8th January 2014 and was initiated by the Chair of the Bristol Community Safety Partnership in compliance with legislation. The Review process follows the Home Office Statutory Guidance.

1.5 The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Holly and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation.

1.6 The Chair of the Review thanks all of the members of the review panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. He is joined by the Review Panel, in thanking Veronica Shorttle for the efficient administration of the DHR.

2 Domestic Homicide Review Panel

David Warren QPM, Home Office Accredited Independent Chair

Linda Davies, Adult Safeguarding, University Hospitals Bristol NHS Foundation Trust

Detective Chief Inspector Simon Wilstead, Avon and Somerset Constabulary

Fiona Tudge, Bristol City Council Children and Young People's Services

Rhiannon Griffiths, Bristol City Council Crime Reduction

Jackie Beavington, Bristol City Council Public Health

Paulette Nuttall, NHS Bristol Clinical Commissioning Group

Kenny Chapman, Home Office, Immigration Enforcement

Carol De Halle, NHS England

Nicola Bowden-Jones, Next Link Domestic Abuse Support Service

Police Senior Investigating Officer:
Detective Inspector Julie Mackay, Avon & Somerset Constabulary

Administrator:
Veronica Shorttle, Bristol City Council

3 Introduction

3.1 This Overview Report of the Domestic Homicide Review examines agency responses and support given to the victim, Holly, an adult resident of Bristol prior to the point of her death on 7th January 2014.

3.2 Bristol is the largest city in the South West of England with a multi-cultural population of approximately 450,000. With the surrounding urban zone there are an estimated 1,100,000 residents. It is the largest centre of culture, employment and education in the region and is home to two Universities. Its prosperity has been linked with the sea since its earliest days, but over the past thirty years, the city centre docks have been regenerated as a centre of heritage and culture and the busy commercial docks have moved to the outskirts of the city, at the mouth of the River Avon. Bristol's economy and prosperity have over the same period developed through the creative media, financial, "high-tech" and aerospace industries, and the introduction of a large science park on its northern edges.

3.3 **Incident Summary:**

3.3.1. Holly (pseudonym) was a single mother of an 18-month-old boy; she was no longer with the boy's father, but was in a relationship with the perpetrator, Arturo (pseudonym), a Mexican national, who was an "over-stayer" in the UK. She allowed him to stay with her in her rented 2 bedroomed flat in Bristol. At the time of her death, her son was with his father in Leicester.

3.3.2. Holly was in the early stages of a pregnancy and the father is believed to be Arturo.

3.3.3. On the 7th January 2014 Holly went to visit a female friend and told her that 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 texted, asking if she was OK.

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

3.3.5. At 10.15am on 8th January, Arturo contacted one of his friends and said he had "hung" (Spanish for strangulation) Holly and at 11.56am he made a 999 call to the police. In that call he stated that his girlfriend was dead and that he had choked her.

3.3.6. The Police attended the flat, Holly was confirmed as dead and a later 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.

3.3.7. 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 they read "Die Whore". His blood alcohol reading was over 330 micro grammes of alcohol per 100 milliliters of blood (drink drive limit is 80mg). He said he had consumed alcohol after the offence. No drugs were detected, although he later indicated he had taken Ketamine.

3.3.8. 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.

3.4 The key purpose for undertaking this Domestic Homicide Review (DHR) is to enable lessons to be learned from Holly's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened and, most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.5 The Review has considered all contact/involvement agencies had with Holly, her son or Arturo from 8th January 2012; it also considers events prior to that date which are relevant to violence, domestic abuse, or Holly's life choices.

3.6 The DHR panel consisted of senior officers, from statutory and non-statutory agencies, listed in section 2 of this report, who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the Panel or any of the Independent Management Report (IMR) authors have had any previous contact with Holly, her son or Arturo.

3.7 Expert advice regarding domestic abuse service delivery in Bristol has been provided to the Panel by the Bristol City Council Crime Reduction Project Officer (Domestic and Sexual Abuse) and Next Link Domestic Abuse Service, which provides domestic abuse services in Bristol. The victim's mother and brothers have been provided with advice and support from Advocacy After Fatal Domestic Abuse (AAFDA) during the Review process.

3.8 The Chair of the Panel, who possesses the qualifications and experience required of an accredited independent DHR Chair, as set out in section 5.10 of the Home Office Multi-Agency Statutory Guidance, is not associated with any of the agencies involved in the Review, has had no dealings with either Holly, her son Michael (pseudonym) or Arturo and is totally independent.

3.9 The agencies participating in this Domestic Homicide Review[1] 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

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

- Bristol MARAC
- Immigration Enforcement Directorate*
- Leicestershire Police
- Leicestershire 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

3.10. During the preparation of this report the DHR Chair has consulted with the victim Holly's mother and brothers and with the perpetrator, Arturo. The perpetrator's family all reside in Mexico and, at the request of Arturo, have not been contacted. Notes of the subsequent conversations are set out in Appendix D of this report. Holly's friends and immediate neighbours were contacted, and their comments are also noted in Appendix D.

3.11. Holly's mother asked the DHR to include a review of the Border Agency (now Border Force) as the family would like to know what enquiries were made to find the perpetrator when he became an "over-stayer" in this country. They would also like "Leicester Social Services" to be included as they think the decision made by the "Social Services" not to let Holly have joint custody of her 18 month old son, adversely affected her life choices and consequently her decision to let the perpetrator stay at her home.

3.12. Holly's mother and two brothers accompanied by their Advocate from AAFDA, attended the final meeting of the review on 14th January 2015, when they were informed of the lessons learnt, recommendations, and conclusions of the Review and what happens next. On behalf of the family, Holly's eldest brother thanked the Panel for their work and the thoroughness of the Review. Holly's mother thanked the panel for inviting her and her sons to the meeting and explained how much comfort she felt from being there and hearing the outcomes.

4 Parallel Reviews

4.1 The Coroner's Inquest has been opened but in view of there being a criminal trial for Holly's murder, it was not continued.

4.2 There were criminal proceedings which have been completed. Arturo was charged with Holly's murder and was found guilty of murder and sentenced to life imprisonment with a tariff to serve not less than 26 years' imprisonment. He will then be deported to Mexico.

5 Timescales

5.1 The decision to undertake a Domestic Homicide Review was taken by the Chair of the Bristol Community Safety Partnership on 6th June 2014 and the Home Office informed on 17th June 2014.

5.2 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. However consideration about commencing a Review was postponed until the 6th June 2014, after the completion of the criminal proceedings. Due to the Christmas and New Year holiday period it was not possible to arrange a final meeting for the Review until 14th January 2015.

6 Confidentiality

6.1 The findings of this Review are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved, for publication, by the Home Office Quality Assurance Panel.

6.2 As recommended within the “Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews” to protect the identity of the deceased, and her family, the following pseudonyms have been used throughout this report.

6.3 The name Holly will be used for the deceased, who was aged 22 years at the time of her death. It was chosen by her mother on behalf of the family. The name Arturo will be used for the perpetrator; it was chosen after discussion with him and with his solicitor.

6.4 The Executive Summary of this report has been carefully redacted, as the Chair of the Bristol Community Safety Partnership will publish it after it has been through the Home Office Quality Assurance process. After it has been considered by the Home Office Quality Assurance Panel, this Overview Report will be fully redacted prior to publication.

6.5 The Review Panel has obtained the deceased’s confidential information (including police and medical records) initially by way of public interest, but on 4th July 2014 Holly’s mother signed an authority for the DHR to access all such confidential documents.

6.6 On 22nd September 2014 the perpetrator signed a consent form for the Review to access his confidential and medical records.

7 Dissemination

7.1 Each of the Panel members (see list at beginning of report), the IMR authors, and Chair and members of the Bristol Community Safety Partnership have received copies of this report. The Report has also been discussed in detail with Holly's mother, brothers and with their advocate from AAFDA. The perpetrator has also been informed of the outcome of the Review through his prison probation officer, who has provided excellent support throughout the Review.

8 The Terms of Reference

8.1. The purpose[2] 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.

8.2. **Overview and Accountability:**

8.2.1. The decision for Bristol to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Bristol Community Safety Partnership on the 6th June 2014 and the Home Office informed on 17th June 2014.

8.2.2. 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.

8.2.3. 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.

8.3. **The Domestic Homicide Review will consider:**

8.3.1. 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.

[2] **Paragraph 3.3 Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews**

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

8.3.3. 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.

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

8.3.5. 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.

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

(a) Professional standards

(b) Domestic Abuse policy, procedures and protocols

8.3.7. 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.

(e) The quality of any risk assessments undertaken by each agency in respect of Holly, her son or the perpetrator**.**

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

8.3.9. 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.

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

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

8.3.12. 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.

8.3.13. 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.

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

9 The schedule of the Domestic Homicide Review Panel meetings is:

- 22nd July 0900-1300 at Princess House, Princess Street, Bristol.
- 30th October 2014 0930-1300 at Princess House, Princess Street, Bristol.
- 14th January 2015 0930-1200 at Princess House, Princess Street, Bristol.

10 Methodology

10.1 This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) of participating agencies;
- The Police Senior Investigating Officer;
- The Criminal Trial and associated press articles;
- Members of the victim's family, friends and three of her neighbours;.
- The perpetrator;
- Discussions during Review Panel meetings.

11 Contributors to the Review

11.1 Whilst there is a statutory duty that bodies including the police, local authority, probation trust and health bodies must participate in a DHR, in this case nineteen organisations have contributed to the Review (listed in Para. 3.9). Eleven have completed Individual Management Reviews (IMRs) or reports. The perpetrator, the victim's family, friends and neighbours have also provided information to the DHR. (See Appendix D).

11.2 Individual Management Review Authors:

Caroline Howard, Avon and Somerset Constabulary

Lisa Hill, Border Force

Nicola Caldecoat, NHS England

Adam Bond, Bristol City Council Children & Young People's Services

David Ingerslev, Compass Centre

Jonathan Watson, Immigration Enforcement Directorate

Jude Atkinson, Leicester Social Care and Safeguarding Service

Michael Clayton, University Hospitals Leicester NHS Trust

Mexican Ministry for Foreign Affairs

James Ferry, Reeds Solicitors

Sarah Windfeld, University Hospitals Bristol NHS Foundation Trust

11.3 Senior Investigating Officer:

Detective Inspector Julie MacKay, Avon and Somerset Constabulary, who briefed the Review Panel about the circumstances of the case.

12 The Facts

12.1 Holly was born in 1991 and was brought up in Christchurch, Dorset in a loving family. Her mother still lives in the family home; her father died two years ago in 2012. She has two older brothers. Holly is described by her mother as a free spirit who would do anything to help others.

12.2 Arturo, a Mexican national, met a 19-year-old English girl backpacking in Mexico in January 2009. Their friendship developed into a relationship over a period of months. On one occasion, during an argument, Arturo grabbed her around her throat with his right hand and squeezed it for about twenty seconds He did not say anything while he was doing this. He then stopped and said sorry. She did not report it to the authorities but left Mexico a few days later and returned to England.

12.3. In approximately 2010 Holly moved to Bristol and stayed in different squats, as she was homeless and had no regular employment. She had a number of short relationships and some of her friends drank too much alcohol and used a variety of illegal drugs, including ketamine. She was arrested on two occasions in 2011, once for refusing to pay for a meal, for which she received a caution, and on the second occasion for shoplifting foodstuff to the value of £4; restorative justice was used in this case.

12.4. Having formed a relationship with someone also living in the squat, in November 2011 Holly, pregnant and homeless, was placed in emergency accommodation. A community midwife, at the University Bristol Hospital Midwife Service, did a full clinical and social assessment of Holly, including asking her whether there was any domestic abuse in her relationship and documenting in her notes that this had been asked.

12.5. On the16th March 2012, when she was 37 weeks pregnant, Holly attended the Accident and Emergency department at the Bristol Royal infirmary accompanied by her then partner. She had reportedly been hit by a cyclist travelling at high speed, and fallen and hit the side of her head. She was assessed and discharged with advice.

12.6. Prior to the birth of her son, Michael, in April 2012, with the help of Bristol City Council's Children and Young People's Service, Holly secured a two-bedroom flat in the Fishponds area of Bristol. She gave birth at home, without complications. 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.

12.7. Michael was seen in the Bristol Children's Hospital in December 2012 with wheezing, a chesty cough and fever. The appropriate safeguarding assessments were made in the Accident and Emergency unit and his GP and Health Visitor made aware of his attendance. It was noted and recorded that Michael had not had any immunisations, at his mother's choice, but that Holly was given advice for him to have them and the Health Visitor was asked to follow up.

12.8. On 25th December 2012 Arturo flew from Mexico to Heathrow on a visitor's visa which could cover a six months' stay. He was questioned at length by Border Force officers, under schedule 2 of the Immigration Act, to determine whether he qualified for leave

to enter the country. He told the officers, he was intending to backpack around the UK for twenty days, before visiting other countries in Europe. He was able to show that he had sufficient funds to do so and he was allowed entry.

12.9. He met with the English girl whom he had previously known in Mexico (see paragraph 12.2) and stayed with her for a short time in a hotel in London. After this, she returned to her home in Oxford and he went travelling. They kept in touch through Facebook and he told her that he was living in hostels in Bristol. He said he was drinking again and had tried ketamine, the drug of choice of people he had become friendly with in Bristol (he had previously told her in Mexico that he had had an alcohol and drugs problem and had been in “Rehab”). She visited him once in Bristol in February 2013, staying with him for one night in a hotel; on that occasion he was not violent, although they argued. She never saw him again but she spoke to him once on the telephone.

12.10. On the 23rd March 2013 a Police Community Support Officer (PCSO) found Arturo begging in the “Bear Pit” a pedestrian area in the centre of Bristol, which is popular with people who are homeless and/or have alcohol and/or drug problems. The officer gave him advice about begging in a public place and moved him on, after correctly recording his details.

12.11. Arturo stayed on in Bristol and by the end of June 2013 had overstayed his visa period. He did not sign on with any GP practice, nor did he claim any benefits.

12.12. In June 2013 Michael was taken to Accident and Emergency Department at the Bristol Children’s Hospital by Holly, after being seen in the Bristol “Walk in” Medical Centre by a nurse. He had fallen out of his high chair and hit his chin and had bruising and swelling to his chin. In the Accident and Emergency department, safeguarding assessments were made. Michael was noted to be happy and interacting with his mother, so there were no triggers to suggest anything other than an accidental injury.

12.13. In around June/July 2013 Holly met Arturo in the “Bear Pit” and by September 2013 she had invited him to stay at her flat; this was not unusual for Holly, nor did it indicate any commitment by her, as she was known to allow homeless people to stay on occasions.

12.14. In August 2013 Michael’s father, who was living with his new partner, took Michael to a GP practice in Leicester. He explained he was worried because Holly refused to allow the child any vaccines, and every time he collected Michael, he had something wrong with him: too small clothing and recurring head lice. He thought the child was at risk. The GP raised a safeguarding alert and Leicester Social Care and Safeguarding Service were informed. A section 17 (child in need) investigation commenced. Holly was informed and Michael’s father kept him in Leicester, telling Holly that Michael had been placed in his care and he had been told by a social worker not to return Michael to her. This was later found to be untrue.

12.15. On Monday 30th August 2013, after a period of two and a half months, Michael’s father did allow Holly a supervised visit with Michael at the “Surestart" Centre in Leicester. Holly was extremely upset that she could not have access to Michael and she sought the help of a solicitor.

12.16. By the beginning of September 2013 Arturo was staying at Holly’s flat on a regular basis and they had started a relationship, although according to Holly’s friends, “He was more into it than her”. Holly never saw it as long-term.

12.17. There were no agencies involved with them until November 2013 when Holly attended the Broadmead Medical Centre in Bristol for the morning-after pill. It was also about this time that a neighbour recalled hearing a loud argument from Holly's flat. The next day, that neighbour told another neighbour, who she knew was on speaking terms with Holly, what she had heard. That woman then called on Holly to check if she was OK and later described her as having red eyes and bruising on her neck area. Holly refused to elaborate other than to say something had happened the night before.

12.18. Friends of both Holly and Arturo claimed the relationship was deteriorating towards the end of 2013. On1st December 2013 a male friend staying overnight at Holly's flat overheard Holly and Arturo having sex and thought it turned violent. When he asked Holly the next day if she was OK, she said she was fine. Later Arturo told him, Holly did not want to be with him anymore and she wanted him to leave. The same night, a female friend staying at the flat said she heard Holly and Arturo arguing in the bedroom just after midnight. There was a loud thud and Holly made a wailing sound. When the friend went to the bedroom, Holly was crying, but said she was fine. The friend challenged Arturo and he said he had pushed her and she had hit the socket on the wall. Later, the friend saw a large purple bruise on Holly's right hip.

