

# A Domestic Homicide Review into the Death of Adult A

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A report for the Safer Cornwall Partnership

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**April 2014**

I would like to express my sincere condolences to the family and friends of Adult A.

My gratitude is also extended to the professionals, agencies and panel members who dedicated their time, commitment and tenacious attention to detail throughout the Domestic Homicide Review.

Martine Cotter

Independent Chair 2014

**The names of individuals have been changed to protect identity**

**FOI statement to be added here.**

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# SECTION ONE

## Introduction

1. At 1037 hours on the 13<sup>th</sup> May 2012 Ambulance Services were called to *(Redacted)* in the small village of *(Redacted)* near *(Redacted)* and found Adult A unconscious with a wound in his chest and a pair of scissors lying next to him. Adult A was airlifted to *(Redacted)* but efforts to resuscitate him failed and he was pronounced dead at 1147 hours on Sunday 13<sup>th</sup> May 2012. His wife, Adult B admitted throwing the scissors during an argument and was convicted of manslaughter due to diminished responsibility on the 8<sup>th</sup> November 2012. Adult B was sentenced to 9 years in prison.

## Reasons for Conducting the Review

2. Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The act states that a DHR should review ‘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 he was related or with whom he was or had been in an intimate personal relationship, or
  - (b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death’
3. Adult A and Adult B were married and living in the same household at the time of the homicide. The Safer Cornwall concluded that the death of Adult A met the criteria for a DHR and commissioned a review in consultation with partners in line with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011) with the purpose of:

- Establishing what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked or work, individually and together to safeguard victims;
- Identifying 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;
- Applying these lessons to service responses including changes to policies and procedures as appropriate; and
- Identifying what needs to change in order to reduce the risk of such tragedies happening in the future
- Improving service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

## Scope of Review

### 4. *The Victim*

5. Adult A moved to Cornwall from Bedfordshire with Adult B and her three youngest children in 2004. The Review Panel requested that records be secured in Cornwall, Bedfordshire and Luton.
6. No information (relevant to the Terms of Reference of the Domestic Homicide Review) was held on Adult A by any agency in Bedfordshire or Luton.
7. To ensure that opportunities were not missed to identify signs and symptoms of domestic abuse during the time that Adult A resided in Cornwall, the Panel decided to review agency contact with Adult A from the **1<sup>st</sup> January 2004** up to the date of his death on the **13th May 2012**.

## 8. *The Perpetrator*

9. During the murder trial, the jury were informed of a letter from Education Welfare Services to Adult B's General Practitioner dated 17<sup>th</sup> March 1978 (When Adult B was 15). The letter stated that Mrs N (Adult B's Mother) had pleaded for help with Adult B's violent temper, informing the Welfare Officer that *"Adult B will end up murdering someone."*
10. This disclosure and information obtained as part of the criminal investigation confirmed a history of violent behaviour leading back to Adult B's childhood and continuing through her adult life. Presented with this evidence, the Domestic Homicide Review Panel considered extending the scope of the review for Adult B to include her early years.
11. The Domestic Homicide Review Panel is aware that the timescale for review is unusual in its duration, however, applying the principle of thoroughness, the panel wished to establish whether opportunities existed in Adult B's past for agency intervention which might have had a bearing on her behaviour and her subsequent actions on the 13<sup>th</sup> May 2012 that led to Adult A's death.
12. The Domestic Homicide Review Panel decided to review agency contact with Adult B from the **1<sup>st</sup> January 1963** up to the date of the death of Adult A on the **13<sup>th</sup> May 2012** unless it became apparent that the timescale in relation to some aspect of the review should be extended or reduced.

## Terms of Reference

13. The following areas are addressed within the Individual Management Reviews and the Overview Report;
14. Review the actions of the agencies (defined in section 5.3 of the Home Office Guidance for Conducting a Domestic Homicide Review 2011) involved with the family and - at the initiative of the Chair and subject to the agreement of the Review Panel - any other relevant agencies or individuals.

15. In the event that the family had no known contact with any specialist domestic abuse agencies or other relevant services, the review will address whether the incident in which Adult A died was a 'one off' or whether there were any warning signs that would indicate that more could be done in Cornwall or Bedfordshire to raise awareness of services available to victims and perpetrators of domestic violence.
16. Seek to involve family, friends, key workers or colleagues (including employers) to participate in the review and establish whether they were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons), prior to the homicide and include their potential contribution to the review in the way set out within the review framework.
17. Establish whether there were any barriers experienced by the family/ friends/colleagues in reporting any abuse or concerns in Cornwall, Bedfordshire or elsewhere, including whether they (or the victim) knew how to report domestic abuse had they wanted to.
18. Identify whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the household.
19. Establish whether the perpetrator had any previous concerning conduct or a history of abusive behaviour and whether this was known to any agencies.
20. Identify whether there were opportunities for agency intervention in relation to the perpetrator (e.g. aggression, mental health issues or child protection arrangements) that were missed.
21. Identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county.
22. Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator or family members e.g. age, disability, gender

reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

23. Consider any other information that is found to be relevant.

24. The Review will exclude consideration of how Adult A died or who was culpable.

25. The Terms of Reference was shared with key family members of Adult A and Adult B with an invitation to comment. No changes were offered or made.

## **The Independent Chair**

26. The Cornwall Council on behalf of Safer Cornwall, Cornwall's Community Safety Partnership, commissioned Martine Cotter as Independent Chair to undertake this external review.

27. It is the responsibility of the Independent Chair in consultation with the Review Panel to:

- Conduct the review in accordance with the Terms of Reference and Provisional Review Framework;
- Prepare this Overview Report for Safer Cornwall.

28. The Independent Chair has liaised (and will continue to communicate) with the Domestic & Sexual Violence Strategy Manager on all matters including the process of publication of this report. The Independent Chair is responsible for the final overview report and its summary.

29. Martine Cotter is a qualified strategic manager and a member of the Chartered Institute of Management with over 10 years' experience in the field of domestic abuse and sexual violence. Martine was the former Chief Executive of a specialist charity and was instrumental in developing the first Sexual Assault

Referral Centre (SARC) in the Southwest. From 2009 - 2011, Martine was seconded to the Department of Health's National Support Team for the Response to Sexual Violence as a Sessional Expert. In 2010 Martine completed the DASH 'Train the Trainers' Master Class and has since delivered Domestic Abuse training to more than 500 frontline professionals throughout the UK, including workers from Children Centres, Sexual Assault Referral Centres (SARCs), Social Services, Education, Armed Forces, Mental Health and Criminal Justice Agencies. Martine is the Independent Chair of three Domestic Homicide Reviews (at the time of this report). She has never worked for any of the partner agencies and has had no prior contact with the families concerned.

## Review Panel

30. The primary responsibilities of the Panel include;

- a. Reviewing the Individual Management Reports
- b. Summarising concisely the relevant chronology of events including the actions of all the involved agencies;
- c. Analysing and commenting on the appropriateness of actions taken;
- d. Making recommendations which, if implemented, will better safeguard victims of domestic violence in the future;

31. The Panel have been sourced according to the specific modus operandi of the homicide. Core members include;

(Table 31a)

| Representative of | Occupation/Professional Management Status     |
|-------------------|-----------------------------------------------|
| Safer Cornwall    | Domestic and Sexual Violence Strategy Manager |

|                                                                                                                  |                                                                                             |
|------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Devon and Cornwall Police                                                                                        | Public Protection Unit Lead for Cornwall                                                    |
| Community Safety & Protection                                                                                    | Community Safety Manager                                                                    |
| NHS Kernow (Clinical Commissioning Group)                                                                        | Head of Strategic Communications                                                            |
| Cornwall Foundation Trust<br>(Delivering Mental Health, Learning Disability and some Children's Health Services) | Adult Safeguarding Lead Professional                                                        |
| Children's Social Care                                                                                           | Senior Manager Children's Social Work & Psychology Service                                  |
| Children's Schools & Families                                                                                    | Deputy Safeguarding Children Manager & Local Authority Designated Officer                   |
| Children's Schools & Families                                                                                    | Senior Manager Social Inclusion and SEN Support Services                                    |
| Devon & Cornwall Probation Trust                                                                                 | Senior Probation Officer (Truro and Falmouth) and Quality Development Manager for Cornwall. |
| Specialist Voluntary Sector                                                                                      | Manager of Independent Domestic Violence Advisors (IDVAs) – Cornwall & Isles of Scilly      |

## Statement of Independence

32. Independence and impartiality are fundamental principles of Domestic Homicide Reviews. The ethical principles and impartiality of the Independent Chair and Panel are essential elements to protect the quality, legitimacy and credibility of the review and subsequent overview report.