12.19. On 9th December 2013 Arturo told a female friend that he did not think things were working out with Holly and he was thinking of handing himself in to the authorities, in order to return to Mexico.

12. 20. Holly returned home to Dorset for Christmas with her mother, leaving Arturo at the flat. It was during the Christmas period that Holly disclosed to friends in Dorset, that she was pregnant and discussed the fact she was considering an abortion, although Arturo wanted her to keep the child. She told them Arturo was aggressive during sex and that he had "power trip", throwing her around the room and biting her often on the rear of her neck. She showed one male friend the back of her neck which was reddening. She confided to one female friend on 13th December 2013, that Arturo would rape her when drunk, take her money to buy alcohol and would not leave her flat.

12.21. On 1st January 2014 Holly asked Arturo to leave her flat as the relationship was over. On 3rd January 2014 she asked a male friend to search for an abortion clinic in Bristol, as she did not have access to the internet without Arturo being present.

12.22. The next day, the 4th January 2014, Holly made a telephone appointment with a clinic to discuss terminating the pregnancy. The telephone appointment was arranged for 10.15am on 8th January 2014.

12.23. On Monday 6th January 2014 Holly told a friend that Arturo had stolen £70 from her wallet. A friend of Arturo said Arturo claimed he had taken £20 from Holly's wallet to buy beer and get drunk. This resulted in a loud argument at the flat, during which Holly's mobile phone was broken. Holly was heard shouting that he was violent and selfish. She took Arturo's mobile phone and he obtained another phone from a friend.

!2.24. On 7th January 2014 Arturo went to the "Bear Pit" where he met friends and commenced drinking. He went with one friend to the Compass Centre to ask for information about returning to Mexico. He told the friend about the argument the previous day, and said he knew the relationship with Holly was over. Later Arturo went with his friends to a party, where a large quantity of alcohol was consumed. During this time he sent a number

of abusive texts to Holly. He eventually left the party and returned to Holly's flat at about 10.30pm.

12.25. While Arturo was at the party, Holly had gone to a female friend's flat together with another friend. While her friends drank, she was not drinking much. She discussed with them the failing relationship, and that she intended to ask Arturo to leave her flat the following day. She received a number of abusive text messages from Arturo in which he called her a whore and a baby killer. Her friend asked her to stay the night, but she declined, saying it was her flat and she would sort it out. She told her friends she thought he was mental or crazy. She returned home about 12.30am and her last communication was texts from two of her friends asking if she was OK, at about 3.20am.

12.26. Arturo was known to have left Holly's flat at about 2.30am, it is believed to purchase more alcohol, although this was never confirmed. He returned just before 3am, and at about 6am a neighbour described hearing a loud bang.

12.27. Arturo contacted one of his friends by telephone at about 10.30am on 8th January 2014 and said that he had "hung" (Spanish for strangulation) Holly. The friends went to the flat at noon, which was when the police arrived, responding to a 999 call from Arturo, that his girlfriend was dead and that he had choked her.

12.28. Holly was confirmed as dead and a postmortem 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.

12.29. Following his arrest Arturo was interviewed by the police and made no comment except to confirm that words written on the headboard were in his writing and they had not been there the previous evening, but were present following Holly's death. Translated from Spanish they read "Die Whore". Arturo's blood alcohol reading was over 330 micro grammes of alcohol per 100 milliliters of blood, (The drink drive limit is 80). No drugs were detected, although he later indicated he had taken Ketamine.

12.30. Arturo pleaded guilty and was sentenced in accordance with Section 5 of the Criminal Justice Act 2003, (murder involving sexual conduct). He received a tariff of 31 years' imprisonment, which was reduced by 5 years to reflect his early guilty plea. He will be deported upon his release.

12. 31. A full chronology of agencies' contacts with Holly, her son Michael and Arturo is set out in full in Appendix E of this report.

13 Overview

13.1 The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that every aspect of the review has been conducted in a thorough and accurate manner in line with the Terms of Reference.

13.2 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010, i.e. age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation. In line with the Terms of Reference all of the IMRs detail how these were considered. The fact that Holly was pregnant by the perpetrator and had told him she was considering an abortion was identified as a motivating factor in her murder. Arturo said he considered an abortion to be the murder of the unborn baby. There is nothing to indicate that Holly's views on abortion had any bearing on the way she was treated by the agencies with whom she had any contact.

13.3 Agencies completing IMRs or reports were asked to give chronological accounts of their contact with Holly or Arturo, prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference, the DHR has covered the period from 1st January 2010 to 20th July 2013 with relevant information prior to the 1st January 2010 being included. The recommendations of individual agencies to address lessons learnt are listed in section 17 of this report and their action plans to implement those recommendations are catalogued in Appendix C.

13.4 Holly's mother when consulted about the Review stated she wanted to be involved with the Review and would like the Panel to 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 initially under the supervision of a social worker, she would have stopped taking in homeless people and would not have allowed Arturo to stay at her flat.

13.5 Nineteen agencies / multi-agency partnerships were contacted about this review. Eight have responded as having had no relevant contact with Holly, Arturo or Michael. They are:

- The then Avon and Somerset Probation Trust
- Bristol City Council Safeguarding Adults
- Bristol City Council Public Health
- Bristol MARAC
- Leicestershire Police
- NHS England

- Next Link Domestic Abuse Service
- North Bristol Hospital NHS Trust

13.6 Two organisations have had no direct contact with Arturo but have provided reports relating to him:

13.6.1 **Home Office – Immigration Enforcement**
Immigration Enforcement is a law enforcement command within the Home Office. It is responsible for preventing abuse, tracking immigration offenders and increasing compliance with immigration law. It works with partners such as the police to regulate migration in line with government policy, while supporting economic growth. They are an intelligence-led organisation. They were able to report that they held a record of Arturo's entry but none regarding him leaving the country. There were no records of any information concerning Arturo being received by Immigration Enforcement. There is no system currently in the place to record people exiting the country. This has now been explained to Holly's mother and brothers.

13.6.2. **Mexican Ministry for Foreign Affairs**

The Review received a report confirming that Arturo was a Mexican citizen, but that there were no records of him having any convictions in Mexico.

13.7 Nine agencies have had contacts with Holly or Arturo. They are:

13.7.1 **Avon and Somerset Constabulary.**

The police IMR indicates that there had been only limited contact with Holly, when in 2011 she was arrested for two minor thefts of food, and in August 2013 when, on behalf of Leicestershire Police, they did a check on Holly's home conditions. They reported that whilst the flat was untidy there were no safeguarding concerns to prevent her having custody of her son. These contacts were dealt with appropriately and had no bearing on the circumstances surrounding her death. The Police had had only one contact with Arturo prior to the homicide, when in March 2013 he was warned about begging in the "Bear Pit" in Bristol, by a PCSO, who recorded the incident correctly in line with the Force policy.

13.7.2 **Home Office - Border Force**

Border Force is a law enforcement command within the Home Office. They secure the UK border by carrying out immigration and customs controls for people and goods entering the UK. As detailed in paragraph 12.7 of this report Arturo was questioned at length about the reasons for his intended visit to the UK. As Arturo admitted he had not made any definite plans about his stay, merely that he would be looking for a hostel to stay in as he backpacked around the country, the initial Border Force officer referred the case to a higher

grade officer. After a search of his baggage revealed a guide book, some camping equipment and money he was eventually allowed leave to enter the UK.

13.7.3. **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.

13.7.4. **Compass Centre**

The Compass Centre is a centre providing 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 he visited the Centre to find out if there was any funding available for him to return to Mexico. He had an appointment to return to the Centre the week after the homicide.

(Arturo informed the DHR Chair that he never made contact with any other body or organisation in the UK as he was afraid as he was an "overstayer").

13.7.5. **Leicester Social Care and Safeguarding Service**

In August 2013 Michael's father took Michael, who was then 16 months old, to a GP practice in Leicester. He explained that he had shared access to Michael on alternative weeks. He told the GP that Michael's mother had declined to have Michael vaccinated and that he was concerned that Michael had recurring head lice and he had noticed lice in Michael's eyelashes. The GP contacted Leicester out-of-hours social work service, with the following safeguarding issues to reflect the father's concerns:

a) "Recurring nits and head lice since 3-4 wks; Mother not treated them? On the eyelids? Sexual abuse?

b) Child still wears 6 months' clothes even though he is 16 month

c) Losing weight

d) No childhood vaccinations by Mother (she refused)

e). Clingy to Dad when dropping at Mother's place, refusing to be at Mother's

f) Lots of people at house/couple/ 2 kids/ adults moving in and out according to dad

g) Had a fall from a kitchen platform, and sustained injury to mouth and teeth - she stated she took him to the GP clinic - 2 days later: *(Note This appears to refer to the incident in June 2013 when both Holly and a man, presumed to be Michael's father, took him to the Broadmead Walk- in Centre and then to the Bristol Children's Hospital)*

h) Does not take him to the clinic when he is ill"

Over a five week period social workers assessed and tried to verify those concerns. It was confirmed that Michael had lice, which were removed under anaesthetic. It was assessed there were no concerns over Michael's care whilst he was with his father, but that there would be concerns if he returned to his mother's care, although there was no reason she could not have contact with him.

On 25th September 2013 a letter was sent to Michael's father and to Holly informing them that there would be no further involvement with the family and that they should seek their own legal advice regarding Michael's custody.

Michael's father had allegedly misinformed Holly that it was Leicester Social Care that had made the decision that she could not have Michael home. Holly's solicitor was in the process of arranging mediation, as a first step to Holly regaining joint custody of Michael, at the time of Holly's death.

13.7.6. **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 has been considered in detail within the IMR. Holly favoured going to the Broadmead Walk-in Centre in central Bristol rather than to a GP surgery; however in August 2012 she attended a GP practice near her home for a post-natal eight-week check-up after the birth of Michael. There were no problems reported.

In June 2013 Holly took Michael to the Broadmead Walk-in Centre after he had fallen out of his chair and hurt his chin. The Centre referred him to A & E at the Bristol Children's Hospital. Michael's injury was properly treated and a safeguarding assessment was completed. It was noted that Michael was happy and interacting well with his mother. There were no triggers to suggest anything other than an accidental injury. A note of this was faxed to Holly's GP.

Holly's other visits to the GP and the Walk-in Centre were focused on contraceptive issues, the last being on 26th November 2013.

13.7.7. **Reeds Solicitors**

When Michael's father refused to return Michael to Holly and made allegations relating to safeguarding issues, Holly sought the professional help of a solicitor. The firm has provided the Review with a copy of all of their correspondence relating to Holly. Those documents clearly show that Leicester Social Care and Safeguarding Service wrote to Michael's father, with a copy to Holly, informing them that Leicester Social Care would have no further involvement with the family and recommended that they sought individual legal

advice to resolve Michael's custody issues. They also show that while the solicitor tried to arrange mediation meetings, Michael's father had moved house and had refused to give Holly his new address (as he said he was afraid Holly might try to snatch Michael from him). Holly employed a private enquiry agent to trace the father's address. 7th January 2014 was a date set aside for a mediation meeting in Leicester, but Michael's father did not agree to the meeting.

13.7.8. **University Hospital Bristol NHS Foundation Trust**

When Holly first contacted the Hospital's Community Midwife Service in November 2011 she was homeless and had been using illegal drugs. Holly engaged with the service and stayed off drugs in her pregnancy. She was allocated a social worker and helped to obtain a flat. Holly had a home birth without complications on 14th April 2012.

13.7.9. **University Hospitals Leicester NHS Trust**

In August 2013 a safeguarding referral of Michael was made to the hospital regarding a lice infestation. Leicester Social Care was the lead agency and after a review of the safeguarding notes and medical records the hospital was able to confirm that the referral to them and the subsequent treatment of Michael was in accordance with set procedures.

13.8. **General information**

The information from Holly and Arturo's friends which is set out in paragraphs 12.15 to 12.25 shows that Holly was open with her friends 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. The information was only provided to the police during their investigation into Holly's murder.

14 Analysis

14.1. The Panel has considered the individual management reports carefully through the view point of Holly, to ascertain if each of the agencies' contacts was appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel has deliberated whether the lessons have been identified and properly actioned.

14.2. The authors of the IMRs have followed the Review's Terms of Reference carefully and addressed all of the points within it. They have each been honest, thorough and transparent in completing their reviews and reports. The following is the Review Panel's opinion on the appropriateness of each of the agencies interventions.

14.3. **Avon and Somerset Constabulary**
The police had two contacts with Holly in 2011. Neither had any relevance to the circumstances her death and both were dealt with in the correct manner. They had one contact with Arturo, when in March 2013 he was moved on by a PCSO for begging in the "Bear Pit" area of Bristol. The officer acted properly and completed the relevant paperwork in accordance with Force policies and procedures.

The Review Panel accepts that the limited police contacts were correct in accordance with force policy and procedures. The Panel also welcomes the identified lesson to be learnt and recommendation made, relating to the absence of any of the many people, who knew Arturo was assaulting Holly, reporting the matter to the police or any other official body.

14.4. **Border Force**
The Border Force IMR and Chronology indicate the thoroughness of the enquiries made prior to allowing Arturo leave to enter the UK when he arrived at Heathrow Airport on 25th December 2012. There were no lessons learnt.

The Review Panel is satisfied that the Border Force personnel who had contact with Arturo acted in accordance with existing policy and procedures in allowing him to enter the UK on a visitor's visa. The Panel was particularly impressed with the vigilance and tenacity of the first officer who came into contact with him.

14.5. **Bristol City Council Children & Young People's Services**

The Bristol Children & Young People's Service IMR shows only two contacts with Holly.

The first was after Holly contacted the Emergency Duty Team (EDT) in November 2011 when she was 5 months pregnant and homeless. While she was assisted in obtaining accommodation, the Social work department at the maternity hospital was informed in accordance with the Bristol City Council Expected Baby Protocol (2011). This was Holly's first pregnancy and vulnerabilities had been highlighted in relation to accommodation and substance misuse. A Social worker was allocated to undertake an assessment. Whilst the decision on allocation was made within the required timescale of 24 hours, the action of allocating the case was delayed by two weeks. An initial assessment was undertaken focusing on the unborn baby's needs and the mother's ability and circumstances in meeting those needs. The outcome of the assessment was for No further Action to be taken.

The second contact related to a notification from Leicester Social Care and Safeguarding Service that there were safeguarding issues being investigated, in Leicester, relating to Holly's son. As Michael was then in Leicester with his father, no action was required by Bristol.

The Review Panel is satisfied that Bristol City Council Children & Young People's Services carried out their responsibilities in accordance with their procedures. The Panel acknowledges that the IMR author has included as a lesson learnt, that there was a short delay in Holly being assessed prior to the birth of Michael, but accepts that this is not unusual in the case of referrals relating to unborn babies and as it was completed well before Michael's birth there are no appropriate recommendations to be made.

14.6. **Compass Centre**

The only contact known by the Centre was that Arturo had called at the Centre on 7th January 2014 to make an appointment to receive advice regarding finances.

The Review Panel thanks the Compass Centre for their response and accepts there are no lessons to be learnt.

14.7. **NHS Bristol Clinical Commissioning Group**

The IMR reveals that Arturo never accessed medical services whilst he was in the UK. Holly's few contacts with the GP and the Broadmead Walk-in Centre about her own health and welfare were about issues not relevant to her homicide. Possible opportunities to enquire about domestic abuse were identified by the Review when Holly attended primary care services seeking emergency contraception. Holly and Arturo met in July/ August 2013. Holly sought emergency contraception on the 14th, 17th, 28th August 2013 and 26th November 2013 at different primary care services (having never done so before, during the scope of the Review). From the Police investigation we know that Holly disclosed to friends that Arturo would rape her. It is therefore reasonable to conclude that Arturo's sexual violence against her was also unprotected sex.

The Review panel is satisfied that the GP practice dealt with Holly properly in accordance with accepted policy and procedures.
With the benefit of hindsight, the Panel questions whether in light of research which shows that genitourinary medicine services are opportune points of intervention for women affected by domestic violence (http://www.caada.org.uk/policy/bacchus-et-al-2007-full-report-mozaic.pdf), there was an opportunity to ask Holly if she was the subject of domestic abuse, when she repeatedly sought emergency contraception in 2013.

14.8. **Immigration Enforcement Directorate**

The Immigration Enforcement Directorate is an intelligence-led organisation that is responsible for locating and dealing with anyone who is in the UK illegally. The Directorate has provided the Review with a report confirming that Arturo had overstayed the six-month period set out in his visa and therefore remained in the UK illegally. Currently there are no

exit checks made of people leaving the UK, therefore the Directorate would not know if someone has overstayed unless they are provided with that information from another body.

The Review Panel accepts that as there are currently no exit checks made of people leaving the UK, it would not have been possible for the Immigration Enforcement directorate to have known that Arturo had not left the country, unless he had come to the attention of the police or any other statutory organisation after the period allowed on his entry. The Panel thanks the Home Office for the introduction of exit checks from 1st April 2015.

14.9. **Leicester Social Care and Safeguarding Service**
The IMR Author has carefully reviewed the involvement of Social Care and Safeguarding Services with Holly, Michael and with Michael's father. The information available about events that took place, and decisions that were made, during the period of involvement highlights a number of areas where

- assessments were not completed or completed in a timely way
- there was a lack of evidenced interagency information sharing
- the process of decision making was not fully explained or recorded.

Michael was initially presented to the GP by his father who at that time and during subsequent discussions expressed a range of concerns about the care provided to him by Holly. These included concerns about

- poor overall hygiene and presentation,
- lice, including pubic lice
- safety and supervision in the home
- lack of appropriate medical attention
- potential risks posed by visitors and friends at Holly's home
- possible weight loss

Some of these concerns were addressed during the process of assessment. For example, liaison took place with health agencies and police about the concerns about pubic lice and discussion also took place about this with both parents. There was also some discussion with Holly about the potential risks posed by visitors and friends to her home and about concerns that she may not always seek medical attention for Michael appropriately.

However, these concerns could have been addressed more fully in order to develop a comprehensive assessment of Michael's needs, his parents' needs and his wider family's needs.

Michael's needs:

- Information provided by Holly - e.g. about her attendance at health services in Bristol with Michael – was not verified through liaison with the GP or health visitor there.

- Information from health services in Leicester, i.e. about how Michael may have contracted pubic lice, appears contradictory. There is no evidence within children's services records of conclusive medical opinion about whether these were or were not pubic lice or how they could have been contracted, although there are several references to information being requested from or offered by health agencies.

- Although the police were evidently involved in strategy discussions at an early stage of children's services involvement and before it was confirmed that Michael had pubic lice, there is no evidence that they were notified subsequently when this was confirmed and they do not appear to have been involved in any further enquiries or assessment.

- Holly herself offered the suggestion that Michael could have contracted pubic lice whilst in his father's care; this does not appear to have been explored with Michael's father, although given that he had been having care of Michael on alternate weeks this is not an impossibility. No visits were made to Michael's father's home to assess home conditions or hygiene there. There was no assessment or exploration of his relationship with the father's partner, whereas Holly was clearly spoken to over the phone in her first contact with a social worker, about her intimate relationship with her partner and the possibility that he may have pubic lice.

- Although the health visitor spoke of plans to visit Michael's father and Michael, there is no evidence of feedback from the health visitor as to whether this visit took place or about whether she had any ongoing concerns about Michael's hygiene while in his father's care or about Michael's health or development overall. It is not clear whether the health visitor was made aware of the father's expressed concerns about Michael's weight loss or whether she had concerns about this herself and how, if so, she addressed these. It is also not clear whether the health visitor was made aware that Michael had had an operation under anaesthetic to remove the lice and there is no evidence in children's services records as to the impact of this operation on Michael or the father's care of Michael.

- As noted no visits were undertaken to Michael's father's family home to assess conditions there and there appears to have been little assessment of his overall circumstances: for example, relationships, lifestyle and his overall ability to care for Michael and meet his needs. Michael's father said that he did not want any further support, although he had recently assumed full-time care of Michael and said that he planned to care for him permanently. He was therefore not signposted or referred to support services e.g. local children's centre. However Michael's father later complained about lack of proactive involvement by social workers and may in fact have benefitted from further support from agencies.

- Cross-boundary issues and the geographical distance between the two Local Authorities involved appear to have been complicating factors within the assessment process: there was a clear intention on Michael's father's part for Michael to remain in Leicester, therefore beyond a "safe and well check" reported to have been undertaken by children's services in Bristol, and telephone discussions with Holly undertaken by children's services in Leicester, a more holistic assessment of Michael and Holly's circumstances in Bristol was not developed.

In terms of parental needs:

- Further exploration with Holly and Michael's father about their past relationship, any violence or control or the possibility that Michael could be being "used" in their adult disputes could have been undertaken. Evidently Holly and Michael's father were having discussions with each other outside of their discussions with social workers and Holly was presenting as receiving very different messages from him about contact with Michael, from those received by the social worker. For example, she is referred to as

commenting that Michael's father was "refusing" to allow her to have contact with Michael although he had commented that he was willing to allow safe contact between them and did not want to prevent Holly from seeing Michael. Exploration of these issues at this time may possibly have resulted in an opportunity for Holly to disclose any concerns that she may have had about her relationships overall and her relationship with Arturo in particular, and thus to be signposted towards appropriate help and support.

- Holly and Michael's father between them experienced contact with 4 different social workers and there seems to have been a lack of clarity about who was dealing with their family and how this was communicated to them. This may have made it difficult for Holly in particular to share any concerns that she may have had, had she wished to do so, about Michael, his father's care of him, or her own circumstances.

In term of the needs of wider family and environmental factors:

- There is no explicit discussion evidenced in social work notes of the impact of culture, identity and heritage on the family.

- Although Michael's father referred to Holly's limited support networks in Bristol and to having had some contact with her mother, there was no discussion or contact with wider family.

Overall, there is a clear conclusion within the social work assessment that Michael's father was a "protective" parent for Michael and that there were potential concerns about Holly's care of Michael. However, this is based on limited evidence: limited direct discussion with Holly and Michael's father, limited observation of Michael and limited information from other agencies. There was no liaison with wider family. There appears to have been a loss of focus within the assessment on the need to verify and quantify the range of concerns raised by the father, in addition to his concern about pubic lice, and on the need to ensure that Michael's overall needs were being met. Rather, there is evidence of a developing, more dominant focus on the need for parents to resolve contact and residence issues through independent legal advice and without intervention from statutory agencies.

The Review Panel commends the IMR Author for conducting a thorough and open review which contains such a clear analysis and explicit lessons that must be learnt from this case. The Panel is satisfied that the recommendations made will ensure that those lessons are properly addressed.

14.10. **Mexican Ministry for Foreign Affairs**

As a suggestion was made by the English girl Arturo had met in Mexico that he did not always use his correct name when she was with him, the Review requested a check with the Mexican authorities on whether Arturo was known in his correct name or by any variation. The Mexican Ministry for Foreign Affairs responded with a report confirming that no one with that name or a variation had any convictions in Mexico.

The Review Panel accepts the response provided. Arturo also told the Review he had never been in any trouble in Mexico.

14.11. **Reeds Solicitors**

Reeds Solicitors has provided the Review with the complete set of papers detailing the company's contacts with Holly in relation to the custody of her son Michael.

The Review Panel thanks Reeds Solicitors for their assistance and is satisfied that Holly was being provided with the correct level of legal support. Holly never discussed with the firm any information relating to domestic abuse.

14.12. **University Hospitals Bristol NHS Foundation Trust**

On 16th November 2011, in accordance with expected practice, the Community midwife did a full clinical and social assessment of Holly, including asking her whether there was any domestic abuse in her relationship and documenting in her notes that this had been asked. The midwife also found out from Holly that she and her partner were homeless and had taken drugs in the past. With Holly's consent, she made referrals to the Children and Young Person's Services, so that Holly would receive housing assistance and to the Consultant Obstetric drug clinic, to enable Holly to stay off illegal drugs during her pregnancy.

The Review Panel thanks the IMR author for the thoroughness of her report, which includes lessons to be learnt and recommendations for actions to address them, even though it focused on events not totally relevant to the homicide.

14.13. University Hospitals Leicester NHS Trust

In August 2013 Michael was referred to the hospital for treatment of a lice infestation. A full review was conducted and safeguarding notes and medical records confirm his treatment was in accordance with accepted practice.

The Review Panel with the thoroughness of the internal review and accept there are no lessons to learn or recommendations to be made.

15. Effective Practice/Lessons to be learnt

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

15.2. **Avon and Somerset Constabulary**

15.2.1. In partnership 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.

15.3. **Bristol City Council Children & Young People's Services**

15.3.1. 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.

15.3.2. 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.

15.4 **Bristol Clinical Commissioning Group**

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

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

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

15.5. **Leicester Social Care and Safeguarding Service**

15.5.1. 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.

15.5.2. 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.

15.6.3. 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.

15.7 **University Hospitals Bristol NHS Foundation Trust**

15.7.1. 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.

15.7.2. 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 that 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.

15.7.3. 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.

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

15.8 **All Bristol-based Organisations**

15.8.1. 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.

15.8.2. 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.

15.8.3. 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.

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

16. Conclusions

16.1. 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?

16.2. 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).

16.3. 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.

16.4. 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.

16.5. 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.

16.6. 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 "overstayer" in this country, he could have been detained prior to removal to his country of origin, Mexico.

17. Recommendations

17.1. **National Recommendations**

17.1.1. 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.

17.2. **Cross-Agency Recommendations**

17.2.1 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.

17.2.2 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.

17.2.3 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.

17.3 **Individual Agency Recommendations**

17.3.1. **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.

17.2.2. **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.

17.2.3. **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.

17.2.4 **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.

18. Postscript

Action to be taken after presentation of the Overview Report to the Bristol Community Safety Partnership.

On receiving the Overview Report and supporting documents, the Partnership should:

- Agree the content of the Overview Report and Executive Summary for publication, ensuring that they are fully anonymised, apart from including the names of the Review Panel Chair and members.
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate and in line with Home Office Guidance.
- Sign off the Overview Report and supporting documents.
- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@homeoffice.gsi.gov.uk.
- The document should not be published until clearance has been received from the Home Office Quality Assurance Group.

On receiving clearance from the Home Office Quality Assurance Group, the CSP should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency.
- Provide an electronic copy of the Overview Report (this must first by carefully redacted) and Executive Summary on the Safer Bristol Community Safety Partnership webpage.
- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan.
- Formally conclude the review when the Action Plan has been implemented and include an audit process.

Appendix A - Glossary

Abbreviation	Explanation
DASH	Domestic Abuse Stalking and Harassment Risk Assessment model
IDVA	Independent Domestic Violence Advocate.
MARAC	Multi Agency Risk Assessment Conference
PCSO	Police Community Support Officer
ED	Emergency Department

Appendix B Bibliography

CAADA Responding to Domestic Abuse: Guidance for General Practice.

Care Act 2014

Delivering a Standard Operating Model for Investigating Mental Health Homicides for NHS Services in England. (NHS England 2014)

Department of Health Care and Support Statutory Guidance

Domestic Homicide Review Toolkit.

Domestic Violence, Crime and Victims Act 2004.

Equalities Act 2010

Guidance to doctors & GPs on the release of medical records into a Domestic Homicide Review. Sheffield Safer & Sustainable Community Partnership.

HM Government Information Sharing: Guidance for practitioners and managers.

Nice Guidance on “Domestic Violence and Abuse: How Health Services Social Care and the Organisations they work with can respond effectively”. (February 2014)

Safer Bristol:- Information-Sharing Protocol For Assessing and Protecting Victims Of Domestic and Sexual Violence and Abuse (April 2011)

Safer Bristol: Violence and Abuse: a strategy against violence and abuse against women and girls and domestic and sexual violence against men 2012 - 2015

The Revised Multi-Agency Guidance on the Conduct of Domestic Homicide Reviews. (Home Office 2013).

Appendix C 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 bolster border security	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	
That the Bristol Domestic and Sexual Abuse Strategy Group organises a domestic abuse awareness campaign focused on third-party reporting from all communities, but	Cross-Agency	Campaign to be developed alongside partner agencies and disseminated across the city.	Bristol Domestic and Sexual Abuse Strategy		Ongoing June 2015	

particularly from people less able to easily access mainstream services.			Group			
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.	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.	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 admission	University Hospitals Bristol NHS Foundation Trust		February 2015	
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 infor-	Local	Information and good practice to be re iterated via training.	University Hospitals		February 2015	

mation on answer phones but speak directly to colleagues or send written information if time allows.			Bristol NHS Foundation Trust			
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 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 organisa-	Local	The DA lead for the Constabulary considers all possible methods of raising awareness and encouraging third party reporting including through media opportunities Local policing teams establish good partnership working with their communities and encourage third party reporting including through Crimestoppers	Avon and Somerset Constabulary		Ongoing Ongoing	

tions, 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 Coordination 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 and driven by the force DA lead through the Gold Group	Avon and Somerset Constabulary		July 2015	
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	Leicester		Leicester			

relevant to Child in Need team managers and social workers, via team meetings or briefing session.			Social Care and Safe-guarding Service			
Within this process, the need to seek and evidence decision-making, inter-agency discussion, and third-party or triangulating in-formation (e.g. health information which corroborates or reduces concern about a child) should be reinforced to social work staff. Rel-evant 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 assess-ment or intervention should be highlighted.	Leicester		Leicester Social Care and Safe-guarding Service			
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 envi-ronmental issues or issues for the wider family should be reinforced. In particular, reminders should be offered about promoting and ensur-	Leicester		Leicester Social Care and Safe-guarding Service			

ing 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.	Leicester		Leicester Social Care and Safeguarding Service			
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	Local	DHR Report to be taken and presented to the Bristol Safeguarding Adult Board (SAB); Safeguarding Board asked to add this recommendation to their work plan;	Health – BNSSSG AT NHSE SAB Board Member	DHR on Bristol SAB Agenda; Recommendation contained on SAB Work Plan	March 2015	

Appendix D - Interviews with family, friends, neighbours and work colleagues

Family of victim

After letters had been sent to the mother and brothers of the victim, on 27th June 2014, the Review Chair spoke on the telephone to Holly's mother and one brother. Mother confirmed she would prefer to be the main point of contact and would like to be kept informed about the Review. She was very upset having also lost her husband and a sister to cancer in 2012. She asked that the DHR include a review of the Border Agency (now Border Force) as the family would like to know what enquiries were made to find the perpetrator who was an "over-stayer". They would also like "Leicester Social Services" to be included as they think the decision made by the "Social Services" not to let Holly have her 18-month-old son at home adversely affected her life choices and her subsequent decision to let the perpetrator stay at her home. Mother told the Chair that her daughter had employed a solicitor to help her re-access to her son.

2nd July 2014 Mother would like the name Holly to be used by the Review for her daughter. She also chose the name Michael as a pseudonym for her grandson.

Arrangements were made for her to sign a consent form giving the Review permission to access medical records.

Chair gave her contact details for AAFDA service.

3rd July 2014 mother of Holly 'phoned to ask about perpetrator's passport and spelling of his name with a "D" not "T". She also said how much relief she felt over such a small thing as being asked to choose a name by which her daughter would be called. It helped her a lot. She is pleased that the Review is taking place as she is already learning more than she did previously.

14th July 2014 Chair telephoned mother and told her he would be visiting the perpetrator in prison and asked if was there anything she would particularly like included. She said she was surprised he had agreed to the visit. Said she would be seeing her case worker from AAFDA at the weekend. AAFDA case worker contacted the Chair by email.

11th November 2014 the victim's mother and brothers, accompanied by case worker from AAFDA, met with the Panel Chair and with Panel member, Bristol City Council Crime Reduction Project Officer. The Chair informed the family of the findings of the Review, and provided them with the conclusions, lessons learnt and recommendations sections of the draft overview report. The family were happy with the thoroughness of the Review but asked if the word 'lifestyle' could be taken out of the Report and replaced with 'life choices' prior to publication.

Solicitors,

3.45pm on Friday 27th June 2014 Chair contacted perpetrator's solicitors who agreed that the Chair could contact his client through the Prison Governor.

Perpetrator

On 23rd August 2014 the Chair saw the perpetrator in prison.
He agreed to sign a consent form permitting the DHR to access his medical records in the UK but not in Mexico, which he felt were not relevant.

He said his parents were still alive and hoped to come to see him. His sister has already been over to see him.

Regarding the incident with his previous girlfriend, who had alleged he had tried to strangle her: he claimed she was hysterical and had been throwing things at him so he had tried to restrain her, not to hurt her.

Re Border Staff, he said that they treated him properly and respectfully. He felt they had done their job well and had no choice but to let him stay, as he had told them he was a holiday-maker going to travel around the country and Europe. He had shown them his return ticket to Mexico.

He said he had never used any medical services in the UK as he was an "illegal". The one place he did visit was the Compass Centre in Bristol. He went there with friends who were homeless and had an appointment to see them about finding ways to return to Mexico, the week after he killed Holly.