33. The Independent Chair and Panel Members were asked to disclose or declare any matters that could affect their impartiality or that could reasonably be perceived to do so, and any other matters that might be of interest for transparency purposes. No such declarations were made.
34. The Chair certified that she had no connections or ties of a personal or professional nature with the family or any participating organisation which would affect a fully independent judgement regarding the outcomes of the review, in either a positive or negative sense.
35. The panel members were appointed based on their independence, having had no previous connection or tie to the family or any responsibility for direct line management of any member of staff involved with the case over the past 5 years.

### **Guiding Principles for Panel and Review**

36. The review panel were committed to the ethos of equality, openness, and transparency. There was no suspicion of concealment and all factors were thoroughly considered with an objective, open-minded, impartial and independent view. Due regard was paid to confidentiality and the balance of individual rights and the public interest.
37. The review panel sought to involve family, friends and employers to participate in the review and approached this with sensitivity, compassion, patience and respect. Where additional support for family members was required, the Panel sought the assistance of AAFDA (Advocacy After Fatal Domestic Abuse).
38. The review panel gave appropriate consideration to any equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to the victim, perpetrator or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

## Panel Meetings

39. The first Review Panel was scheduled on the 14<sup>th</sup> January 2013 to review secured records. This was approximately 9 weeks after the sentencing of Adult B. Appropriate consideration was given to Christmas holidays and allotted annual leave of panel members.

The Domestic Homicide Review Panel met on four further occasions;

- 15<sup>th</sup> May 2013
- 5<sup>th</sup> June 2013
- 20<sup>th</sup> January 2014
- 27<sup>th</sup> January 2014

Full minutes were recorded for all meetings.

## Timescales

40. The Home Office was informed of the intention to conduct a DHR on the 31 July 2012. This was within 2 months of being notified of the domestic homicide (17 May 2012).

41. The Statutory Guidance for Conducting Domestic Homicide Reviews (March 2011) recommends that the Overview Report should be completed, where possible, within 6 months of the commencement of the Domestic Homicide Review (not including any judicial investigation and court proceedings)

42. On advice from the Senior Investigating Officer, the Review Panel deemed it necessary to temporarily delay the Overview Report until the conclusion of the criminal case. In this situation all relevant agencies were notified of the requirement to secure records pertaining to the homicide against loss and interference.

43. The Independent Chair and Review Panel ensured all records were reviewed and a chronology drawn up to identify immediate lessons. All early lessons were shared with the relevant agencies for action and secured for the subsequent Overview Report.

44. Table 44a (below) sets out the original timescale for the completion of the DHR as stated within the full Terms of Reference;

(Table 44a)

| <b>ACTION</b>                                   | <b>ACHIEVE BY</b> |
|-------------------------------------------------|-------------------|
| Request for IMRs                                | 25.01.13          |
| 1 <sup>st</sup> Draft of IMRs completed         | 12.04.13          |
| 1 <sup>st</sup> Panel Meeting to Review IMRs    | 19.04.13          |
| Clarifications/Questions/Family Participation   | 10.05.13          |
| Panel Meeting to conclude and agree chronology  | 17.05.13          |
| 1 <sup>st</sup> Draft Overview Report completed | 12.07.13          |
| Panel Meeting to Review Overview Report         | 19.07.13          |

45. Unfortunately the timescale for completing the Domestic Homicide Review was delayed by a number of unexpected factors;

- Complications with cross-border communications and the request to grant IMR authors with an extension for 1<sup>st</sup> draft submissions;
- A delay in obtaining a license for the ChronoLator Programme;
- A prison transfer mid contact with Adult B, resulting in a significant delay in completing the Overview Report;
- Receipt of notification of 3 DHRs within 2 months of the statutory duty to undertake the process; which resulted in significant resource issues for agencies to identify and appoint IMR authors and undertake Individual Management Reviews.

The Panel also allocated adequate time and support for family members (of Adult A and Adult B) to read a copy of the draft overview report. This was undertaken with the help of AAFDA (Advocacy After Fatal Domestic Abuse)<sup>1</sup>.

<sup>1</sup> The Domestic and Sexual Violence Strategy Manager commissioned AAFDA in the hope to improve the likelihood of family participation. AAFDA offered a further layer of independence and together with input

Due to security and confidentiality, visits were made in person to two counties of the UK. With the assistance of AAFDA each family member provided a written response to the report, including additions.

The Overview Report was finally completed for Panel and family approval by December 2013, six months after the original timescale was set. The Review Panel is apologetic for the delay and has aimed to complete the Overview Report in the earliest possible time, without compromising quality.

## Methodology

46. This Review was guided by:

- The key processes outlined in the Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011);
- A guide for the Police, Crown Prosecution Service and Local Safeguarding Children's Board to assist with the Liaison and the Exchange of Information when there are simultaneous Chapter 8 Serious Case Reviews and Criminal Proceedings (April 2011);
- Learning from other Domestic Homicide Reviews and Serious Case Reviews of child/vulnerable adult deaths across the UK;
- The cross-government definition of domestic abuse (March 2013);

*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:*

- *psychological*

---

from the Independent Chair; the family were supported to contribute to the Overview Report, having initially declined to participate.

- *physical*
- *sexual*
- *financial*
- *emotional*

47. The Review comprised of a thorough examination of all relevant information including documentation provided by the criminal justice investigation (including key witness statements), individual professionals, commissioners and agencies.

48. Twelve professionals were interviewed from three different organisations.

Individual professionals employed during the period of social services involvement (1985-2001) are no longer in post. The review panel were unable to discuss their involvement or ask questions in relation to their actions or records.

49. The Review Panel did not need to seek the expert advice or opinion of any other specialist during the review as all questions were answered by members of the Panel or the original authors of the Individual Management Reviews. The Panel did seek additional guidance and expertise around support for the family members of Adult A and Adult B from AAFDA (Advocacy After Fatal Domestic Abuse) leading up to the sharing of the overview report.

50. The views and conclusions contained within this overview report are based on findings from both documentary evidence and some interview testimony and have been formed to the best of the Review Panel's knowledge and belief.

## **Family involvement**

51. The Review Panel invited Adult B and family members of Adult A to participate in the review. Each family member considered the invitation but initially declined to participate.

52. On advice from the Senior Investigating Officer the Review Panel did not make contact with the families until the conclusion of the trial. On reflection, and

following Home Office training in April 2013, the Review Panel now understand that this was a missed opportunity for the family to be involved with the Domestic Homicide Review from the outset.

53. The Review Panel accept responsibility for this decision; which conflicted with Statutory Guidance for Conducting Domestic Homicide Reviews (2011) and the Terms of Reference for involving family members, at the time. This is a matter of regret for the Review Panel but also an opportunity to learn for future Domestic Homicide Reviews.
54. The Review Panel is unable to comment on whether the timing of the contact with family members had an impact on the decision of individual family members to participate or not.
55. The family of Adult A and Adult B each received a copy of the Overview Report to read before its submission to the Home Office (19<sup>th</sup> March and 7<sup>th</sup> April respectively). The Review Panel welcomed comments, views and suggestions from family members during this process.
56. Adult A and Adult B's employers also declined to participate in the review although the Independent Chair and the Employer agreed to communicate on conclusion of the report in relation to any recommendations for the employer.
57. Both Adult A and Adult B worked for the same company leading up to the homicide. Key witness statements from the Branch Manager indicate that domestic abuse was witnessed by co-workers. The Head of Human Resources at the Employers Head Office expressly asked to be informed of the outcome of the Domestic Homicide Review and any recommendations for the company that will help improve the welfare of its employees.
58. It should be noted that in the absence of the views of family, friends and co-workers, the Review Panel has referred to testimonies obtained from witness statements provided to the criminal justice investigation.

59. To assist with producing a balanced Overview Report, the Independent Chair invited Adult B to participate in the Domestic Homicide Review. Adult B agreed to participate and arrangements were made to interview her at HMP (*Redacted*). Three weeks prior to the interview Adult B was transferred to (*Redacted*). A professional visit was rescheduled through the Prison Governor for a second time which resulted in a delay of 4 months.
60. An analysis of Adult B's participation is recorded within Section Three of this report. In the absence of participants representing the views and experiences of Adult A, the Review Panel included an analysis of witness statements obtained as part of the criminal justice investigation. This information was shared in the public interest under the prevention of crime and disorder.

## Confidentiality

61. The Independent Chair and Review Panel observed strict rules of confidentiality with regard to all information that came to their attention in connection with the Domestic Homicide Review insofar as confidentiality could reasonably be maintained.
62. When considering whether to breach confidentiality the Review Panel applied the P.L.A.N.E criterion e.g. was the need to share information Proportionate, Legal, Appropriate, Necessary and Ethical?

## Disclosure of Records

63. During the criminal investigation, Adult B denied access to her medical records which created an ethical challenge for the Domestic Homicide Review and in particular for the IMR author writing on behalf of the Clinical Commissioning Group.
64. The Review Panel sought guidance from previous Domestic Homicide Reviews and referred to the *Sheffield First Domestic Homicide Overview Report produced*

by Professor Pat Cantrill (December 2011). Professor Cantrill obtained legal opinion and a supporting statement from the General Medical Council; which stated that:

*We (the General Medical Council) feel that there is a strong parallel with Serious Case Reviews. Our 0-18 years guidance for doctors (paragraph 62) says that doctors "should participate fully" in Serious Case Reviews; it goes on to say "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." We think it reasonable that this should be the principle that doctors should follow in cooperating with DHRs as well".*

65. To further reassure health agencies, particularly general practitioners, the Sheffield First Review Panel developed a guidance document which was adopted by the Safer Cornwall Partnership and circulated to the IMR Authors on behalf of this Domestic Homicide Review. It is the understanding of the Review Panel that this document has been acknowledged by the General Medical Council.
66. Safer Cornwall would like to express thanks to Professor Cantrill and her Review Panel for seeking national guidance and legal advice on accessing medical records (without consent). The guidance document and accompanying statement from the General Medical Council undoubtedly helped to overcome the challenge of access to Adult B's medical records as part of this Domestic Homicide Review.
67. To gain an understanding of the level of risk Adult B posed to Adult A (and may pose to others on her release from prison (from 2016 onwards), the Review Panel also requested access to Social Care Records for each of Adult B's children in the interest of public security and the prevention of crime and disorder (*Article 8 Human Rights Act*).

## **Requests to Secure Information**

68. To ensure that early lessons were not missed, the panel decided that the DHR should not be delayed by pending legal action against Adult B and sought to

notify agencies and interested parties of the requirement to secure records pertaining to the homicide to inform the subsequent Overview Report. Each agency was asked to contact the Independent Chair outlining the nature of the contact with the family. As the family moved from Bedfordshire to Cornwall in 2004, records were secured in both counties.

69. The panel sought the assistance of Bedfordshire Community Safety Partnership to assist with sourcing contact details for agencies in Bedfordshire and Luton.

70. The agencies asked to secure information are listed in table 70a (below).

Agencies highlighted in red confirmed that they held information relevant to the DHR. The remaining agencies (not highlighted in red) did not hold any information deemed relevant to the Terms of Reference;

(Table 70a)

| County/Area         | Agency/Professional                            |
|---------------------|------------------------------------------------|
| <i>Bedfordshire</i> | Head of Intake and Family Support              |
|                     | Bedfordshire Police/ Head of Public Protection |
|                     | Local Business Development Manager             |
|                     | Head of Housing                                |
|                     | Bedfordshire Probation Trust                   |
|                     | Head of Learning and School Support            |
|                     | Bedfordshire Clinical Commissioning Group      |
|                     | Bedfordshire Domestic Abuse Coordinator        |
|                     | Victim Support                                 |
|                     | Head of Alcohol Services                       |
|                     | Head of Mental Health                          |
|                     | Head of Disabilities & Vulnerable Communities  |
|                     | Central Bedfordshire Community Safety          |

|                 |                                                  |
|-----------------|--------------------------------------------------|
|                 | Partnership                                      |
|                 | Bedfordshire Children and Young People's Service |
| <i>Luton</i>    | Luton Children's Social Care                     |
|                 | Luton Adult Social Care                          |
|                 | Luton Borough Council - Housing                  |
|                 | Education                                        |
|                 | Environmental Health                             |
| <i>Cornwall</i> | Devon and Cornwall Police                        |
|                 | Education                                        |
|                 | Cornwall & IOS Primary Care Trust                |
|                 | Adult Social Care                                |
|                 | Children's Social Care                           |
|                 | Cornwall Partnership NHS Foundation Trust        |
|                 | Safer Cornwall                                   |

71. Agencies *with* relevant information were notified in writing of a request to undertake an Individual Management Review (IMR) under Section 9 of the Domestic Violence, Crime and Victims Act 2004. Correspondence included;

- A Guide for Appointing an IMR Author\*
- An IMR Author's Guide\*
- An IMR Template and Guidance for completing an IMR\*
- A copy of the Terms of Reference

❖ Copies of these documents are available on request.

## Commissioning of Individual Management Reviews (IMR)

72. The aim of Individual Management Reviews is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be implemented.

73. The IMR Authors were asked to provide a chronology of agency involvement and draw overall conclusions from the involvement of the agency with Adult A or Adult B (and dependents).

74. The findings from the IMR reports were endorsed and quality assured by the senior officers within the organisations who commissioned the report and who are responsible for ensuring that the recommendations of the IMRs are acted upon.

75. Each agency was asked to;

- Critically appraise their agency's involvement with Adult A or Adult B (and/or Adult B's dependents) and to identify any safeguarding or welfare concerns leading up to the homicide of Adult A;
- Consider whether concerns were acted upon appropriately, and if not, identify what professional or agency issues/barriers prevented this from happening;
- Consider the earlier history of Adult B to identify early warning signs and/or opportunities for early intervention (if applicable);
- Construct a comprehensive chronology of involvement by their agency over the period of time set out within the scope of the Terms of Reference.

76. The Review Panel requested Individual Management Reviews from;

- Bedfordshire Police
- Luton Children's Social Care
- Bedfordshire Children and Young People's Service
- Primary Care Trust (to cover health records in Bedfordshire, Luton and Cornwall)
- Cornwall Education (Schools, Achievement and Special Educational Needs)

77. Following examination of Individual Management Reviews, the Review Panel asked for additional information (where relevant) from each agency to address the specific requirements of the Terms of Reference.

78. A significant amount of information was sought on the behaviour of Adult B during her parenting years. This information was requested to establish whether there were opportunities missed by agencies to risk assess Adult B's behaviour and provide appropriate support, safety planning and intervention to the family to reduce the level of risk to her children and Adult A.
79. Where case records were un-dated, the Review Panel sought additional information from partner agencies to assist with the triangulation of material to gain a more definitive chronology of events.
80. Upon viewing each of the IMR's and seeking further clarification from Luton and Bedfordshire Children's Departments the Panel was satisfied that the IMR from Bedfordshire Children's Service did not provide any additional information relevant to the Terms of Reference. The engagement of Children's Services with Adult B and her dependents was adequately covered within the Luton Children's Services IMR.
81. Section Four of this report includes an analysis of each Individual Management Review (IMR). Under each heading, the Review Panel has added a conclusion about the agency's response and whether the practice was in accordance with national and local requirements at the time. The Review Panel has drawn overall conclusions about what, if anything should have been done differently and, where appropriate, makes recommendations about what actions are required by each agency and by the Safer Cornwall Partnership to address the findings of the review. In addition, the Panel has made recommendations regarding any implications for national policy arising from the case.

## Parallel Investigations

82. The Independent Chair contacted the HM Coroner for the County of Cornwall in writing on the 24<sup>th</sup> September 2012 advising Dr (Redacted) of the

commencement of the Domestic Homicide Review and inviting discussions on how to dovetail the Domestic Homicide Review and the Coroner's Inquest.

83. The Coroner did not hold an inquest into Adult A's death as the criminal investigation and subsequent trial sufficiently established who the deceased was and how, when and where the deceased came by his death.

84. Other than the Criminal Investigation, the Review Panel was not informed of any other parallel investigation or Serious Case Review (SCR).

## Dissemination

85. It is anticipated at this stage that the final Overview Report and Executive Summary will be published. Internal Management Review reports will not be made publicly available. Whilst key issues will be shared with specific organisations the Overview Report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

86. In order to secure agreement, pre-publication drafts of the overview report were shared with the membership of the Review Panel, IMR authors and the Safer Cornwall Partnership Board.

87. The content of the Overview Report and Executive Summary have been suitably anonymised to protect the identity of the victim, perpetrator, relevant family members, staff and others to comply with the Data Protection Act 1998. The Overview Report will be produced in a form suitable for publication with any further advised redaction before publication. To assist and inform the redaction process the Safer Cornwall Partnership once again referred to guidance developed by *Sheffield First* in 2011.