He said he had had drink and drugs (cannabis and cocaine) issues and had gone into rehab. in Mexico. In UK he had taken alcohol and ketamine regularly. He said he could not handle Ketamine well, but that was the drug of choice of all his friends. He could not go for help as he was illegally in the country.

Re his relationship with Holly, he said he met her in about July 2013 and moved in with her a couple of months later. He had only met her son once. She was a good mother to him. He considered Leicester "Social Services" were not very helpful to Holly. He said the social worker seemed to be always on holiday and did not give her any answers. It was a bad time for Holly.

He said he had only pushed Holly on one occasion, ("It was not really a fight") before the night he killed her.

17th July 2014 Reeds Family Law Solicitors who had acted for Holly when she was seeking custody of her son Michael. The solicitor who had met with Holly, agreed to provide the Review with copies of his papers as soon as he received the necessary authority from Holly's mother. *(These were later supplied to the Review*).

Friends and neighbours

Several of Holly and Arturo's friends and two neighbours were interviewed and detailed their individual knowledge of Arturo's assaults on Holly. None claimed to know about domestic abuse support services in Bristol. Two said they did not want to contact the police because it was "not my business that was down to her". "I did not want to appear to be a busybody".

Appendix F - Home Office Quality Assurance Panel correspondence

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T **020 7035 4848**
F **020 7035 4745**

www.homeoffice.gov.uk

Crime Reduction Project Officer (Violence and Abuse Against Women and Girls)
Housing Solutions and Crime Reduction
People Directorate
Bristol City Council

22 May 2015

Thank you for submitting the Domestic Homicide Review (DHR) overview report for Bristol to the Home Office Quality Assurance (QA) Panel. The review was considered at the April Panel meeting.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report. In terms of the assessment of reports, the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report and I am pleased to tell you that it has been judged as adequate by the QA Panel.

The QA Panel would like to commend you on a well considered report which represented the victim well. The Panel wanted to commend you on your good practice regarding the engagement with the victim's family, particularly the tribute to the victim and their participation in selecting a pseudonym.

The Panel felt that the report might benefit from consideration of the following points prior to publication:

- The victim's family asked that the word 'lifestyle' be taken out of the report– please ensure that this request is acted upon. Consider replacing 'lifestyle' with 'life choices'.
- The Panel sought clarification on why the family was not shown the full report and only given sections. The DHR guidance states that prior to sending the final review to the Home Office, a completed version of the review should be shared with the family.
- Reconsider the placement of the date of death on the front of the report as this may compromise the anonymity of the victim.
- Please ensure that the report is fully anonymised, including details of those working with the family. Please remove the personal details of the case worker (Ref: Page 7, para 3.7 and Appendix D, Page 48).
- The Panel thought that the inclusion of generic statements could be revisited, for example the statement at Page 13, paragraph 4.6 (Executive Summary) which the Panel thought could not be categorically verified.
- The Panel noted the recommendation for the UK Visas and Immigration. Where a local authority makes a recommendation for another body it is good practice to ensure that the body is made aware of the local authority's intention to make a recommendation for them.

The DHR QA Panel secretariat will provide you with details of who to contact regarding this recommendation.

- The Panel was generally content with the action plan but felt that a mechanism to review whether current policies are fit for purpose could be included.
- The Panel commended your identification around the issues of third party reporting and the wider point of raising awareness around domestic violence and abuse. You may wish to consider whether an action around this issue should be included in the Review (Ref: Page 35, para 15.8.1)

The Panel does not need to see another version of the report, but we would ask you to include our letter when you publish the report.

I would like to thank you once again for providing this report for consideration by the Home Office Domestic Homicide Review Quality Assurance Panel.

Yours sincerely,

Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team
Public Protection Unit

Chair of Safer Bristol Partnership
Strategic Director for Neighbourhoods
Bristol City Council
100 Temple Street
Bristol
BS1 6HT

Tel: 0117 914 2222

26th May 2015

Re: DOMESTIC HOMICIDE REVIEW QA PANEL RESPONSE

Many thanks for your letter of the 22nd May notifying us that the Domestic Homicide Review report has been considered adequate.

As chair of the Safer Bristol Partnership, I would like to thank you for the consideration you have given to the report, and I am writing to respond to the issues you raised in your letter:

- *The victim's family asked that the word 'lifestyle' be taken out of the report – please ensure that this request is acted upon. Consider replacing 'lifestyle' with 'life choices'.*

This has been actioned as appropriate.

- *The Panel sought clarification on why the family was not shown the full report and only given sections. The DHR guidance states that prior to sending the final review to the Home Office, a completed version of the review should be shared with the family.*

We understand from the Independent Chair that the family were indeed shown the whole report on the day of the final review meeting; the reference in the report to 'the sections on lessons learnt, conclusions and recommendations' were about the parts handed to the family at a meeting prior to that date.

- *Reconsider the placement of the date of death on the front of the report as this may compromise the anonymity of the victim.*

This has been actioned. We note however that this is a departure from earlier Home Office guidance and we therefore trust this will be reflected in any subsequent guidance issued.

- *Please ensure that the report is fully anonymised, including details of those working with the family. Please remove the personal details of the case worker (Ref: Page 7, para 3.7 and Appendix D, Page 48).*

This has been actioned.

- *The Panel thought that the inclusion of generic statements could be revisited, for example the statement at Page 13, paragraph 4.6 (Executive Summary) which the Panel thought could not be categorically verified.*

We have considered this feedback and the wording of the report has been amended to read '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'. We trust this addresses any concerns you may have had.

- *The Panel noted the recommendation for the UK Visas and Immigration. Where a local authority makes a recommendation for another body it is good practice to ensure that the body is made aware of the local authority's intention to make a recommendation for them. The DHR QA Panel secretariat will provide you with details of who to contact regarding this recommendation.*

We thank you for your assistance and look forward to receiving details from the secretariat. For information UK Border Force were notified, via Kenny Chapman, of this recommendation during the review process.

- *The Panel was generally content with the action plan but felt that a mechanism to review whether current policies are fit for purpose could be included.*

The relevant policies/strategies were read by the Independent Chair during the Review; it is minuted that they asked Panel Members if they were satisfied that they were fit for purpose. Nevertheless the Partnership can revisit this when we review the action plan before 12 months of the conclusion of the Review.

- *The Panel commended your identification around the issues of third party reporting and the wider point of raising awareness around domestic violence and abuse. You may wish to consider whether an action around this issue should be included in the Review (Ref: Page 35, para 15.8.1)*

We have considered this feedback and do not feel it is necessary to incorporate further actions or recommendations in this Review but are confident that the issue has been picked up through the wider Domestic and Sexual Violence Strategy Group action plan on behalf of the Partnership.

Yours sincerely,

Chair of Safer Bristol Partnership

Appendix G – Family Statement (20th May 2016)

The loss of Holly will never leave us. It is with great sadness that we have to write this statement to this report. Holly has been described negatively and not at all in keeping with who she was and this report does not do credit to her. We are sad and disappointed that the DHR has judged Holly so harshly. We who knew and loved her think they are wrong. We knew her to be a generous woman who shared the little she had and a devoted mother who took her young baby everywhere with her. Her dedication to him was one of sacrifice of her own needs and she always put him first.

Before her pregnancy, like many young people, her choices weren't always wise and she was learning at a very fast pace to make thoughtful choices since expecting Michael, when her life choices were "sensible and mature", as one of the professionals in contact with her is quoted as saying. She was dedicated to the pregnancy and birth of her baby, with healthy eating, yoga and meditation. Holly had travelled to Bristol and chosen to stay there as she liked it very much. She was in contact with us and we saw her as often as we could. In March 2012, before her Dad died, we and some family members visited her flat. Her partner (who was later to become Michael's father) was with her, the flat was clean, tidy and beautifully presented. Time and effort had been given to it and we were very proud of Holly and she was so happy. That's how we knew her to be strongly independent, self-sufficient and full of joy.

Holly had met Arturo before August 2013, but she never invited him to stay then, when Michael was in her home. She was the unlucky one, she met Arturo. He was the one who took advantage of her kindness and hospitality, he was the one drinking, violent and out of control. He brutally hurt her, he failed to call an ambulance and he left her to die alone.

We are comforted that many facts of this report have been correctly altered, but we fail to see why so many unnecessary facts remain included when they have no relevance to her murder, at times reflecting an underlying theme that her life choices may have led to her murder.

We disagree with many of the inclusions in this report. They paint a negative and unreal picture of Holly, who was loved by so many. Some facts of the report are statements with no backing proof to their truth; some reference points are assumptions. We fail to understand why Holly has been described in this negative way. This is our heartbreak: the DHR should never cause harm but it has, as we believe some facts are unnecessary to publish, have caused great sadness to our family and that is wrong.

Homeless people, travellers, were not the cause of her death. We feel it was wrong of the DHR to highlight homeless and people living in rented accommodation for not reporting domestic violence. People who live in affluent areas are even less likely to report domestic violence. People are caring or uncaring, afraid to get involved or unafraid to get involved, they are all types in all walks of life, rich or poor.

Only one person is responsible for Holly's murder and it was her misfortune to meet him. Arturo was described to be deeply upset about the abortion of his baby on religious and moral grounds, yet he killed Holly and his own baby. His behaviour was possessive and controlling and we are so sad to find that this is not a well-balanced report.

Appendix E Chronology

- Avon & Somerset Police
- Bristol Children's Services
- University Hospitals Bristol
- Bristol Clinical Commissioning Group (inc Leicestershire medical records)
- Leicester City Council
- Border Force

Date	Time	Source of Information	Subject of Recording	Event Description, Actions and Outcomes	Expected Practice/Standards	Action Taken	Author Comment
09/01/11		Maternity Notes	Holly	Holly did not attend appointment	Midwife to follow up	Midwife re booked appointment for 11/1/11	
11/01/11		Maternity notes	Holly	Seen by Community Midwife for routine ante natal care. Urine taken for Toxicology.		Further appointment made and seeing social worker the next day.	
24/01/11		Maternity notes	Holly	Seen in Consultant clinic.toxicology negative. Still awaiting housing.		Further appointment made with Consultant at 34 weeks	
26/01/11			Holly	Seen by Midwife still awaiting housing.		Follow up appointment made	
17/02/11		Maternity Notes	Holly	Saw midwife . Reported visiting flat		To be seen in Consultant clinic on 7/3 and with midwife at 35 weeks	
12/07/11	21.55	Avon & Somerset Police - Custody Report	Holly	Police were called to a disturbance at a restaurant in the Horfield area of Bristol. Holly and 3 others had eaten their meal to the value of £30 and refused to pay. Two people ran off and the other	Simple Caution given and released from custody. She was subject of	Holly was arrested and taken to Trinity Rd Police station where subsequently cautioned.	Caution correctly authorised.

				stated he had only drunk water. They had been drinking. Holly was the only person prosecuted as she admitted eating some of the meal. She was arrested and subsequently cautioned for obtaining services dishonestly. Holly gave no fixed abode but it was recorded that she was born in Boscombe.	regular checks and drug tested (negative result) whilst in custody and a medical form completed. She was recorded as having been drinking alcohol- 2 pints and may be pregnant.	Whilst in custody a medical form was completed. Holly stated that she thought she might be pregnant, has been anaemic in the past and denied having any drug or alcohol addiction. She was lucid and orientated.	
23/08/11	11.45	Avon & Somerset Police	Holly	Holly was detained in a large store in Broadmead Bristol for concealing goods (foodstuffs) to the value of £4 and leaving the store without making payment. Address given as Dorset although she had left home at the age of 17 and was living a transient/nomadic lifestyle.	Restorative Justice used in this case was correctly authorised by an Inspector. She was also banned from the store.	Restorative Justice used in this case. This was a minor offence so this disposal was appropriate.	Force guidance states that no RJ should be given if a previous Community resolution (RJ) has been given within last 12 months (or one has been given for the same offence more than 12 months ago). There is no guidance in relation to previous Cautions having been given, so the RJ on this occasion would appear to meet guidelines.
16/11/11	12.17	Maternity Notes	Holly	Booked with Midwife as pregnant. Consultant booking as admitted previous drug use. Homeless at present.	Asked about Domestic Abuse at booking. Normal practice to ask this of all women. Partners details obtained- also homeless. Did not disclose any Domestic Abuse	Referred to Children and Young people services due to housing. Referred to Drug Obstetric clinic	Midwife showed good practice by after assessment at booking making appropriate referrals and also asked about domestic abuse and documented that she had done so.
22/11/11		Maternity Notes	Holly	Saw Community Midwife Social worker visiting 12/1/11. Holly going to Bournemouth to see father.		Further appointment made for 09/01/11	
24/11/11		EDT referral - Bristol Children's Services	Holly	Homeless and 4 months pregnant , living with a friend for a week until this morning, when she was "kicked out". Squatting before that - last slept	EDT - placed in emergency accommodation, information	Discussion with Community Midwife, on 25/11/2011. On	Referral made by EDT due to emergency homelessness and pregnancy. Concerns raised by

				rough 2/12 ago. Saw housing 1/52 ago. Advised eligibility gained through 6mth residence but required to supply birth certificate to complete eligibility. Holly says her mother has not yet supplied this left home 12m ago. No crash-pads available: no beds at hostels. Holly does not believe she will be able to get to office tomorrow nor call. She fears she is becoming depressed and broke down during our conversation, in a fit of uncontrolled sobbing, protesting she can no longer do all she has to do to help herself: She is registered at Boots and does not have a formal GP for support. The father of her child " has to be away" at present but wants to care for the baby and she expects him to return before the birth.	passed to relevant Social Work Team at St Micahels Hospital. Hospital SW - contacted Community Midwifery service	16/11/11 Holly booked she was 20 weeks. EDD 1/4/12. She has homelessness and drug misuse issues (historic and current) cannabis , ketamine, speed and ecstacy. Holly was very late at seeking antenatal care. She is not with the father of the baby. A referral has been made to St Michael's drugs clinic. Holly's GP is at the Broadmead Medical Centre.	Midwives regarding substance misuse. Decision made to allocate for assessment of needs of unborn linked to another referral. Decision appears appropriate given the issues raised and potential risks identified.
24/11/11		EDT referral - Bristol Children's Services	Holly	Holly has a card with her midwife's name and an appt for a scan at St Michael's 24th November 11.00 she will ask the nursing staff to contact the S W Team whilst she is there : for support in liaison with housing, with Mum for the Birth Certificate and perhaps to assess for depression and M H Services. Referral passed by EDT to SW Dept. at St Michaels Hospital,			
25/11/11		Maternity Notes	Holly	Midwife chased referral to social services- still on duty desk. Holly has had fetal anomoly scan Expected date of delivery confirmed as 17/04/12	Midwife following up referrals as expected practice		
26/11/11	18.08	Avon & Somerset Police	Holly	Call made to police reporting a disturbance between a man and a woman outside the Tesco Express store, Bristol. The third party caller stated that the man was at the back of the store holding a woman and shouting at her, pushing her against a bin. At some point she was lying on the floor. It was recorded at one point that she was trying to shout back at him and afraid of him. Holly gave Dorset as her home address.	Police appropriately attended as an 'immediate response' and were at the scene in 5 minutes. Correctly recorded as a Domestic disturbance.	Recorded by the police communications centre as a domestic disturbance. Officers spoke to both parties who stated that it was a verbal argument only between two friends. The informant told the officers that	Although report does not confirm if she was checked for injury, the officers were satisfied that no evidence of crime. Recorded as a verbal argument only. Recorded as friends but no further details of their relationship. Male party named on incident is later listed as one of Holly's

						his reporting of the incident was what he heard rather than what he saw and lighting was minimal.	friends who had exchanged nice text messages with her on the afternoon before her death which suggested that they had recently seen each other and had previously been intimate partners.
06/12/11		Maternity Notes	Holly	Seen in drug clinic at St. Michaels by Consultant. Wanting home birth Documented that no drug use in pregnancy.	Patients will be referred back to Community Midwives for on-going care if Consultant believes there are no obstetric issues.	Referred back to Community Midwife with follow up with consultant and growth scan.	Normal practice
09/12/11		Maternity Notes	Holly	Did not attend Community Midwifery appointment.	Midwives are required to chase patients who DNA and to chase social work referrals they make	Midwife contacted patient and gave her another appointment over the phone. Chased CYPS regarding referral	Midwife demonstrated good practice
14/12/11		PARIS - Children's Services	Michael	Unborn child allocated to Social Worker for Initial Pre-birth Assessment.	3 week delay in allocation		Why the delay in allocation? Very insecure housing where living?
16/12/11		Maternity Notes	Holly	Seen by Community Midwife for routine ante natal care. Urine forToxicology negative.	If no obstetric problems identified patients seen by Community Midwives for routine care	Follow up appointment made	
21/12/11				Social worker rang midwife and left message for her to phone him			
22/12/11		Case note - Bristol Children's Services	Holly / Michael	22/12/11 TCF & CMW Holly booked in with them late at 20 weeks. She DNA'd one appointment but rebooked and attended at 22 weeks. This had negative toxicology for substances. Next appointment booked on 9/1/11. No concerns re. Mental health at the appointment. I gave update on my conversation with Holly.	Reference is made to conversation with Holly, no record of conversation is recorded in the case notes		Incomplete case recording. Case records throughout are quite poor lacking in detail and referencing issues/events that haven't been recorded.