88. Adult A and Adult B's family have been briefed about the Home Office Quality Assurance Panel and understand to expect a paper copy of the report following approval to publish from the Home Office. The Independent Chair has made

arrangements for the family to receive a paper copy of the report two days prior to publication. AAFDA<sup>2</sup> have also discussed media attention and have offered to support the families with media requests following general publication.

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<sup>2</sup> AAFDA – National Charity ‘Advocacy After Fatal Domestic Abuse’

# SECTION TWO

## SYNOPSIS OF CASE

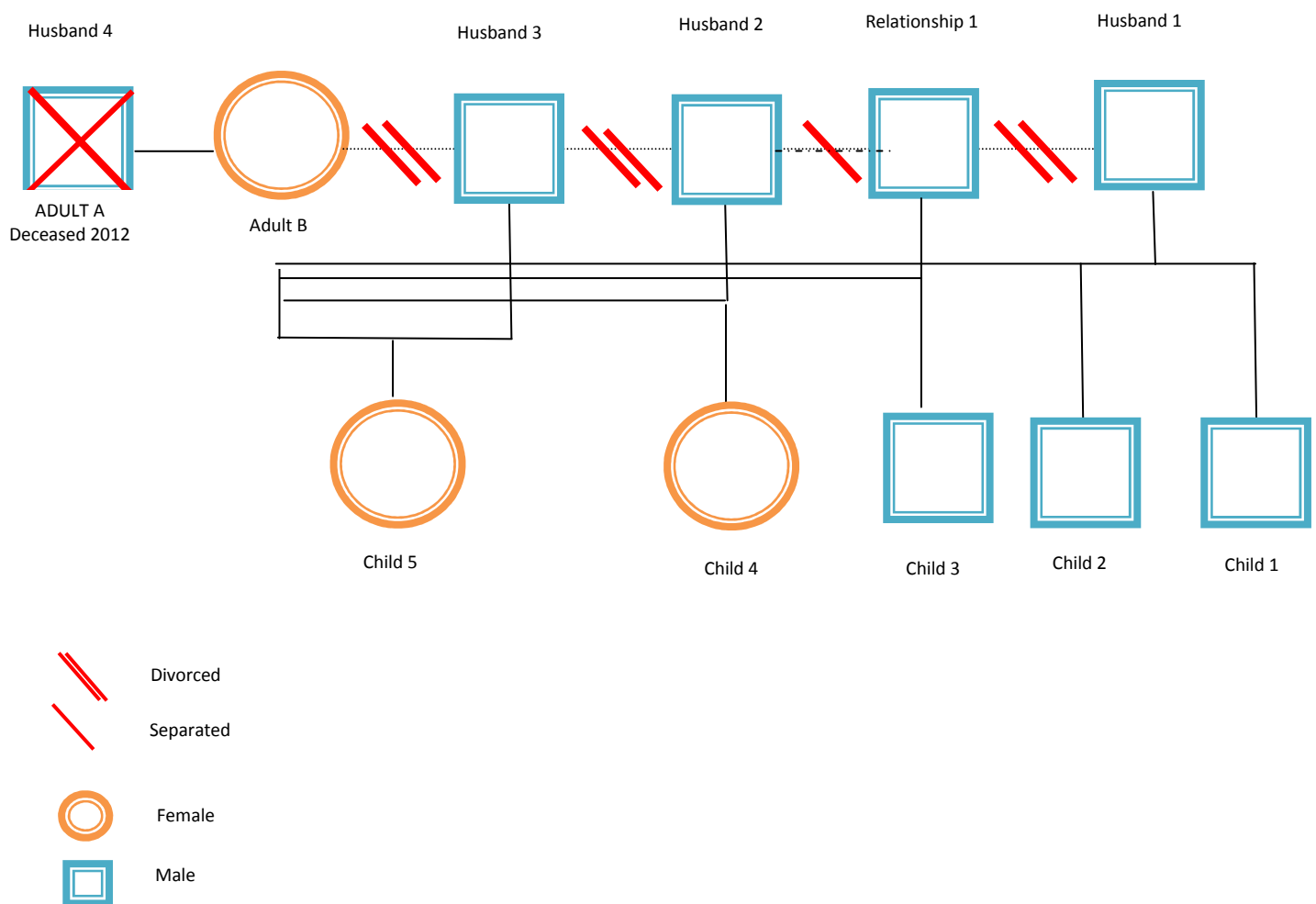
**Table A: Key Relationships**

| Name                         | Year of Birth | Relationship                                                                  |
|------------------------------|---------------|-------------------------------------------------------------------------------|
| <b>Adult A (M)</b>           | <i>1963</i>   | Victim                                                                        |
| <b>Adult B (F)</b>           | <i>1963</i>   | Perpetrator and wife of victim                                                |
| <b>First Child – C1(M)</b>   | <i>1980</i>   | Eldest son of Adult B (from marriage to First Husband)                        |
| <b>Second Child – C2 (M)</b> | <i>1981</i>   | Second son of Adult B (from marriage to First Husband)                        |
| <b>Third Child – C3 (M)</b>  | <i>1984</i>   | Third son of Adult B (from a relationship 1984-1986)                          |
| <b>Fourth Child – C4 (F)</b> | <i>1988</i>   | Fourth Child and eldest daughter of Adult B (from Marriage to Second Husband) |
| <b>Fifth Child – C5 (F)</b>  | <i>1993</i>   | Fifth child and youngest daughter of Adult B (from marriage to Third Husband) |

M = Male      F= Female

**Table B: Adult B's Key Relationships**

|                                 |                                              |
|---------------------------------|----------------------------------------------|
| <b>First Husband – H1</b>       | Married 1981, Divorced 1984                  |
| <b>Relationship – R1</b>        | 1984 – 1986                                  |
| <b>Second Husband – H2</b>      | Married 1986 – Separated 1991, Divorced 1994 |
| <b>Third Husband – H3</b>       | Married 1995 – Separated 2001, Divorced 2006 |
| <b>Fourth Husband – Adult A</b> | Married 2009                                 |

**Table C: Family Genogram**

# SUMMARY OF CASE

## Circumstances

89. At 1037 hours on the 13<sup>th</sup> May 2012 Ambulance Services were call to (*Redacted*) in the small village of (*Redacted*) near (*Redacted*) and found Adult A unconscious with a wound in his chest and a pair of scissors lying next to him.
90. Adult B was hysterical and had been the original caller to the Ambulance Service. She admitted throwing the weapon, a pair of dress making scissors, at her husband during an argument about cleaning the house.
91. Adult A was airlifted to (*Redacted*) but efforts to resuscitate him failed and he was pronounced dead at 1147 hours on Sunday 13<sup>th</sup> May 2012.

## The Deceased – Adult A

92. Adult A was born in London in 1963. He had one elder brother. His mother states that Adult A was a loving person who loved animals and wildlife. As a child he was a member of the Cubs and Scouts.
93. Whilst living in Cornwall Adult A was employed as a (*Redacted*) at (*Redacted*) for six years. He was described by his employer as a private man, polite and friendly, laid back and a thoroughly nice person. His work colleagues thought of Adult A as a *'bit of an old hippy'* in that nothing seemed to upset him. Nobody at his workplace could ever recall Adult A losing his temper or being in a bad mood.
94. Adult A belonged to a car club and collected money for charity through his love of motor cycles. He was considered to have integrity and was trusted as a signatory. Adult A was described by fellow club members as soft spoken, laid back with a chilled approach, never showing pressure at all. He was a good organiser and was a much respected member who became the *'mainstay and backbone'* of the club.
95. Adult A met Adult B in 2001 in Luton. He sold his house and moved into Adult B's council accommodation in 2004. Adult A and Adult B later moved out of their Council accommodation into private rented accommodation and subsequently

moved two or three times more within Luton before moving to Cornwall (also in 2004). Adult A told his family that the moves were necessary because Adult B's children were unhappy at school.

96. Following perusal of the draft overview report, A's brother added that his family were surprised by Adult A's decision to leave a *'good job which supported him despite significant health issues that affected his work capacity. His job in Luton gave him long-term financial security; which was important to Adult A as he was always careful with money'*. They were also surprised that Adult A had entered into a relationship with Adult B who had 5 children, as Adult A had never wanted children.
97. Adult A married Adult B in 2009. Leading up to the marriage, the couple separated on at least three occasions and Adult A would move out of the home for a short period of time. Following the wedding, Adult A lost contact with his brother and sister-in-law in *(redacted)*. He would occasionally invite his elderly mother down to holiday with them in Cornwall, but would arrange for her to stay in alternative accommodation and not in the family home.
98. None of Adult A's family disclosed knowledge that Adult B was physically abusive towards him.