10/01/12		Case note - Bristol Children's Services	Michael	TCF - Holly is not on her books			Incomplete case record
13/01/12		Case Direction - Bristol Children's Services	Michael	Case Direction mother with mental health problems possible substance misuse and housing issues. Jo due to visit yesterday mother cancelled visit. Jo to visit next week	Clear plan to pursue visit to undertake assessment.		No record of arrangements to visit on 12/01/2012 recorded in the case. notes. Incomplete case recording. What is the nature of mental health problems? These should be addressed within the IA.
17/01/12		Case note - Bristol Children's Services	Michael	TCT Holly, Booked up initial visit for 24th January.	What number was called? Time of call? No record of any other issues discussed?		Incomplete case recording.
19/01/12		Case Direction - Bristol Children's Services	Michael	C18, Case Issues, Mother with unstable housing, mental health issues - post substance misuse issue. Initial visit required asap. cancelled last week. Jo due to visit Tuesday 24th. Jo liaising with professionals	Concern outlined regarding cancelled home visit, urgency of undertaking initial visit clearly indicated.		Would be helpful to specify which professionals have been contacted and whether this has been done with or without consent?
24/01/12		Case note - Bristol Children's Services	Michael	HV to Holly . See initial assessment for further details.	Reference made to content of Initial Assessment.		Lack of detail regarding how the visit was conducted and presentation of Holly.
24/01/12		Bristol Children's services - Initial Assessment	Michael	Initial assessment commenced on 24 January 2 months after initial referral from EDT. Issues addressed include unstable accommodation history, mental health issues, substance misuse and potential of domestic abuse. Strengths and risks identified, primary risk being that of unstable accommodation.	Initial Assessments at time were expected to be undertaken within 10 working days.		2 month delay in undertaking Initial Assessment is a matter of concern. Why was there such a delay?
27/01/12		Case Direction - Bristol Children's Services	Michael	Case Issues: Mother in unstable housing and mental health issues; previous ecstasy and cannabis use. Recent Events & Updates: Jo undertook Initial Assessment visit this week as mother previously away in Bournemouth. - Mother living at Phoenix House,	Concerns raised in referral and discussions with Midwife addressed and level of concern reduced.		Lack of detail regarding how the information relating to substance misuse and Mental Health history was this corroborated and if so with whom? How was the history

				mature 19 year old. - Mother attend St Michaels drug clinic but no recent drug use. - Mother proactive regarding parenting support. - Attending antenatal appointments. Analysis - No previous mental health issues just illness. - Complete Initial Assessment and close case as no concerns.	Decision made to 'close case as no concerns'.		of substance misuse explored and also corroborated?
01/02/12		A&S Police - From Homicide investigation	Holly and Michael's father	Holly is pregnant and with Michael's father moves into Bristol address.			
07/02/12		Case note - Bristol Children's Services	Michael	7/2/11 [12] TCT FA - re. Holly. MDMA, amphet, cannabis, ecstasy. Doesn't pick up cannabis or ketamine. Toxicologies all negative from the 6/12/11; 24/1/12; 6/3/12 Appears she has stopped using. No further concerns to raise.	Not clear who is being contacted? Good practice to inform other agencies of intention to cease involvement.		Incomplete case recording.
09/02/12			Michael	9/2/12 TCT - Phoenix Place support worker. No concerns regarding Holly, she is very self-sufficient and mature. Holly will have continued support until she leaves Phoenix Place. The plan is then for floating support provided by Shelter. She is on home choice band 2 to move into a 2 bed flat, it will not be long before she is offered somewhere appropriate. I informed Christine that we would be closing the case.	Good practice to inform other agencies of intention to cease involvement.		Brief but better case record, should include phone number.
18/02/12		Closure - Bristol Children's Services	Michael	Case Closed in PARIS			Was this too soon? Should there have been a period of monitoring and support. Was it considered that Primary care services would cover this?
06/03/12		Maternity Notes	Holly	Saw consultant. Case closed with CYPS. Has moved house			
16/03/12	18.09	Accident and Emergency Notes	Holly	Admitted with Head injury after being hit by cyclist. Fell and hit side of head	Safeguarding to be considered and assessed. Maternity	Discharged home with advice	Assessment of safeguarding not completed in documentation. Midwifery not informed.

					service to be informed as pregnant		
16/03/12		Maternity notes	Holly	Did not attend Community Midwifery appointment.		New appointment given	
19/03/12		Maternity notes	Holly	Drug midwife noted Holly had been in A and E as saw this on IT system	To share information with Community Midwife	Community Midwife informed- message left on answer phone but Holly seeing Midwives in Easton	Drug liaison Midwife spoken to about this assumed Holly had changed Midwife as changed address
20/03/12		Maternity notes	Holly	Saw Community midwife. Aware CYPS have closed case		Follow up made	No discussion about A and E admission / communication and information not shared
26/03/12		Maternity Notes	Holly	Routine Antenatal appointment. Home birth chat organized			
30/03/12		Maternity Notes	Holly	Home birth chat		Home birth planned	
10/04/12		Maternity Notes	Holly	Routine appointment			
14/04/12		Maternity Notes	Holly	Home birth		Post natal care	
14/04/12			Michael born	Michael born			
27/04/12		Maternity Notes	Holly	Transferred to Health Visitor			
06/08/12		Air Balloon Surgery Medical Notes	Antenatal Care	Gynaecological History (Review): Antenatal care 8 week check. No signs of post natal depression. Condoms for contraception, breast feeding, no problems reported	NA	NA	? Inaccuracy in this entry - Michael was born on the 14th April 2014 - so presume this was an 8 week post natal check - not antenatal as entry suggests.
01/12/12		A and E notes	Michael	Taken to A and E by Mum with wheezing , chesty cough and fever,possible bronchiolitis	On admission to A nad E safeguarding	Safeguarding assessment documented. Of	All appropriate action taken

					assessment always performed. GP should and HV informed of admission	note Baby had not had any immunisations. Advised mum to have these done. Discharged with prednisolone and regular paracetamol. GP informed and HVISITO. Asked to follow up re immunisations.	
25/12/2012	17.4	Border Force - CID Port Ref: TN4/4147727	Arturo	Arturo arrived at Heathrow Terminal 4 and sought leave to enter, having started his journey the day before in Mexico City. Records indicate he was questioned at the border check point at Heathrow Terminal 4 by Border Force Officer (BFO). BFO was not immediately satisfied the passenger qualified for entry to the UK as a visitor and served him with Home Office Form IS81 requiring the subject to submit to further examination pursuant to powers under Schedule 2 of the Immigration Act 1971 (as amended). File minutes note that BFO referred the case to Border Force Higher Officer (BFHO). BFHO authorised that further examination should take place along with a baggage search. BFO recommended to BFHO that the subject be granted leave to enter the United Kingdom and he was satisfied the subject met the requirements for leave to enter as a visitor (paragraph 41 of the Immigration Rules as then drafted). BFHO agreed with BFO and case records note that the subject was granted entry for 6 months (with a prohibition on employment and resource to public funds) with an expiry date of 25 June 2013. Case notes indicate the subject was released from immigration detention at 1937hrs on 25 December 2014 and allowed to leave the airport terminal.	Immigration officers interview Non-EU passengers on arrival under schedule 2 of the Immigration Act to determine whether they qualify for leave to enter. In certain circumstances they may be required to submit to further examination as was the case here. Further examination under schedule 2 of the act follows and a decision to either grant or refuse entry ensues. In a case where leave to enter is granted, a passenger is released and the case outcome entered on our system. The information available to us confirms that this case was dealt with in accordance with Bor-		I am satisfied that we handled this case in accordance with procedure and there is nothing that could have alerted us to the subject's future criminality.

					der Force policies and procedures.		
23/04/13		Avon & Somerset Police - Guardian Intelligence report 52040/13	Sergio Arturo Or SAA-VEEDRA	Arturo was seen begging whilst sat on the floor in the 'Bear pit', specifically the underpass under St James Barton roundabout, near to Debenhams in Bristol and spoken to by police officers.		He was given words of advice and moved on from the area by a PCSO who submitted an intelligence report which was forwarded to a 'Streetwise' team officer and was also brought to the attention of the Police Anti-social behaviour team.	The streetwise team work with Bristol City Council with an aim to, where possible, support the homeless and address addiction issues. The two teams who received the intel report work closely together in the cases of begging and problematic rough sleepers. It would appear that no checks or enquiries were made with regards to his immigration status either at the scene or subsequently, however the guidance for ACRO checks of foreign nationals suggests that checks should be made on all foreign nationals detained in custody. This process may need to be examined in respect of a potential recommendation for the possibility of checking all foreign nationals, whether in custody or not and any subsequent raising of awareness of the facility to do so.
30/06/13	15.59	A and E notes	Michael	Taken to And E by parents. Fell of a chair and landed on his chin	On admission to A nad E safeguarding assessment always performed. GP should and HV informed of admission	Safeguarding assessment complete. GP informed of admission	All appropriate action taken
30/06/13		Air Balloon Surgery Medical Notes	List of referrals	Seen in hospital casualty details: clinic letter Broadmead Medical Centre accident and emergency	Copy of Broadmead assessment and A and E attendance information to be contained in notes	No letter present in copy of notes provided for this A and E visit	Author contacted Bristol Children's Hospital casualty services. Confirmed child attendance and that letter faxed to GP. Seen by a nurse for a chin injury at 15.59.

							Triaged and discharged. Copy of letter acquired and represented below within entry dated 30th June 2013 at 15.59.
30/06/13	Printed 4.08pm	Broadmead Medical Centre Bristol Consultation Record	Record of accidental fall - Michael	History - Brought in by mum and dad as fell off a chair 1.5hrs ago landing on chin/face. Seemed to settle initially but then started screaming and crying - parents can't console him. Examination: Trying to escape, very distressed and screaming - cant really get a good look at him. ...Parents happy to take him up to A and E BCH ***(Authors Note: BCH = Bristol Children's Hospital)***	To examine child fully and request detail around incident. Represent this in the records.	Advised to take him to A and E Bristol Children's Hospital	In this situation I would have expected more detail of the incident to be recorded. I would also expect the rationale for advising the parents to visit BCH (Bristol Children's hospital) A and E to be outlined in the records. Spoke with Practice Manager Asked if there was any more detail to be provided from the practice regarding the event. Informed that the nurse no longer works within the walk in centre. It is standard for clinicians to check the child protection register - at the time Michael was not on this. Also reviewing previous visit in March 2013 - the child was noted to be happy and interacting with his mother - so no triggers suggesting anything other than accidental injury. Practice Manager assumed rationale for referral onto BCH referred to injury to the head and child being difficult to assess.
30/06/13	15.59	Casualty Notes:	Fall from high chair (Safeguarding Checklist completed as standard)	No concerns with appearance; behaviour, presenting complaint, issues for the older child eg STI; and no history of concern in records noted (***Author's summary - not verbatim)***	Safeguarding check to occur in the context of accidental injury	As expected	Evident that accidental injury

30/06/13	15.59	Letter from BCH Casualty to Boots Pharma-cy/Broadmead Walk in Centre - Faxed		This child attended here on Sunday, 30 June 2013 at 15:59 accompanied by Parent. The presenting complaint was chin injury. Account of incident/ injury: Triage Nurse: fallen out of high chair and landed on chin - teeth bleeding; referred here. no other injuries. no loc. no vomit-ing. Dr/ ENP (***Authors Note: ENP: Emergency Nurse Practitione***r): Discharge Summary: strapped into her high chair which fell forward hitting her face on the floor, not ko'd, not vomited sustained a mouth injury, seen at the wlc (***Authors Note: WC+ Walk in Centre***) sent to CED (***Authors Note: CED- Childrens Casualty Department***); o/e (***O/E = On Assessment***)- bruising to his chin, talking well eating well, small amount of blood around his top front teeth gum areas front and back, no loose teeth, not moved, no other injury found. Imp ***(Imp = Impression)***- minor mouth/chin injury; plan- home analgesia; investiga-tions: RecordingVitalsigns Treatments: Advice/Reassured; Departure: Dis-charged Follow Up: (including any outstanding results/ in-vestigations)	Assessment, treat; discharge unless any further investigation required	Assessed, treated and discharged	Information acquired from Bristol Children's hospital on 21st August 2014 following liaison with Senior Sister. Evident from assessment that this was in line with acci-dental injury given additional de-tail provided.
01/08/13		A&S Police - From Homicide investigation	Arturo and Holly	Arturo and Holly met each other around this time.			
14/08/13		Air Balloon Surgery Bristol Medical Rec-ords	Emergency Contracep-tion	Unprotected sex 4 days ago during period cycles, regular, counselled. Morning after pill no longer effective. Required IUCD (***Authors note: IUCD= In-ter Uterine Contraceptive Device***) - Declined	Discussion of contra-ception - encour-agement to use.	Care as expected	
14/08/13	3.58p m	Asquith Medi-cal records	Concerns from father regarding care of child and	Dad concerned about the welfare of child staying at mother's in Bristol. 16 month old child - on verbal joint custody since 10 months of age. Has mutual understanding that child stays with him on alter-nate weeks, dad living in Leicester with partner and	Safeguarding alert should be raised and father informed of this.	Plan to refer to Child protection (see entry below for action)	

			potential safeguarding issues	partners son 5 yrs. dads main concerns: 1. recurring nits and head lice since 3-4 wks; mom not treated them? on the eyelids? sexual abuse; 2. child still wears 6 months clothes even though he is 16 months; 3.Loosing weight; 4. No childhood vaccinations by mom (she refused); 5. clingy to dad when dropping at moms place, refusing to be at moms; 6. Lots of people at house/ couple/ 2 kids/ adults moving in and out according to dad; 7. had a fall from a kitchen platform, and sustained injury to mouth and teeth - she stated she took him to the GP clinic - 2 days later: 8. does not take him to the clinic when he is ill. Examination: comfortable, afebrile36.7, ENT (**Ear Nose and Throat**) Examination-NAD (***Nothing to Report***) (2D12)O/E - chest examination normal. Abdomen examined: NAD. Genitals - NAD. Birth mark on right paritoccipital area -4-5 cms and on L Palm 2cm: scales on eyelids; no bruising noted Diagnosis: ?Neglect affecting child NEC (***Not Elsewhere Classified***); Head Louse infestation; Plan: advised referral to child protection service.			
14/08/13	6.09pm	Asquith Medical records	GP Discussion with the emergency social worker	Dr discussed the case with the emergency social worker. Details of Dad and mobile number provided. Living with partner. Both registered with the practice.	Copy of Fax to be held within medical record with date sent; Record of telephone contact to DAS	Faxed copy of note sent to Air Balloon Surgery Bristol at 12.16 on the 15th August 2013.	Care as expected
14/08/13	3.22pm	Asquith Medical records	Concerns from father regarding care of child and potential safeguarding issues	Brought by dad, mum has declined any vaccines, mum lives in Bristol, dad has access alternate weeks, dad and partner concerned as every time has picked up child he has something wrong with him, wearing too small clothes, recurring head lice, says had fall and did not take to hospital, allege this time has had to shave all hair off head as covered with head lice, has tried combing and insecticides but they aren't helping. Keeping diary of issues. Is worried about sending child back home. Is worried child at risk. Says has noticed lice to eye lashes and	Refer to GP re: Lice; Safeguarding alert to be raised representing father's concerns	Referred to GP	Any person is able to action a safeguarding alert - this does not need to be a GP. GP however, took this forwards with social services (see entry 14th August 2013 6.09pm)