## **The Perpetrator – Adult B**

99. Adult B was born in 1963. She was the eldest of three children. The middle sibling has severe learning difficulties most likely caused by oxygen starvation at birth. Her father died at the age of 59 and her mother died at the age of 69. Adult B's mother suffered poor health as a consequence of a number of strokes and heart attacks, having had her first stroke at the age of 34.
100. According to a letter contained within medical records, Adult B's mother suffered sustained violence at the hands of her husband (Adult B's father). Her parents separated when Adult B was approximately 10 years old, but he remained living in the same household.

101. Adult B was placed into care at the age of 14. Her younger siblings remained at home. Adult B stayed at the children's home until she was allocated a flat in the local area at 16.
102. Adult B was married three times before marrying Adult A. She had four children from the separate marriages and a fifth child from a more casual relationship. Adult B did not have any children with Adult A (her fourth husband).
103. Adult B was employed at the same branch of (Redacted) for three weeks prior to the homicide. Her employer described Adult B as *'a very good worker who was always busy doing something... She was pleasant and nice to people and seemed easy going'*.
104. Two of Adult B's ex-husbands (H1 and H2) provided statements to the police describing Adult B as violent and unpredictable. Both husbands reported previous knife attacks and one described a *'red mist that would descend and rages that could shut off like a switch'*.
105. Each of Adult B's five children described an upbringing where they were *'emotionally and physically abused with numerous relationships, addresses and schools'*.

## Police Investigation

106. Devon and Cornwall Police were despatched to (Redacted) immediately following an emergency call to Ambulance Services at 1037 hours on the 13<sup>th</sup> May 2012. The police attended at 1053 hours and cautioned Adult B who admitted to throwing a pair of scissors at Adult A during an argument about tidying the property.
107. At 1122 hours PC (Redacted) arrested Adult B on suspicion of grievous bodily harm and she was conveyed to (Redacted) Police Station where she was detained.
108. Efforts to resuscitate Adult A failed and he was pronounced dead at 1147 hours on Sunday 13<sup>th</sup> May 2012.

109. The murder weapon, a pair of dress making scissors, was seized at the scene.

110. Adult B was interviewed on tape with a solicitor present on Sunday 13<sup>th</sup> May 2012 and on three further occasions on Monday 14<sup>th</sup> May 2012.

111. Adult B was charged with Adult A's murder on 14<sup>th</sup> May 2012 and first appeared at court on the 15<sup>th</sup> May 2012.

112. In addition to Adult B's account, Devon and Cornwall Police also sought witness statements from (not an exhaustive list);

Table D: 112a

| Relationship to ... | Adult A and/or B |
|---------------------|------------------|
| Husband 1 (H1)      | Adult B          |
| Husband 2 (H2)      | Adult B          |
| Child 1 (C1)        | Adult B          |
| Child 2 (C2)        | Adult B          |
| Child 3 (C3)        | Adult B          |
| Child 4 (C4)        | Adult B          |
| Child 5 (C5)        | Adult B          |
| Mother              | Adult A          |
| Brother             | Adult A          |
| Sister-in-law       | Adult A          |
| Friend 1 (FR1)      | Adult A and B    |
| Friend 2 (FR2)      | Adult A and B    |
| Friend 3 (FR3)      | Adult A and B    |
| Neighbour 1 (N1)    | Adult A and B    |
| Neighbour 2 (N2)    | Adult A and B    |
| Neighbour 3 (N3)    | Adult A and B    |
| Neighbour 4 (N4)    | Adult A and B    |
| Neighbour 5 (N5)    | Adult A and B    |
| Neighbour 6 (N6)    | Adult A and B    |
| Employer (E1)       | Adult A and B    |

113. Devon and Cornwall Police were unable to locate Husband 3 (of Adult B). The father of Child 3 (R1) did not wish to be contacted by the Police.

## Findings of Post Mortem

114. The Post mortem was conducted by Home Office Pathologist Dr (Redacted) on Monday the 14<sup>th</sup> May 2012 at the (Redacted) Hospital Mortuary.

115. His findings were that the deceased suffered a stab wound to his left chest causing damage to his lung and heart. There was a large collection of blood in his left chest cavity and blood in the pericardial sac.

116. The wound entry was about 2.5cm wide and about 10 – 12 cm deep and consistent with being stabbed with the pair of scissors seized from the address, with the blades closed.

117. Dr (Redacted) report states;

*“The wound was situated slightly above Adult A’s left nipple with the angle of penetration consistent with a horizontal blow in a slightly upward direction (The slightly upward angle of penetration would depend on the position of Adult A when the blow was struck and may not have been caused by Adult B using an upward blow).*

*The angle of penetration suggest that the wound was inflicted by a person using their right hand to hold the scissors swinging their arms and scissors from right to left, or a person using their left hand in a ‘back hand’ motion.*

*The deceased had a small cut to the back of his right index finger that may be considered to be a defence wound”.*

118. A second post mortem was conducted at (Redacted) Mortuary in (Redacted) on Tuesday 22<sup>nd</sup> May 2012 by Pathologist (Redacted) with (Redacted) present. Dr (Redacted) did not find any evidence to contradict the original findings of Dr (Redacted).

## Coroner's Inquest

119. Paragraph 15.1 of the Ministry of Justice Guide to Coroners and Inquests and Charter for Coroner Services (March 2012) states;

*Where a person has been sent for trial for causing, allowing or assisting a death, for example by murder or manslaughter, any inquest is in most cases adjourned until the criminal trial is over. On adjourning an inquest, the coroner must send the Registrar of Births and Deaths a certificate stating the particulars that are needed to register the death and for a death certificate to be issued. When the trial is over, the coroner will decide whether to resume the inquest. There may be no need, for example, if all the facts surrounding the death have emerged at the trial. If the inquest is resumed, however, the finding of the inquest as to the cause of death cannot be inconsistent with the outcome of the criminal trial.*

120. The Coroner did not resume an Inquest into the death of Adult A after the trial as the criminal justice process sufficiently established who the deceased was and how, when and where the deceased came by his death. This was not disputed by the pathologists or the defence and prosecution teams.

## Court Dates and Outcome

121. The trial at (*Redacted*) Crown Court commenced on the 29<sup>th</sup> of October 2012 and concluded on the 8<sup>th</sup> of November 2012, lasting nine days.

122. Adult B was found guilty of manslaughter on the grounds of diminished responsibility. The Jury's view was contrary to Dr (*Redacted*) conclusion in that the Jury believed Adult B must have had a personality disorder. She was found not guilty of murder.

123. Section 52 of the Coroners and Justice Act 2009 defines a Person suffering from diminished responsibility (England and Wales);

*“(1) A person (“D”) who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which—*

- (a) Arose from a recognised medical condition,*
- (b) Substantially impaired D's ability to do one or more of the things mentioned in subsection (1A), and;*
- (c) Provides an explanation for D's acts and omissions in doing or being a party to the killing.*

*(1A) Those things are—*

- (a) to understand the nature of D's conduct;*
- (b) to form a rational judgment;*
- (c) **to exercise self-control.***

*(1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct."*

124. Sentencing Adult B to an immediate 9 year custodial sentence, Judge *(Redacted)* said;

*"Your principal defence of an accident was nothing more than purely fanciful...."*

*"...The jury were satisfied that you were suffering from a personality disorder at the time you killed and it was that personality disorder that affected your ability to **exercise self-control**...."*

*"It has been a regular feature during your life. The evidence established beyond doubt you have been aggressive, abusive and violent towards previous partners as well as your children."*

Judge *(Redacted)* continued: *"You stabbed a previous partner with a carving knife and assaulted your children on a regular basis."*

*"He [Adult A] was a meek, mild-mannered and gentle man who simply took what you handed out..."*

*"I have no doubt on that evidence that you intended to hurt him badly and you embedded scissors in his heart and immediately after you regretted your actions."*

125. Adult B's likely release date from prison will be in 2016/2017.

### Equality and Diversity Statement<sup>3</sup>

126. Adult A (the deceased) was a white British National. He was 48 years old at the time of the homicide. Adult A had multiple medical problems resulting from insulin dependent diabetes; which was diagnosed in 1978. Adult A was able to carry out normal day-to-day activities despite suffering from kidney disease, peripheral neuropathy and cataract. Adult A did not have any biological children.