				was advised by pharmacy that appears similar to pubic lice, has not had any microscopic investigations. Examination: carried in by dad, bit upset, but alert, some debris to lashes but not obvious signs of insect Plan: advised not sure what can use, review with GP please, dad wants to press ahead as thinks child protection issues and worried about sending babe home			
14/08/13	1717	From Liquid Logic case notes and EDRMS. **Social worker 1**, Emergency Duty Team (**EDT**), Social Care and Safeguarding Service (**SCSS**), Leicester	Michael	**Social Worker 1** faxed the Duty Response Team at SCSS, reporting that Michael had been taken to the GP walk in clinic by his father. Father was concerned that Michael had lice, possibly lice in his eyes and eyelashes. Father expressed a range of concerns to the GP about the care Michael received from his mother Holly. These included concerns that his clothes were too small, concerns about weight loss, concerns that he is not taken to the GP when he is ill or for checkups and that he has not had his vaccinations; concerns that he had fallen from a worktop and hurt his mouth and teeth with medical attention being sought only 2 days later, and that Holly had people "in and out" of her house a lot. The GP notified EDT that he had identified scales on Michael's eyes, lids and lashes and that Father was treating these with creams and had shaved his head. The GP response to concerns about weight loss is not recorded. The EDT fax named Father's current partner noting that she had a 5 year old child although the child was not named.		Followed up by **social worker 2** with GP next day	Information was passed on appropriately by **Social Worker 1**
15/08/13	5.20pm	Asquith Medical records	Community Practitioner telephone conversation with father	Telephone contact from Michael's Father. Father reports that he has shared custody of Michael with his ex partner Holly and the mother of Michael. Michael presented with small particles in his eye lashes and father sought medical advice on several occasions. Michael was ultimately referred to the eye clinic at the LRI and following medical examina-	Community Practitioner to liaise with social services on behalf of Father to find out which agency is dealing with the safeguarding issue	Discussion with Safeguarding Nurse to seek further advice. Home visit assessment arranged.	Seeking support from a safeguarding nurse at this time was a reasonable action as long as follow up then actioned to seek clarity around which social services is leading on safeguarding case. I am assured by the notable effort tak-

				tion it was thought to be pubic lice infestations. The eggs were removed under anaesthetic and sent for laboratory examination. Father states he has contact with Michael alternate weeks usually from a Tuesday to a Tuesday. However Father states that Holly will ask for that time to be extended on a regular basis and following Michael being diagnosed with lice infestation is now adamant that he will not be returning Michael to Holly's care. HV advised Father to seek legal advice as Holly has a rights to contact with Michael. Father has reported that he has contacted the police who visited on Friday 16/8/13 and he has also contacted Bristol Social Services and Leicester Social Services both of whom he reports have not taken responsibility. Father reports that Holly also had two other children staying at her address. A welfare check was completed at Holly's property but the children were no longer there. Father has been advised by he police not to contact Holly. However he sent a text message to maternal Grandmother and Holly was present at the time. Father text messaged Holly enquiring if she had an infection of lice which she stated she hadn't. Father reports that they are about to move house over this weekend and their new address is (Address provided). HV to discuss with safeguarding nurse to seek further advice. HV arranged appointment to complete Home Visit on Friday 30/8/2013	and then to inform the father.		en by health visitor to clarify and communicate with others around issues as represented in entries below. (See subsequent Health Visitor contacts 17th-21st August 2013)
15/08/13	Date and time letter generated: 11.57	Asquith Medical records	Hospital letter informing Air Balloon Surgery of Michael's attendance of the Leicester-	A and E Diagnosis was: Both Eyes - Eyelid and /or Skin - Skin Infection Additional Information: Complex social circumstances, recent severe head lice infestation: now spread to eye lashes, requires examination and treatment under anaesthetic (arranged for tomorrow); At the conclusion of treatment the patient was: Admission to LRI.	Care as planned: communication to primary care services re: outcome of investigation of eyes should follow directly.	As expected	A and E contact letter evident in notes. However no record of formal outcome of investigation under anaesthetic as an inpatient until following outpatient appt on 27th August 2013. Author followed this up with Leicester Royal Infirmary. On reviewing medical notes from Leceister Royal Infir-

			shire Royal Infirmary (LRI) Eye Casualty Service on the 15th August 2013				mary there was a discharge letter generated on the 16th August at 4pm. The letter suggests that it was sent to the GP electronically. However on viewing this I do not see any information confirming the type of lice present
15/08/13		Contact - Bristol Children's Services	Michael	SUMMARY: referral received from Leicester City Council, Concerns raised following GP consultation made by Father. GP raised concerns with CYPS in Leicester. Concerns include, lice infestation in hair and eye lashes. Lack of immunisations, failure to seek medical care following a fall, concerns regarding life choices of mother, people witnessed coming and going from home. Concerns discussed with Health Visitor who advised that mother leads an 'alternative' lifestyle, has alternative views regarding Immunisation. Some evidence shared of appropriate medical care being sought due to an ear infection and received antibiotics which reportedly were completed. A&E presentation following fall from a counter in June, discharged with advice. Father made contact and reported that lice are allegedly 'Pubic lice'. Child in care of Father in Leicester. Care is shared between parents. Decision to refer to Leicester and recommend a Strategy Discussion. Father given advice regarding care of Michael, he advises that he is seeking legal advice.	Child resides in Bristol and Leicester and at the time of the referral was residing in Leicester and there had been no involvement from Bristol since before Michael's birth.	Response to concerns raised are clear and appropriate, had child been in Bristol it is clear that a Strategy Discussion would have occurred and there was liaison with the relevant police team in Bristol to discuss the concerns. Duties lie with the LA within which the child is found and this was Leicester.	Good response to concerns raised, clear recording and decision making.
15/08/13	am	From Liquid Logic case notes. Response Team **Social worker 2** contacted the GP by telephone.	Michael	The GP confirmed that he had seen Michael and his father Father in clinic. Father was concerned about "nits and lice". Father had shaved Michael's head. The GP was concerned that there may be lice in Michael's eyes and eyelashes. The GP response to Father's concerns about possible weight loss was not specified ie whether he agreed with these concerns or had weighed or measured Michael. Over-		No needs identified. No further action.	There is no record of management advice having been sought about the decision to take no further action at this time. At this point Father had not indicated that he was planning to keep Michael in his care. Therefore there was potential for Michael to return to

				all, the GP was reported to have reiterated that Father had "concerns" about Holly's care of Michael although Father's concerns are not specifically recorded. Social worker 2 clarified arrangements for Michael's care, noting that Father and Holly have "joint custody" of Michael, caring for him on alternate weeks.			Holly's care and potential for further concern about Michael's welfare given the range of neglect issues already alleged. There was also no clarity at this time about how Michael may have contracted lice in his eyes. There is a sense that an assumption has already been made that Father is a "safe" carer for Michael.
15/08/13	pm	From Liquid Logic case notes. Response Team **Social Worker 3** received a telephone call from **social worker R** in Bristol	Michael	**Social worker R** stated that she had made a referral to **social worker 2** earlier that day. She said that SCSS in Leicester should refer the concerns about Michael's lice to the police and initiate a section 47 enquiry. **Social worker R** stated that E, Michael's father, had told her that Michael has pubic lice on his eyelashes and that a specialist has confirmed this and that Michael is having an operation. **Social worker 3** responded that there is no medical evidence currently to confirm this and as such SCSS in Leicester will take no further action. She commented that E should seek legal advice (ie about contact and residence issues) and noted that Michael's primary address is in Leicester where he has a GP and health visitor.**Social worker R** responded that Michael's care is shared on alternate weeks by E in Leicester and Holly in Bristol. **Social worker 3** noted that **social worker R** said that this is "nothing to do with Bristol" and that **social worker R** was dissatisfied with **social worker 3's** response and said she would seek management advice.		**Leicester Team Manager 1** was consulted. No immediate safeguarding concerns identified. No further action.	There is no record of **social worker R** having spoken earlier in the day to **social worker 2**. It is not clear what action **social worker R** took or whether she sought her manager's view as to respective responsibilities of children's services in Bristol and Leicester
15/08/13		LRI Records - Paeds/Occular Motility Assessment by dr Hussain (Opthamology	Pre-op assessment bu opthamology	Complex social history - joint custody with mum ….Social services involved as recently head lice infestation and given no ***treatment*** by mum. Dad very concerned. Leicester and Bristol ***social services*** involved. Dad shaved head yesterday as severe infestation.....Both eyelids red and itchy. No	Evaluation under aneasthetic to occur	Planned for 16/8/13	

		Registrar)		squint noticed ***Observation*** lavea eggs +++ no live lice seen.....***Plan*** needs eua (***evaluation under aneasthetic)*** to review nits.			
16/08/13		From Liquid Logic case notes. Strategy discussion between **social worker 4 and team manager 1**		Holly and Father's care arrangements for Michael were discussed. Father's concerns as expressed to the GP at the walk in centre were noted ie poor hygiene, inappropriate clothing, headlice. However Father's expressed concern about possible weight loss were not noted during this discussion. It was discussed that there had been some contact between social workers in Bristol and Leicester and that while this was not an "open case" to Bristol, Bristol had "accepted a referral" as Michael was due to return there on 20.8.14. It was noted that Michael was not previously known to children's services in Leicester but was already known to Bristol children's services. During the strategy discussion it was noted that there had already been some discussion with the police child abuse investigation unit **DS 1** and **safeguarding nurse J** at the hospital. The police view had been that until it was established that these were pubic lice, there was no police role. **Safeguarding nurse J** had stated that Michael would be seen by a consultant prior to discharge and that the consultant would update. **Safeguarding nurse J** had later confirmed that **Dr B senior registrar** and **Dr F consultant paediatrician** had now seen Michael and **Dr F** confirmed that Michael did not have pubic lice but lice which had transferred to his eyes.		Strategy discussion concluded that there are no safeguarding issues. **Social worker 4** to inform Father that SCSS will take no further action, recommend that he seeks legal advice about contact and residence issues and confirm whether he has parental responsibility for Michael. Police to take no further action. Hospital to fax discharge sheet to SCSS.	The nature of Michael's previous involvement with Bristol children's services is not specified. There are no records eg discharge sheet confirming **Dr F**'s view that Michael did not have pubic lice.
16/08/13		From Liquid Logic case notes. Telephone call from **social worker 4** to Michael's fa-	Michael	**Social worker 4** informed Father that Michael had "general lice" not pubic lice. Father stated that the pharmacist had told him they were pubic lice. He talked about his past relationship with Holly and said that he had concerns over some time about Holly's care of Michael, including concerns that at times Michael had no shoes, tight clothes and poor		**Social worker 4** advised Father to seek legal advice about the possibility of obtaining a residence order for Michael.	There is no record of discussion with Father clarifying if he has parental responsibility for Michael. This is the first direct discussion between Father and social workers.

		ther Father		hygiene. Hs also referred to Holly once strapping Michael into a baby chair that was too small and to Michael falling from the worktop and bruising his face and gums.He said he had raised his concerns with Holly but she "didn't get it".			
16/08/13		From Liquid Logic case notes. Telephone call to Response Team **social Worker 4** from **Dr H**, opthalmology, Leicester Royal Infirmary.	Michael	**Dr H** stated that she was concerned that Michael had headlice and pubic lice in his eyelashes. She stated that tests on the lice were being completed but in her opinion they were pubic lice and she was concerned about how these may have been transmitted to Michael. She did not feel that they were likely to have been transmitted on hands or via towels or bedding and recommended further investigation.		Strategy discussion between **social worker 4 and team manager 1**	
16/08/13	4.45pm	Leicester Royal Infirmary Ophthalmology Records	Verbal Report of confirmation of pubic lice	Pubic Lice confirmed. Dad has already gone home with Michael. Safeguarding liaison due to do home visit tonight. Needs to be tested for STD's (Sexually Transmitted Disease). This discussed with GU Medical Registrar (Dr Turner) who recommended paraffin based eye ointmen t(as chemical treatment needs good cooperation) and will arrange. ***Plan***: Follow up for family with GU clinic			Reference to how this information will be shared formally with key agencies in the record would have been useful
16/08/13		LRI Opthamology Records by Dr Hussain	Description of procudure/ findings	Removal of lice and eua (GA) ***(General Anaesthetic):*** EUA - multiple lash lice and eggs bilaterally, upper and lower lids. Lice and eggs removed. Plan - Home today. On call Paediatric Registrar - said responsibility of community paediatricians during office hours. Community Paediatrics faxed - will call back. To call SS (social srvices) - will call back. Carla Sturgess was in charge of this case and will contact dad re: future input			
16/08/13	12.30 (noon	LRI Records by ST3 Baptist	Michael Assessment	Issue-under opthalmology who have raised concern about discovery of pubic lice on eyelids.			As infestation by pubic lice not yet confirmed at this stage, it is thor-

	)	(Paediatric Team)	following request by Hospital Safegaurding Team	Safegaurding have spoken to on call consultant and also informed safegaurding lead. According to opthamology documentation had GUA (***examination under aneasthetic)*** of lids and found lice and eggs. No documentation of lice type.. Happy to discharge from an opthamology perspective. ***Observation:*** Alert and interacting with dad. Well hydrated, well perfused. Head shaved. Skin- no obvious injuries or bruising noted when stripped down.... ***Impression:***1. Lice infestation 2. Medically no concerns 3. Father has concerns about care being provided by mum. No concern or evidence to suggest non acidental injury. Plan: No further input from medical team. Findings communicated to Jason (safegaurding team). Social services already aware to liase with father. All of the above communicated to on-service medical consultant			ough of the LRI to complete a review of Michael re: potential for non-accidental injury. However, sensible given wish to discharge on 16/8/14 - see entry below
16/08/13	4.00pm	University Hospital Leicester Children's Hospital Discharge Summary	Outcome of examination under aneasthetic	Described in brief, treatment and actions taken by LRI. Final paragraph outlines: ACTIONS REQUESTED OF GP - Please be aware of social issues.	Discharge letter to GP and Social services	Reference at head of letter that letter sent electronically to "ENABLED GP PRACTICE". Advises practice to check for electronic receipt	Presume this letter head directs the practice to check electronically for the letter when it has been received in hard copy. GP Practice (Asquith Surgery) informed the author that they did not receive the letter. ? Issue with practice system or LRI.
16/08/13	4.00pm	University Hospital Leicester Children's Hospital Surgical Admission Assessment	Plan of Care and Evaluation	Michael has now been discharged from ward 10. Doctors happy to discharge. Safegarding have been informed went home to dads custody. Opthamlmolgy have confirmed that lice are pubic lice. They are to contact peadiatric Senior Registrar on call. Jason Totten from safegaurding has been contacted and a message left.	Later entry should reflect internal safegaurding contact/action		How is this information going to be shared with external agencies?
17/08/13	Printed 7.23pm	Broadmead Medical Centre medical Records:	Emergency Contraception	Medication: Levonorgestrel ***(Authors Note: this is the morning after pill)*** 1.5mg Take one tablet as single dose as soon as possible (preferably within 12 hours but no later than 72) 1 tablet; Assessment:	Provision of emergency contraception; pregnancy test (as requested)	Care as expected	