127. Adult B (the perpetrator) is 50 (at the date of this report) and is also a white British National. Adult B does not have a physical disability.

128. Adult B has five children (three sons and two daughters) from previous relationships. Adult B had a hysterectomy in 2006 therefore discrimination through pregnancy after 2006 would not be relevant.

129. Neither Adult A nor Adult B had/have ever undergone any gender reassignment. Adult A and Adult B were in a heterosexual relationship for 11 years (2001 – 2012). They married in 2009.

130. Adult A and Adult B's religious and philosophical beliefs are not known. It is not clear from the review that Adult A or Adult B had any religious or philosophical beliefs that had an impact on their life choices or the way in which they lived their lives or cared for Adult B's youngest children whilst residing in Cornwall.

131. There is no evidence that Adult A or Adult B were *directly* discriminated against by any agency based on the nine protected characteristics of people who use services under the Equality Act 2010 *e.g. Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.*

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<sup>3</sup> 1. The diversity statement was written following consideration of The Equality Act 2010 which came into force on 1 October 2010 to legally protect people from discrimination.

132. It is acknowledged that Domestic Abuse is a crime primarily committed against women (12.9 million incidents are committed against women each year compared to 2.5 million incidents against men<sup>4</sup>), however the Review Panel considered whether public perception of domestic abuse created a barrier to services for Adult A (being a male victim), and that this may have resulted in *indirect* discrimination on the basis of gender inequality.

## CONTEXT OF PREVIOUS AGENCY INVOLVEMENT

133. Based on the scope of the review as outlined in the Terms of Reference, the Review Panel reviewed agency involvement over three key timelines;

- a) 1963 – 1980 (From Adult B's year of birth to date of first child)
- b) 1980 - 2004 (From birth of first child to move to Cornwall)
- c) 2004 – 2012 (When Adult A and B resided in Cornwall)

134. **Appendix A** lists the documented evidence available to the Review Panel from individual agencies during each of the key timelines.

## NARRATIVE CHRONOLOGY OF AGENCY INVOLVEMENT

135. As the scope of the review extend over four decades, the Review Panel focussed the summary of events on key contacts with the family that address the specific requirements of the Terms of Reference.

136. A full chronology of agency contact can be found at **Appendix B**.

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<sup>4</sup> Walby & Allen, 2004, British Crime Survey 2003

## Summary of Events (Reverse Chronological Order)

### 1963 – 1980

137. **6<sup>th</sup> February 1975** – Adult B's grandmother (Mrs S) expressed concerns about the *'violent and destructive behaviour which regularly occurs within the family and which is seen as being initiated by Adult B'* (then aged 11).
138. **4<sup>th</sup> September 1975** – Mrs S states that Adult B is still very bad tempered (G.P appointment).
139. **2<sup>nd</sup> April 1976** – Adult B is prescribed valium for 'agitation' after scratching and hitting her teacher. G.P record states *'At home Adult B is violent and breaks the doors (age 12)'*.
140. **6<sup>th</sup> July 1976** – Adult B is referred to GP for refusing to take her medication and kicking her mother.
141. **2<sup>nd</sup> October 1976** – Adult B attacked her mother and smashed up the banisters. G.P home visit.
142. **31<sup>st</sup> January 1977** – Adult B (age 13) is prescribed medication (a tranquiliser) as she is *'uncontrollable'* despite valium.
143. **15<sup>th</sup> February 1977** – G.P refers Adult B to a Consultant Psychiatrist.
144. **28<sup>th</sup> February 1977** – Consultant Psychiatrist states that Adult B has *'swallowed a 'token' overdose of tranquilisers'* and thrown yet another tantrum during which furniture had been broken and the police had been called. Following an assessment she states;  
  
*'...over a two year period and having heard about the family from...school..., from the Health Visitor and the family doctor and now from the Department of*

*Social Services I have pieced together a picture of a grossly dysfunctional family where it is possible to build up a rather fragmentary picture of multiple problems but not to work with them in any constructive way.'*

145. **17<sup>th</sup> March 1978** – The Education Department request to take Adult B to court for poor school attendance and to ask for an Interim Care Order. A letter from the Education Welfare Officer to the GP states;

*'I have visited the home on a number of occasions when mother pleads for help with (Adult B)... telling me of (Adult B's)... violent temper and her own fears for the two younger children. Even saying to me "(Adult B)... will end up murdering someone"'*

146. **2<sup>nd</sup> March 1979** – G.P visits Adult B at home. Medical notes state that Adult B wants to marry at 16 to a boy (18) who *'knocks her about'*.

## 1980 – 2004

147. *(Redacted)* **1980** – Birth of first son (C1).
148. *(Redacted)* **1981** – Birth of second son (C2).
149. **18<sup>th</sup> September 1983** – Adult B visits G.P pregnant with third child. G.P Record states *'Partner deserted her one month ago...now living unsupported, in squalor...frightened'*.
150. *(Redacted)* **1984** – Birth of third son (C3).
151. *(Redacted)* **1988** – Birth of daughter (C4).
152. **10<sup>th</sup> November 1988** – Adult B informs the Health Visitor that she has attempted to strangle her son (C3) by *'putting her hands around his neck, she*

*picked him up by his neck'. Adult B also said that she 'smacked (C2) and knocked a loose tooth out'.*

153. **14<sup>th</sup> November 1988** – A joint visit is completed by the allocated Social Worker and Health Visitor. Adult B admitted picking up C3 and throwing him on to the sofa.
154. **28<sup>th</sup> February 1989** – Social Services case closure summary contains a press cutting of Adult B being taken into care as a child after she tried to strangle a relative.
155. **12<sup>th</sup> May 1989** – A paternal aunt of Adult B informs Luton Social Services that Adult B has stabbed Husband 2 (H2). He is in intensive care at (*Redacted*) Hospital.
156. **8<sup>th</sup> June 1990** – The Health Visitor refers family to Child and Family Guidance due to the level of violence in the family. Family fail to attend appointments.
157. **18<sup>th</sup> June 1990** – (*Redacted*) School Referral to (*Redacted*) Social Services relating to concerns for C3 after he attended school with a bruised lip. C3 alleged that Adult B hit him for not putting on a shirt quickly enough. C3 had a 1-inch swelling to his lip. C2 also attended school with a bruised eye of which he claimed had been caused by his elder brother.
158. **28<sup>th</sup> June 1990** – Joint visit with two Social Workers. Notes state that the explanation provided by adult B were inconsistent with the injury. Closing recording on the report says *"There is a worrying background and the stories about this injury are inconsistent. Seems like a family to watch"*.
159. **30<sup>th</sup> October 1990** – Professional meeting held at Bedfordshire County Council (*redacted*) Area Office. Concerns expressed for C1 (aged 10) *"having*

*difficulties in school due to anger and has been excluded from some lessons and faces exclusion from school". School to monitor C1.*

160. **31<sup>st</sup> January 1991** – H2 refers himself to Bedfordshire County Council Children's Services following an incident in which he assaulted Adult B by pushing her over. Adult B was taken to hospital and sustained severe bruising to left side of face, neck, arm and hand.
161. **18<sup>th</sup> December 1991** – Anonymous referral is made to Luton Social Services alleging that Adult B was frequently hitting C1 because he resembles his father. The referral was *"not considered adequate enough to merit a responsive visit"*.
162. **19<sup>th</sup> June 1992** – Estranged Husband (H2) attends Children's Services alleging that C4 had been hit by Adult B's new partner and that C4 is neglected. No action taken.
163. **18<sup>th</sup> June 1993** – (*Redacted*) Junior School make a referral to Luton Children's Services reporting that C3 had a graze around his right eye. He claimed that Adult B *"did it"*. The Social Worker recorded that C3 *"becomes very worried if he thinks that he will be in trouble when he gets home. Mother is a very violent woman"*.
164. **20th June 1995 - Report of Assault** - At 14:30 hours on the 20th June 1995, Bedfordshire Police Family Protection Unit received a telephone call from (*Redacted*) Junior School, Luton, reporting a possible non accidental injury on an 11 year old pupil, C3, by his mother, Adult B.
165. **25th November 1995 - Report of Assault** - Adult B (new married name) contacted Bedfordshire Police via the 999 telephone system, alleging that her husband, H3, had just 'beaten her up'. Adult B stated that she had locked her husband outside but he was trying to get back in. He had hit her across the back

with a lump of wood but she was not bleeding and did not require an ambulance. Adult B declined to make a formal complaint.

166. **21<sup>st</sup> February 1999 - Report of Incident Involving C4** - An incident was reported to Bedfordshire Police by a third party relating to an incident involving C4. This incident did not involve any member of the family. The incident was referred to the Family Protection Unit for investigation. Bedfordshire Police acknowledge a significant delay in responding to this report due to difficulties engaging Adult B and C4's father H2. C4 was finally interviewed on the 29<sup>th</sup> April 1999; two months after the Police became aware of the allegations. Following consultation with the Crown Prosecution Service, no further action was taken.
167. **26th September 2000 - Report of Missing Person** - Adult B made contact with Bedfordshire Police, reporting her 12 year old daughter, C4, missing from her home address.
168. **1st April 2001 - Report of Missing Person** - At 20:56 hours, H2 made contact with Bedfordshire Police reporting his daughter, C4, missing from the home address.<sup>5</sup>
169. **6th May 2001 - Report of Missing Person** - At 11:41 hours, Adult B made contact with Bedfordshire Police reporting her daughter, C4, missing<sup>6</sup>. It is not clear from the incident log if any further action was taken, but due to there being no Child Protection forms in existence; it would appear that no referrals were made either to the Police Public Protection Unit or to Social Services.
170. **20th May 2001 - Report of Missing Person** - At 21:50 hours, Adult B again made contact with Bedfordshire Police reporting C4 missing.<sup>7</sup>

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<sup>5</sup>URN 449 of the 01/04/2001

<sup>6</sup>URN 154 of the 06/05/2001

<sup>7</sup>F PT form ref. 271/01, URN 457 of the 20/05/2001

171. On this occasion, probably due to the number of incidents involving C4, arrangements were made to hold a strategy meeting with Social Services on the 6th June 2001.
172. **6<sup>th</sup> June 2001 - Strategy Meeting with Social Services** - During the Strategy Discussion two referrals, one from (*Redacted*) School dated the 14<sup>th</sup> April 2000 and one from the Educational Welfare Officer dated the 22<sup>nd</sup> May 2001 were to be discussed with the family. One of these referrals related to an allegation of assault on C4 by Adult B.
173. The Educational Welfare Officer stated on a record dated the 25th May 2001 that there had been poor school attendance, the father (H2) was supportive but did not live at home and the mother (Adult B) suffers from bad PMT. C4 stays away from home out of fear and is alleging that her mother hits her when she is suffering from PMT.
174. **3rd February 2002 - Report of Missing Person** - At 09:21 hours, Adult B made contact with Bedfordshire Police reporting C4 missing<sup>8</sup>.
175. **24th May 2002 - Report of Missing Person** - At 00:53 hours, C4 was reported missing by Adult B<sup>9</sup>.
176. **17th October 2002 - Report of Missing Person** - At 01:24 hours, Adult B reported C4 had been missing since 16:30 hours<sup>10</sup>.
177. **14th January 2003 - Allegation of Assault** - On Tuesday 14th January 2003, XY, aged 19 years, a friend of C4's, reported being assaulted by Adult B during the early hours of the previous day.
178. XY alleged that whilst walking with C4 they were approached by Adult B in her car. The vehicle stopped and C4 got into the front passenger seat. Adult B then

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<sup>8</sup>URN119 of the 03/02/2002

<sup>9</sup>URN 11 of the 24/05/2002

<sup>10</sup>URN 20 of the 17/10/2002

drove the vehicle towards XY and shouted, *"You had better watch your back"*. XY then saw that the car was being driven straight at him, causing him to have to jump out of its path. As he did so, the vehicle hit his right foot. XY felt that it was a deliberate attempt to run him down.

179. **10th February 2002** - Adult B was interviewed and admitted the incident involving XY. Adult B was given a 'Caution'<sup>11</sup>.

180. **2nd May 2003 - Report of Assault** - At 21:23 hours, C4 contacted Bedfordshire Police alleging that she had been 'beaten up' by Adult B at her home address. Officers arrived at 21:43 hours to find that C4 had sustained bruising to an eye and marks to her hand. Adult B was arrested at her home address and accepted into custody. Adult B was released on Police bail pending further enquiries. No further action was taken<sup>12</sup>.

## 2004 – 2012

181. **Circa July 2004** - Adult A, Adult B, C3, C4 and C5 move to *(Redacted)*, Cornwall.

182. **29<sup>th</sup> June 2004** - Adult A and Adult B registered with *(Redacted)* Surgery.

183. **21<sup>st</sup> March 2005**- *(Redacted)* surgery receives a letter from a Consultant Gynaecologist in relation to Adult B's on-going problems with Pre Menstrual Tension (PMT). Adult B was referred for a hysterectomy and removal of ovaries which was performed on the 4<sup>th</sup> August 2006. Adult B was prescribed hormone suppressant therapy and reported that *'her partner calls her a tamed lion'*.

184. **November 2006 - December 2008** - Adult B attended the G.P on five further occasions reporting severe PMT, mood problems, anger and aggression.

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<sup>11</sup>Crime file 04549-03

<sup>12</sup>Custody Record DH/1657/3

185. **25<sup>th</sup> November 2008** - Adult B describes *'terrible moods and the break-up of her relationship'* (with Adult A). She states that she is feeling *'low, angry and volatile'*.
186. **14<sup>th</sup> December 2006**- Adult A completed G.P depression screening questionnaire. Outcome: Not symptomatic of depression.
187. **2<sup>nd</sup> December 2009**- Adult A completed G.P depression screening questionnaire. Outcome: Not symptomatic of depression.
188. **16<sup>th</sup> February 2011** - Adult A completed G.P depression screening questionnaire. Outcome: Not symptomatic of depression.
189. **23<sup>rd</sup> September 2007**- Adult A attended the (*Redacted*) Eye Infirmary and Accident and Emergency with corneal abrasions to the eye.
190. **30<sup>th</sup> April 2008**- Adult A attended Accident and Emergency with corneal abrasions to the right eye.
191. **2005 – 2012** - Adult A receives support for an (*Redacted*) issue which was impacting on his relationship with Adult B.
192. **April 2008** - C4 moves out of the family home because she *'cannot deal with her mother's violence anymore'*. C4 presented at The Zone in (*Redacted*) stating *"either my mother will kill me or I will kill my mother"*.
193. **Circa March 2012** – C5 moves out of the family home following an argument.
194. **13<sup>th</sup> May 2012** – Adult A is found unconscious at home with a wound to his chest.
195. **13<sup>th</sup> May 2012** – C5 calls C4 at midday to say that Adult A had been stabbed. C5 responds that she *"is not surprised by this"* but did not know at the time that Adult A had died.

# SECTION THREE

## ANALYSIS OF WITNESS STATEMENTS

196. In addition to an analysis of the response of *services* involved with Adult A and Adult B and her children (see Section Four), the Review Panel wished to understand the context of societal attitudes, views and opinions of domestic abuse and specifically, female on male violence.
197. This section aims to identify whether *family members, neighbours, friends and co-workers were aware of any abusive behaviour from the perpetrator to the victim* as per the Terms of Reference.
198. The family and co-workers of Adult A and Adult B declined to participate in the review at this time. Their testimony from the criminal investigation and trial has been included to provide a snapshot of their personal experiences;

### Family Member 1 = F1

199. F1 stated within her witness statement that Adult A had never told her of Adult B's physical abuse, although she was aware that they argued and that Adult A had moved out of the matrimonial home for a while in 2005.
200. At some time during the same year (2005) whilst visiting the couple in Cornwall F1 described witnessing Adult B in a rage over an incident in the city centre whilst the three of them (Adult A, Adult B and F1) were shopping. F1 states;

*"I tried on a coat, size 16, but it felt quite snug. I commented to Adult B that it felt tight and she replied "If I was a size 16 I would shoot myself". An argument ensued with Adult A asking why she had said that. Outside the shop, Adult B shouted at Adult A "F\*\*\* Off" and went back to the car alone and*

*drove off. This left Adult A and myself having to catch a bus home”.*

201. This was the only incident that F1 witnessed or knew about.

### **Family Member 2 = C4**

202. C4 described the relationship between Adult A and B as “*volatile*” stating that they would have “*...frequent fights where she (Adult B) would hit and punch him (Adult A)...In some of these incidents she threatened to hurt herself as well. She held knives to her own neck and would also drive off in the car threatening to kill herself that way. I have seen (Adult B) hold a knife to her own throat and she has also threatened partners with knives saying things like “Don’t come near me or I’ll use this”.*

203. C4 said “*I saw her (Adult B) slap, punch, scratch and pull his (Adult A’s) hair many times. I only saw (Adult A) retaliate a couple of time out of frustration but he would normally walk away from her and (Adult B) would follow him and carry on the violence”*

204. Another section of the witness statement reads “*I believe that Adult A was pretty scared of (Adult B), in fact the whole family are scared of her”.*

205. Devon and Cornwall Police do not have any record of C4 calling the police for any of the above incidents but C4 did try to contact Adult B’s GP early in 2012 because she was worried that (Adult B) was “*threatening to kill herself*”. Although C4 managed to speak to a receptionist the call was cut off. Following a further conversation with Adult B, whereby she convinced C4 she was fine, C4 decided not to phone the GP again.