				Advice about long acting reversible contraception. Urine pregnancy test requested. Additional: Emergency contraception advice- last menstrual period - 1st day. time since unprotected intercourse 72 hours. Ectopic risk discussed. Patient currently pregnant; Examination; O/E blood pressure reading 111/78 mmHg -ve HCG....Comment: discussed family planning, STI's ***(Author's Note: STI =Sexually transmitted Disease***), risk of failure			
17/08/13	17.8.13	From EDRMS. Fax from **EDT social worker 5** to Response Team	Michael	EDT fax reported a telephone call from **police officer B**, citing concerns of "ill fitting clothes and pubic lice". **Social worker 5** attempted to follow up with a telephone call to the police officer but found him unavailable. She left a message for him and passed on the information to the Response Team.			**Social worker 5** appropriately attempted to follow up with **police officer B** and appropriately passed on information to the Response Team. There is no record of further follow up with the reporting police officer.
17/08/13		Avon & Somerset Police	Holly and Michael	Leicestershire police requested a police welfare check to be made at Holly's address regarding a report of child neglect that they had received relating to Michael, (then 16 months old). Michael's father reported to Leicestershire that he had collected their son a few days earlier and he was found to have what was later confirmed as head lice. He reported that many squatters and homeless people were staying at her address, using drugs or alcohol and that she often left the child unattended	Police attended as requested and updated the Guardian system so Leicestershire could be updated and this would also advise Bristol safeguarding unit	Officers attended the address and spoke to Holly who confirmed that she did have some people staying at her address who were living in a tent in the garden. She said that these were 'hippies, who travel around' and confirmed that their children had head lice. She stated that she was shocked at the allegations made by Michael's father who wanted son to live with him.	Initial report was made by father to Leics Social Services who requested police welfare check. Officers were satisfied that although the house was not the tidiest, there were no immediate concerns and the child was still living up in Leicestershire with his father. The report was forwarded to the Safeguarding Co-ordination Unit for information.
19/08/13	pm	From Liquid Logic case notes. Tele-	Michael	**S** stated that the **genito urinary registrar** (unnamed) has now confirmed that Michael did have pubic lice and has suggested follow up as "this is		**Social worker 3** discussed with **team manager 1** who requested	No record confirming the **genito urinary registrar's** views and recommendations has been located

		phone call from **S**, Leicester Royal Infirmary (role not specified) to Response Team **social worker 3**		unusual".		that she ask **S** to confirm this in writing and provide information about possible transmission methods. **Social worker 3** duly requested this of **S** who agreed.	within social care records. There is no record of this new information having been shared with police who had previously indicated that further action may follow if it was confirmed that Michael had pubic lice.
20/08/13	11.00 am	LRI Records	Notes of telephone discussion by ward 10 nurse with Father (record by Safeguarding Nurse)	Telephone call from father to staff nurse on ward 10 requesting information on how to obtain STD ***(Sexually transmitted disease)*** testing. Discussion by myself with GU ***(Genito-urinary***)Registrar and informed of the process that social care need informing of confirmed pubic lice and they decide upon a sexual medical and if this takes place they refer to the clinic if required. Information shared back who informed father to contact social services himself. GU report regarding lice obtained and forwarded to social care - copy in notes.	This information should have been communicated by a member of the health and social care MDT involved.	Telephone response to father. GU report describing lice as pubic sent to social services and the GP.	In order to ensure effective communication across agencies, a copy of the report describing the eye lash infestation as pubic lice should also have been sent to Michael's GP for their records and information. It is not clear from the information available whether this occured - and if it did, why it was not received by the practice. Seems to be a lack of connectiveity between departments within the LRI.
21/08/13	12.15 pm	Asquith Medical records	Record of telephone communication Safeguarding Advice Line	Information shared about Michael. HV to contact Father to obtain the name of the police officer who visited and is investigating and clarify whether police have referred to social services. If police have not made a referral HV will need to do this.	Contact Father	As planned and expected (see below)	
21/08/13	12.30 pm	Asquith Medical records	Telephone Communication with Michael's Father	Father advised that PC 1 visited and gave an incident number. Father also states he had an appointment with Child Abuse Investigation Officer on Friday 16/8/13 at 7.30pm but they did not attend the home address. Advised that HV would contact him later to update him	As planned	As planned (see below entry)	
21/08/13	12.35	Asquith Medi-	Telephone	PC 1 is not available today on a rest day and then	As planned	As planned (see below)	

	pm	cal records	communi-cation to Leicester-shire Police	annual leave. Not able to locate any file on Mi-chael. HV to contact father for crime number			
21/08/13	12.40 pm	Asquith Medi-cal records	Telephone Communi-cation with Father's partner	Father's partner not able to give crime reference number as it is on her phone. HV to call back in a couple of minutes	As Planned	As planned (see below)	
21/08/13	12.45 pm	Asquith Medi-cal records	Telephone Communi-cation with Father's partner	Crime number given	Contact police quot-ing reference number to ensure that they are following up inci-dent.	As expected (see below)	
21/08/13	12.45 pm	Asquith Medi-cal records	Telephone Communi-cation with the Police: Discussion with Refer-ral Assis-tant Leices-tershire Police	Police are continuing to investigate but have on their records that the infestation is confirmed as head lice and not pubic lice. Police confirm that they have liaison with Leicestershire Social Services	To investigate whether eye lash infestation was pubic lice or head lice	As expected (see below)	This is addressed via conversation with Safeguarding Nurse Social worker represented below on 21st August 2013 at 1.30pm.
21/08/13	1.15p m	Asquith Medi-cal records	Telephone Communi-cation with Safeguard-ing Nurse	Safeguarding Nurse confirmed that Michael had an infestation of pubic lice and a faxed report has been sent to Social Worker	Communication of this to agencies in-volved	As expected (see below)	It seems that social services are the only agency aware the type of lice in Michael's eye lashes at this time following communication form the LRI Safegaurding nurse - faxed Genito-urinary report.
21/08/13	1.30p m	Asquith Medi-cal records	Telephone Communi-cation with Social Worker	SW states that they are dealing with this referral and have received a medical report confirming pu-bic lice infestation in Michaels eye lashes. SW stat-ed that she has already had discussion with Father regarding referral and clearly stated to him that he	Representation of this information in patient record; com-munication with oth-er agencies and fa-	As expected (see below)	

				needs to seek legal advice regarding custody and future contact with Michael with his mother Holly as she has rights to contact. SW states that the plan is to contact Bristol Social Services and share information for Bristol to complete initial assessment. SW will discuss with Team manager as difficulty in determining whether this infestation was caused by transfer of lice from bed sheets or towels or whether sexual abuse has taken place.	ther		
21/08/13	1.40pm	Asquith Medical records	Telephone communication from HV St Georges Health Centre	Information shared regarding current circumstances and involvement of police and social services. HV confirmed that a welfare check was completed on Holly's propery in Bristol and that there were no concerns identified. HV will transfer paper and records and inform safeguarding nurse in Bristol.	Representation of this information in patient record; communication with other agencies and father	As expected (see below)	
21/08/13	2.00pm	Asquith Medical records	Telephone contact form Safeguarding Nurse	Information shared regarding liaison with all agencies currently involved. Informed regarding social services plan to visit Father and Michael at home and that they will be sharing information with Bristol Social Services in order for Bristol to make contact with Holly. Advised Health visitor to visit Michael on the 30/8/13	Representation of this information in patient record; communication with other agencies and father; Health visitor home visit to ensure Father managing Michael	As expected (see below)	
21/08/13	2.15pm	Asquith Medical records	Telephone communication with Father	Informed Father that the Police and social services are continuing with their investigation and reassured that he had been taken seriously by professionals. Advised Father that the infestation can be caused by sexual abuse but also lice can live in bed clothes and towels and decisions regarding what happens next with regard to further action and will be based on whether social worker feels that sexual abuse has taken place or the mode of transmission was via sheets or towels. Father reports that this is not his only concern that he has had regarding	Health visitor to answer Father's questions around action going forwards outside of a safeguarding forum. This information to be represented in the record	HV 30/8/13	Explanation of the role of health and social care staff in the ongoing monitoring of the situation outside of the safeguarding process should have been explained to Father and represented into he notes. Also the role of cross partnership working between Leicestershire and Bristol services in the event that shared care of Michael was resumed between father and

				Michael's health and welfare whilst in Holly's care and that this was just the tip of the iceberg. Advised Father that Social Worker will contact him to re-arrange visit. Father asked what could be done if he did not agree with the social workers decision if there was no further action to be taken. Advised Father that he and his other family members will need to consult with GP to check they are not infected. Father reports that Michael has follow up eye clinic next week. HV planned for 30/8/13			mother.
21/08/13	4.30pm	Asquith Medical records	Advice to Dr communicated by Clinical Record system	Dear Dr X. I understand that this little boy has recently register with your practice. Please could you view System 1 records as there has been recent child protection concerns and police and social services are currently involved. My telephone contact number is xxxx if you wish to discuss this further with me on the given number. I will update you on the progress of this case as further information is shared. I plan to see this little boy at his home not he 30/8/13. Many Thanks HV			
21/08/13		From Liquid Logic case notes. Telephone call from **C, health visitor**, to **social worker 4**	Michael	**Health visitor C** has spoken to the hospital and to Father and is visiting the family on 23.8.14. She has advised that the whole family seek GP advice to ensure they are lice free.			There is no record of any follow up discussion with **Health Visitor C**
21/08/13		From Liquid Logic case notes. Telephone call from **K, safeguarding lead** at Leicester Royal Infirmary to **social work-**	Michael	**Safeguarding lead K** confirmed that to her knowledge Michael had been with Father since 13.8.14. He had been treated initially for headlice which Holly was reported to have said he had caught from visiting friends' children. However, it had since been confirmed that he had pubic lice and had been treated by **opthalmologist Dr T**. **Safeguarding lead K** noted **Dr T**'s views about transmission methods. **Safeguarding lead K** agreed		Single assessment agreed. **Social worker 4** telephoned Father and notified him. Noted from discussion with Father that Michael is still in his care although Holly said to be unhappy about this.	There is no record of written confirmation from either **safeguarding lead K** or **opthalmologist Dr T** being sent to or received by SCSS

		er 4		to email this information from **Dr T** to SCSS.			
21/08/13		From Liquid Logic case notes. Telephone call from **social worker 4** to **social worker R** in Bristol	Michael	**Social worker 4** informed **social worker R** that it is now confirmed that Michael had pubic lice and agreed to fax hospital report confirming this to her. They discussed that E had said that Holly is caring for other children in Bristol but that social workers in Bristol had completed a "safe and well check" on 16.8.14 and that there were no children at Holly's home. **Social worker R** commented that there had been a "lot of conversations" between children's services in Bristol and Father.			There is no record of hospital report being sent to **social worker R.** The nature of "conversations" between Bristol children's services and Father is not specified.
22/08/13		From Liquid Logic case notes. Allocated to **social worker 6**	Michael				It is not recorded whether or how Holly or Father were made aware that **social worker 6** had now been **allocated.**
22/08/13		Bristol Children's services – Letter	Michael	Leicester passing on a letter from medical team in Leicester for records. Information given regarding the nature and likely concerns to be considered in relation to possibility of a Pubic Lice infection	Information recorded on case record.	Information recorded on case record.	
27/08/13		Air Balloon Surgery Bristol Medical Records	Telephone Consultation	No answer when called			
27/08/13	No time registered	LRI Ophthalmology Service Records	Outpatient assessment notes	16 month old with pubic lice infestation in eye lashes - ***evaluation under anaesthetic*** on 16/8/13. Confirmed presence of live lice and confirmed the specimen with microbiology lab. Has come in with dad who has parental custody for now (social services and police at Leicester involved) No itchy or sore eyes now. Observation: Looks very well. Not seen at close distance but eyelashes and lid marging appear not inflamed. Clear Cornea ***bilaterally.*** PLAN: explain to father. Review in 6/12.	Signature should be followed by printed name - absent in this entry.	Only initials signed	The quality of notes represented could have been better re: time and appropriate sign off.

28/08/13		Air Balloon Surgery Bristol Medical Records	Emergency Contraception	History: Uses condoms; not so happy on the pill as mood change; light smoker - 1-9 cigs/day- Health ed - Smoking; unprotected sex 12 hours ago, has post coital contraception 2 w ago and had bleed last week: Medication: Levonelle One Stop 1.5mg tablets. Take one tablet as a single dose as soon as possible but no later than after 72 hours)1 tablet mycogynon 30 tablets - one daily for 21 day; Subsequent Course repeated after 7 day tablet free interval 126 tablet; Comment: Medication usage explained not to start coc ***(Authors Note: coc =course of contraception***) until bleed post coital cx.....			
30/08/13	10.45 am	Asquith Medical records	Notes from Health Visitor Home visit	Discussion about child health record discussed with parents and left in the home. Discussion about information sharing. Health visitor child 9-12 contact. Use of electronic records discussed. (Full detail of HV assessment and results outlined - information that follows is of relevance to the case) Michael has not received any immunisation to date. Father reports that mother did not give consent; Head lice and pubic lice infestation resolved; Michael appears to be growing and developing within normal limits; Social services are still investigating recent pubic lice infestation whilst Michael was in care of his mother in Bristol. HV to follow up; Observed emotional warmth and positive attachment between father and child. Warm verbal interaction and eye contact evident. Father seen to handle Michael appropriately and confidently. father appears to be meeting Michael's basic needs dressed appropriately for age and environment hygiene was of a good standard. To date Father has not received any further contact from social service or police regarding further action, Father feels Michael should remain in his care as mother currently stating that she is unable to course the pubic lice infection and denies that it was passed on by her friends or herself. Father reports other concerns around mothers care			

				of Michael and reports that he recently took him to have his feet measured and was advised that Michael was at risk of toe curl if age appropriate socks were not used. Michael's mother is reported to not believe in wearing shoes and feels that children should be bare foot. Michael is also reported to be dressed by his mother in clothes that are not age appropriate. HV advised Father that Social Services were looking to share information with Bristol Social services and that they planned to visit Father and Michael at xxx address. HV advised Father to seek legal advice regarding placement arrangements for Michael; Father and Michael's mother currently have shared care of Michael (prior to recent safeguarding concern had contact with father on alternate weeks). This is a private arrangement. Mother is enquiring as to when she can have Michael back in her care, although Father is stating that Michael's mother has been quite laid back about the situation. Plan: HV to share information with GP and social worker regarding visit. Father to seek legal advice regarding placement arrangements for Michael.			
30/08/13	NA	Asquith Medical records	Scanned in One Year Review Notes from Health Visit	Detail as above - hand written			
30/08/13		From Liquid Logic case notes. Telephone call to **social worker 7** from Holly	Michael	**Social worker 7** advised Holly that allocated **social worker 6** is on leave and will call her next week. Holly said she had been contacted by E and is aware that Michael has had pubic lice. She was told that by **social worker 7** that an assessment is being undertaken and that Father has had other concerns about Michael's care.			This is the first recorded discussion between social workers in Leicester and Holly.

05/09/13		From Liquid Logic case notes. Allocated to **social worker 8.**	Michael				It is not recorded whether or how Holly or Father were made aware that **social worker 8** had now been allocated.
10/09/13		From Liquid Logic case notes. Telephone call from Holly to **social worker 8**	Michael	**Social worker 8** explained she had been on leave for 2 weeks. Holly was concerned she had had no contact with Michael for 6 weeks as Father would not allow it. **Social worker 8** advised her to seek legal advice about contact and said that there was no evidence to suggest she should have no contact with Michael although there would be concern should Michael return to her care. Holly queried on what basis E was caring for Michael. **Social worker 8** stated that Michael was not "placed" with Father. They also spoke about concerns about Michael. Holly said she did not know how Michael had contracted pubic lice: neither she nor her partner had them but she would "check" with other visitors. She and Father had talked before about Michael's eye and were bathing it with salt water: she saw no need to take him to the GP because Father's GP was "running tests". She said he may have contracted the pubic lice in Leicester. She said Michael had not had his vaccinations because she and Father did not want him to have certain vaccines. She said she had treated Michael's headlice and shaved his head but the GP had "nothing" ie no medication to offer because of his age. She said he caught headlice from children at nursery. She said she had taken him to a walk in centre in Bristol, the Air Balloon Health Centre, when he fell off the worktop.			It is unclear on what basis it was suggested that there would be concern if Michael returned to Holly's care. Although it was confirmed that Michael had pubic lice, the method of transmission had not been confirmed - as Holly commented, there was a possibility that Michael had contracted these in Leicester. Other concerns raised by Father about possible neglect of Michael by Holly had not been evidenced eg there is no record of attempts to quantify weight loss.
13/09/13	930 am	From Liquid Logic case notes. Office visit by E, his partner C and	Michael	Michael was noted as smartly presented and comfortable with both E and C. E spoke about longstanding concerns about Holly's care of Michael. He spoke about her lack of support and overall life choices, referring to concerns about poten-			This is the only time that Michael was seen by social workers. Father was now clear that he wanted to assume full time care of Michael: however he was not offered fur-

		Michael: seen by **social worker 8**		tial risks from visitors and friends. He was given advice about contact and residence issues and it was recommended that he seek legal advice. He spoke about his willingness to enable Michael to have contact with Holly but said that he wanted this to take place in a safe environment. He did not identify any further support needs for Michael or the family.			ther support or signposted to local support services. There is no record of discussion about Michael's health eg his weight or the fact that he had recently had an operation under anaesthetic to remove the lice from his eyes. There is no record of discussion with Father about the possibility that Michael may have contracted pubic lice whilst in his care.
13/09/13	pm	From Liquid Logic case notes. Telephone call from Holly to **social worker 8**	Michael	Holly asked for Father's address. She said he was refusing to allow her to have contact with Michael. She was advised to seek legal advice to resolve the issue. **Social worker 8** highlighted to her that Father had expressed he was happy for her to have contact with Michael. **Social worker 8** stated that Father's concerns about Holly's care of Michael could not be evidenced as they had not been reported to authorities and that they should resolve contact issues privately with the benefit of legal advice. Holly was reported to "understand" this.			Holly had clearly had a lot of discussion with Father about the situation and presented as receiving very different messages about her future contact with Michael than those Father had presented in discussion with **social worker 8**. There was no exploration with Holly as to whether Father was behaving in a controlling manner towards he or whether there was an element whereby Michael was being "used" in disputes between his parents.
13/09/13		Single assessment concluded - Leicester City Council		Closure summary notes that although the hospital confirmed that there were pubic lice on Michael's eyelashes, there is no confirmation that these were contracted as a result of sexual abuse although Holly had given "mixed information" to **social worker 8** and Father about a "potential partner who may have had pubic lice". It also noted that the parents had discussed previous concerns about Michael's care between themselves and had not reported them to any agencies therefore after "team manager consultation" it was agreed that they should address the remaining concerns, ie about contact,			There is no record of which team manager was consulted about the conclusion of the single assessment. The focus within the closure summary is clearly on residence and contact issues, with concerns about pubic lice pre-eminent over other concerns indicating possible neglect. There has been no further assessment of the ability of Father to offer safe care and permanence to Michael.

				with solicitors. There was "no evidence of risk or abuse" to Michael. It was noted that Holly was chaotic and that Holly had commented that Michael could have contracted pubic lice in Leicester.			
17/09/13	1.50pm	Asquith Medical records	Advice to Dr1 to read information	I have completed a 1 year development assessment on this child which identified no concerns. Michael has been discharged from ophthalmology services at Leicestershire Royal Infirmary. As far as I am aware Michael will be staying in the care of his father until investigations are completed by social services .			
20/09/13		Source: Asquith Medical Notes: Clinic Letter from Leicester Royal Infirmary to Asquith Surgery	Ophthalmology Out Patient Letter appointment dated 27/8/2013: time 14.00	This 16 month old baby with a complicated family history was brought into eye casualty by his father 2 weeks ago. He underwent an examination under anaesthetic and was noted to have live lice infestation in his eye lashes. Microbiology confirmed them to be pubic lice....On examination today he looked a well child...there is an arrangement for him to be referred to GUM clinic to rule out concomitant infections. Social services at Leicester are involved. I will review him again in 4-6 months and will discharge him at the next visit if all remains well.			Note the time delay between A and E attendance on the 15th August 2013, investigation under anaesthetic on 16th August 2013, and formal notification of outcome of investigation under anaesthetic represented in the primary care notes. The outcome is represented first formally from LRI in an o/pt. follow up letter that occurred on the 27th August 2013 (letter generated same day). Also there is delay between o/pt. appointment date and letter received date of 20th September 2013 stamped by the GP. 19th August 2014 - spoke with Assistant Practice Manager Asquith Surgery to confirm date of letter received post o/pt. clinic appt on the 27th August and date stamp. Letter was received in hard copy by them on the 20th September 2013 and the electronic version of the letter was received on the 16th September 2013. This repre-

							sents a two week time gap between appt and information being shared with the practice. 22nd August 2014 -he had completed the investigation under anaesthetic whilst on call and supporting the registrar of a colleague. However, as this child was not registered under her care the discharge letter would have been generated by the allocated consultant. 30th September 2014 - copies of LRI records received. It is apparent that a discharge letter from LRI was generated on the 16th August 2013 and was expected to go out electronically and in hard copy. However, as it did not contain clarification (?why not as it was known)of the type of lice found in Michaels eyes. ? why letter did not get to GP - GP admin issue or LRI admin issue (?)
25/09/13	2.53pm	Asquith Medical records	Incoming Call from Health Visitor Bristol	She wanted to confirm where the child is residing?? According to HV Sys1 - child residing in Leicester with father. HV has informed that she will be sending over the child's records to the Leicester Team. If this is not the case then these will need to be returned to them			
25/09/13	8.03am	Asquith Medical records	Letter to Dr1	Thank your your recent communication. Michael as far as I am aware is still residing with his father. He will not be discharged from the HV service unless he moves back down to Bristol to go live with his mother. Following recent face to face contact there are no concerns highlighted. Michael has been discharged from Ophthalmology. Await Social services decision. I will keep you informed			

25/09/13		From Liquid Logic case notes. Letter from **social worker 8** to Holly, copy to E.	Michael	The letter informed Father that SCSS would no longer have any involvement with the family, emphasising that E had made the decision that Michael should live with him, rather than this being the decision of the Local Authority. It noted that there was no evidence to suggest a risk of sexual harm to Michael.			
30/09/13	2.25pm	Medical Notes - Asquith Surgery	Reminder/Alert	THIS CHILD IS CURRENTLY UNDER INVESTIGATION BY SOCIAL SERVICES AS CONCERNS ABOUT HIS CARE WITH HIS MOTHER IN BRISTOL. FATHER LIVES IN LEICESTER. PLEASE DOCUMENT CAREFULLY AND LIAISE WITH HEALTH VISITOR/AND SOCIAL SERVICES ANY ENCOUNTERS SEPT 2013 - Priority- Normal			
02/10/13	917 am	From EDRMS. Copy of email from Father, dated 29.9.14, sent by City Council Customer Services team to SCSS DAS aka Response team	Michael	E's email is completed on a standard format: it is very evidently a complaint although he appears to have recorded that he is sending a "compliment". He raises concern about the closure letter sent to him by **social worker 8**, stating that he was originally told (unclear by whom) that Michael must stay with him and that the Local Authority now appear to be "pulling away" from this view. He noted that he is very unhappy that in his view there has been a very limited and inadequate investigation into how Michael contracted pubic lice. He complains that Michael's home environment with Holly was not checked. He also complains that he has had limited contact with social workers and has had to be proactive in following up information from them.			
08/10/13		From manual records held by Complaints Officer. Written response to Father's complaint from	Michael	This response confirms that Michael had pubic lice and notes that the Local Authority wereinvolved because of concerns as to whether this evidenced "sexual abuse". It reiterates that contact and residence arrangements for Michael need to be resolved between Holly and Father, noting that children's services in Bristol had completed a "safe and			Dr T's opinion as to the means of transmission is not detailed elsewhere and in fact conflicts with information shared in discussion between Dr H and social worker 4 on 16.8.14 which refers to transmission through poor hygiene as

		team manager 2		well check" at Holly's home and had no concerns "for any child at her address". It also notes that Leicester are "entirely satisfied" that Father has acted protectively towards Michael. The response notes that **Dr T**'s opinion has been that poor home and personal hygiene as well as sexual contact could result in pubic lice being transmitted. It states that the "risk of sexual abuse has not been substantiated or established from an evidential perspective" and states that it is not possible to "corroborate that the risk [of further infection] is caused by the care afforded to Michael by his mother". It notes that children's services in Bristol have been advised to further assess neglect issues by Holly should Michael return to her care and highlights Holly's responses to Father's concerns in her telephone call with **social worker 8** on 10.9.13.			unlikely . There is no record elsewhere of the agreement reached with Bristol children's services about the need for further assessment of Holly should Michael return to her care.
16/10/13	2.15pm	Medical Notes -LCCHS Health Visitor and School Nurse South	Information shared with GP via GP template	Thank you for your recent task. I have clarified with social care that they have closed the case as Michael is residing with his father Father at (Address) and he is meeting Michael's needs appropriately (recent safeguarding concerns arose whilst Michael was in care of his mother Bristol). Social care have advised that parents seek their own legal advise regarding custody and residency. Thank you.			
05/11/13		Avon & Somerset Police - Homicide investigation	Holly and Arturo	Two separate reports (between 7-8pm and around 10pm) from neighbours of a 'large argument' between Holly and Arturo with a female screaming for 10-15 minutes and lots of banging	Not reported to police until homicide investigation enquiries		
06/11/13		Avon & Somerset Police - Homicide investigation	Holly and Arturo	Having been told of the argument by one of the neighbours who had heard it, a third neighbour called on Holly and when she answered the door, she was seen to have red/purple bruises on her throat and she appeared to have been crying.	Not reported to police until homicide investigation enquiries		
06/11/13	4.30p	Medical Notes-	Clinical	History: Came as was asked to see. Came with fa-			

	m	Author: (General Medical Practitioner) Asquith Surgery	contact with Michael	ther and his partner. Mother in Bristol and child in father custody. Mother is seeking help -legally to get more access. Mother is still allowed to see him under supervision at Sure Start. Child growing well with no concerns			
26/11/13	Printed 26th No 2013 7.13pm	Broadmead Medical Centre medical Records:	Unprotected Sex	History: UPSI (***Authors Note: UPSI=Unprotected Sexual Intercourse***) 24hrs ago, no condom used. Pt not sure when LMP was, rpts beginning of the month. Denies any UPSI since imp. Has tried pill, doesn't get on with it, wants to continue with condoms. Meds_ not on any regular meds; discussed STI's. Refuses testing. last took eoc (***Authors Note: eoc - emergency oral contraception***) 2/12 ago. (previously notes liver disease, on pmh, but pt denies this) Examinations: O/E (***Authors Note; O/E = on examination***)- blood pressure reading 112/89 mmHg Comment: General contraceptive advice			
28/11/13		From Liquid Logic case notes. Telephone call from Holly to **social worker 9**	Michael	Asking for information to support her in resolving contact issues and for access to records.		Some advice given over the telephone, information about how to access records sent in post by **social worker 9.**	
01/12/13		Avon & Somerset Police - Homicide investigation	Holly and Arturo	A male friend staying overnight at Holly's overheard Holly and Arturo having sex and this appeared to turn violent. When he asked her later if she was ok, she said she was fine. Later Arturo told him that Holly did not want to be with him anymore and she wanted him to leave	Not reported to police until homicide investigation enquiries		Late November 2013/early December 2013
01/12/13		Avon & Somerset Police - Homicide investigation	Holly and Arturo	A female friend staying at the address heard Holly and Arturo arguing in the bedroom just after midnight. There was a single loud thud and Holly made a short wailing sound. When the friend went into the bedroom Holly was crying. Holly said that she was fine and when the friend challenged Arturo, he	Not reported to police until homicide investigation enquiries		Early December 2013

				said he had pushed her and she had hit a socket on the wall. Later that day the friend saw a large purple bruise on Holly's right hip			
09/12/13		Avon & Somerset Police - Homicide investigation	Holly and Arturo	Arturo tells a female friend that he didn't think things were working out with Holly and that he was considering handing himself in to authorities in order to return to Mexico	Not reported to police until homicide investigation enquiries		
13/12/13		Avon & Somerset Police - Homicide investigation	Holly and Arturo	Whilst staying in Dorset, Holly confides to a female friend that Arturo would rape her when drunk, takes money to buy alcohol and would not leave her flat.	Not reported to police until homicide investigation enquiries		Between 13 and 16th December 2013
27/12/13		Avon & Somerset Police - Homicide investigation	Holly and Arturo	During the Christmas break when Holly is staying in Dorset with her family she tells a male friend that she might be pregnant with Arturo's child and that he was aware and if confirmed, he wanted her to keep the child.Arturo was aggressive during sex and that he had 'power trips', throwing her around the room and biting her (often to the rear of the neck) and she showed him reddening to the rear of her neck	Not reported to police until homicide investigation enquiries		
28/12/13		Avon & Somerset Police - Homicide investigation	Arturo	Whilst she was in Dorset with family a male friend of Holly's was staying at her home with Arturo and saw that he had been drinking and started screaming and became violent, breaking items in his room including a lamp and two glasses	Not reported to police until homicide investigation enquiries		
31/12/13		Avon & Somerset Police - Homicide investigation	Holly and Arturo	Having returned from Dorset, Holly has pregnancy confirmed at doctors. She tells a male friend over the phone that she had already decided to end the relationship but now had to decide what to do about the baby, and that she was unsure whether to confirm the pregnancy to Arturo. Arturo confirms to a male friend that he knows Holly is pregnant and that she does not want to keep the baby. He appears very upset.	Not reported to police until homicide investigation enquiries		

01/01/14		Avon & Somerset Police - Homicide investigation	Holly and Arturo	Holly asks Arturo to leave the house as the relationship is over	Not reported to police until homicide investigation enquiries		01/01/2014 OR 02/01/2014
03/01/14		Avon & Somerset Police - Homicide investigation	Holly	Holly asks a male friend to search for abortion clinics in Bristol as she does not have easy access to the internet without Arturo present	Not reported to police until homicide investigation enquiries		
03/01/14		Avon & Somerset Police - Homicide investigation	Arturo	Information that he has been searching for flights from Bristol to Mexico	Not reported to police until homicide investigation enquiries		
04/01/14		Avon & Somerset Police - Homicide investigation	Holly	Holly makes a telephone appointment with a clinic to discuss termination of her pregnancy. This telephone appointment is arranged for 10.15am on Wednesday 8th January	Not reported to police until homicide investigation enquiries		
06/01/14		Avon & Somerset Police - Homicide investigation	Holly and Arturo	Holly tells a friend that Arturo has stolen money from her wallet (£70). Another friend of Arturo says that Arturo has taken £20 from Holly's wallet, buys beers and gets drunk. This results in a big argument between Holly and Arturo during which he breaks Holly's mobile phone by stamping on it. This argument is reported to have been overheard by a neighbour, with Holly shouting that he is violent and selfish.	Not reported to police until homicide investigation enquiries		
07/01/14		Avon & Somerset Police - Homicide investigation	Holly and Arturo	Holly and Arturo are seen together just before midday walking in the direction of Bristol city centre. Arturo meets up with a male friend at the 'Bear Pit' and together they go to the Compass Centre on Jamaica Street so that Arturo can see someone to get information about returning to Mexico. Arturo tells his friend about the argument with Holly the previous day and says that he knows the relationship with Holly is over.	Not reported to police until homicide investigation enquiries		

07/01/14	13.3	Avon & Somerset Police - Homicide investigation		Holly arranges to meet a male friend at 1.30pm at a pub on Cheltenham Road and a short while later they both go to a female friend's house 'so that Holly can 'get away from' Arturo'. She is further described as not being her 'normal happy self' due to her relationship issues with Arturo.	Not reported to police until homicide investigation enquiries		
07/01/14	1600to 1700	Avon & Somerset Police - Homicide investigation	Holly and Arturo	Arturo goes to a house party and would appear to start drinking. At approximately 9.30pm he is seen walking unsteadily on his feet across the Bear Pit	Not reported to police until homicide investigation enquiries		
07/01/14	20.3	Avon & Somerset Police - Homicide investigation	Holly	Talked of having an abortion the following week.	Not reported to police until homicide investigation enquiries		
07/01/14	2300 to mid-night	Avon & Somerset Police - Homicide investigation	Arturo and Holly	Arturo sends a series of texts to Holly that consist of abusive language. Examples- Whore, Baby killer, Don't come back. By that time he had returned to the house. Holly replies "What to my house?Really?". Holly attempts to call him, was very upset and told her friend "I just want him to go". She text him, telling him to pack his belongings as he was leaving the next day. He replied "Yes baby killer can't stand another minute around you" Further texts between them. Holly tells a friend that she thinks he is "mental or crazy"	Not reported to police until homicide investigation enquiries		
08/01/14	00.30 to 0200	Avon & Somerset Police - Homicide investigation	Holly	Holly returns home, telling her friend " I need to go home and sort this out"	Not reported to police until homicide investigation enquiries		
08/01/14	02.27 to 02.52	Avon & Somerset Police - Homicide investigation	Arturo	He is seen to leave the house and return with a drink in his hand.	Not reported to police until homicide investigation enquiries		
08/01/14	0245	Avon & Somer-	Holly	Two of Holly's friends either called or text Holly to	Not reported to po-		

	to 0321	set Police - Homicide investigation		check on her welfare.	lice until homicide investigation enquiries		
08/01/14	10.15	Avon & Somerset Police - Homicide investigation	Arturo	He uses Holly's mobile phone to call his friend and tells him he has "messed up", "crossed the line" and killed Holly.	Not reported to police until homicide investigation enquiries		
08/01/14	11.56	Avon & Somerset Police - Homicide investigation	Arturo	He called 999 and stated that he had killed his girlfriend.	He was correctly taken to hospital but once concerns passed he was returned to police custody later that evening. He was volatile and emotional,handcuffs were required.The procedure was videoed.	Police attended and he was arrested and taken into custody. He was at that time uncooperative and was under the influence of alcohol and by his own admission ketamine. An ambulance attended when he was thought to be unconscious and he was taken to hospital as a precaution.	All police procedures in relation to detention, interview and charge were recorded as standard.
09/01/14		Air Balloon Surgery Medical Notes	Report Path of Local Record for Holly	(administration note) Death (First) - notified by Police. Detail may follow. Coroner involved and notes copied to police.			
09/01/14		Contact - Bristol Children's Services	Michael	Notification of homicide of Holly received from Police Safeguarding Co-Ordination Unit	information recorded on case record.	information recorded on case record.	Child in care of father in Leicester no involvement in Bristol.
09/01/14		From Liquid Logic case notes. Telephone call from FM, Avon and Somerset Police to **social worker 9**	Michael	Advising that Holly has been unlawfully killed and seeking information about whether Father has a residence order for Michael or what contact Holly has had with Michael.			

10/01/14		Custody record	Arturo	Arturo charged with the murder of Holly			All police procedures in relation to detention, interview and charge were recorded as standard.