### **Family Member 3 = C5**

206. C5 described Adult A and Adult B having arguments “*on a virtual daily basis....The arguments would almost always be about trivial matters, such as her*

*not liking the jeans that he (Adult A) was wearing, and frequently resulted in (Adult B) assaulting (Adult A) often scratching him and throwing things at him”.*

207. C5 said that *“(Adult A) would have scratch marks on his face which often confirmed that (Adult B) had assaulted him”.* On these occasions C5 states *“that (Adult A) was reluctant on these occasions to admit what had happened”.*

208. When questioned about the relationship as part of the criminal investigation, C5 said *“There were days when (Adult B) and (Adult A) got on well and I could hear them laughing and talking but those days were rare. Arguments would sometimes end up with (Adult B) shouting at (Adult A) and telling him that she hated him and wished that he was dead.....(Adult A) did move out on two occasions. (Adult B) regularly visited him there and asked him to come back. Despite him moving back at (Adult B's) request the violence did not stop and I witnessed her both punch (Adult A) and throw things at him. Items thrown by (Adult B) included crockery, TV remote controls and lamps. (Adult A) never retaliated aggressively and only occasionally offered passive resistance”.*

209. C5 describes a particular incident during early 2012 *“I cannot recall the exact date but remember that I wanted to have a bath. (Adult B) "Flipped" on that occasion because of the cost of the water that would be used and threw a small coffee table at myself and (Adult A). (Adult A) and I went upstairs and a short time later I could hear (Adult B) coming up. I feared for (Adult A) and blocked the door to their bedroom to stop her going in when I knew that she would assault (Adult A). He had played no part in the argument about the price of water”.*

210. These incidents were not reported to the police.

#### **Family Member 4 = C3**

211. C3 describes *“(Adult B) hitting (Adult A), scratching his face and throwing things at him”.* On one occasion C3 witnessed C4 step in and stop an attack on

Adult A.

212. These incidents were not reported to the police.

## Neighbours

213. Six neighbours provided witness statements to the criminal investigation. These are identified as N1, N2, N3, N4, N5 and N6.

214. **N1**

215. N1 described hearing “*constant arguments*” with the majority of the shouting coming from Adult B. N1 recalls witnessing one incident in the garden where Adult B shouted at Adult A “*I told you to do it*” followed by “*I’ll have you for that*” after threatening to kill him.

216. N1 said that the arguments were never prolonged and they never felt the need to call the police.

217. **N2**

218. N2 said that when arguments were heard coming from the address it was always Adult B’s voice that could be heard shouting and swearing. N2 described hearing Adult B using ‘*curse language*’ towards Adult A. N2 witnessed Adult B call Adult A “*A f\*\*\*ing waste of space*” and stating that he was “*Useless*”. N2 also witnessed Adult B throw a glass bottle at Adult A which hit him on the back before smashing on the ground. Adult A did not retaliate and continued to walk down the path towards the garage.

219. N2 described Adult A as the ‘*quietest person ever*’ and said that they never witnessed Adult A retaliate in any way because “*(Adult A) was scared of (Adult B)*”. N2 said that Adult B would ‘*flip*’ over the slightest thing.

220. N2 never contacted the police to report any of the incidents.

221. **N3**

222. N3 described Adult B as *'blowing up'* and *'being livid'* over trivial things often using horrible and threatening language, slamming doors and shouting. On one occasion N3 witnessed Adult B shout at Adult A *"F\*\*\*ing c\*\*t"* and *"You're useless"*.

223. N3 said that arguments in the house occurred every couple of nights over the six months prior to the homicide and Adult A had not been himself and looked *'down trodden'* when previously he had been *'jovial'*.

224. N3 never contacted the police to report any of the incidents.

225. **N4**

226. N4 recalled an incident in 2009 when Adult B was shrieking at Adult A in the garden. Adult B was shouting profanities at Adult A including *"You f\*\*king s\*\*t"*. N4 said that Adult A did not retaliate or reply.

227. N4 did not contact the police.

228. **N5**

229. N5 described an incident approximately three years prior to the homicide when N5 overheard a loud and public argument between Adult A and Adult B. N5 heard Adult B screaming and shouting at Adult A. Adult A did not retaliate or reply.

230. N5 did not contact the police.

231. **N6**

232. N6 was aware of frequent arguments at the address and describes hearing Adult B's voice, shouting, slamming doors and heavy foot fall.

233. N6 said that in the preceding six months of the homicide Adult A appeared *'sad and deflated when speaking about normal day to day matters'*.

234. N6 never contacted the police to report any incident.

## Friends

235. Three friends provided witness statements to the criminal investigation. These are identified as FR1, FR2 and FR3.

236. **FR1**

237. FR1 described Adult A as *'laid back'* and Adult B being more *'enthusiastic'*. FR1 thought their different characters suited each other.

238. **FR2**

239. FR2 said Adult B was *'excitable'* and *'wore the trousers'* in the relationship. FR2 described Adult A as *'quiet'*. FR2 never heard the couple argue or have cross words.

240. **FR3**

241. FR3 said that Adult A and Adult B *'always seemed happy'*. FR3 had never witnessed them ever having an argument and described the relationship as *'50/50, never expecting them to be aggressive to each other'*.

242. FR3 described Adult A as *'soft spoken, laid back'* and *'chilled'*. Adult B was described as *'more bubbly, quite self-confident and always with a happy smile'*.

## Employer = E1

243. Adult A and Adult B were employed by the same organisation and worked at the same branch. Adult B had been employed for approximately 3 weeks prior to the homicide. Adult A was an employee for six years.

244. E1 knew Adult A on a professional basis. He did not socialise with Adult A or B outside of the workplace. E1 said that Adult A only ever exhibited anxiety when he was collected from work by Adult B. These were the only occasions that he would witness Adult A *'run and rush to leave work'*.

245. E1 describes an incident that he witnessed approximately 12 months prior to the homicide;

*"(Adult B) had come to collect Adult A at lunchtime. I recalled seeing their (Redacted) in the car park. I could see the right hand, or off side of this vehicle.*

*(Adult B) was sat on the side closer to me, and I believe that (Adult A) was on the far side...I could see (Adult B) using both hands to hit the person I believed to be (Adult A) around the head. This was a frenzied assault which only lasted a short period of time.*

*I then stopped looking and never spoke to (Adult A) about this incident. (Adult A) was too private a person, and very protective of (Adult B). I believe that (Adult A) would have denied that the incident ever took place.*

*I remember another time (Adult A) came to work with scratches around his face. These scratches appeared to have been caused by fingernails. I remember asking (Adult A) what had happened and he told me that he had been cutting a rose bush in his garden which had caused the cuts.*

*A few weeks later I again saw (Adult A) with more scratches around his face and made a flippant joke that the rose bushes were taking some time.*

*In fact (Adult A) frequently came to work with facial cuts, sometimes of a very minor nature. (Adult A) always glibly and plausibly accounted for these*

*injuries being innocently obtained.*

*Other members of staff ... were of the opinion that (Adult B) would knock (Adult A) about”.*

246. E1 did not report any incidents to the police. E1 studied the personnel files of Adult A and Adult B and found ‘*nothing of any relevance*’. There appears to be no report of any incident to the human resources department at the company’s head office.

247. The Chair of the Domestic Homicide Review was unable to speak to any employee at the branch during the criminal justice investigation, therefore, a letter was sent to the Human Resources Manager at Head Office on the 31<sup>st</sup> January 2013 informing them of the Domestic Homicide Review and inviting the organisation to participate. A representative of the employer contacted the Independent Chair by telephone and declined the invitation to participate in the review. Following a positive conversation the employer requested further communication with the Chair on completion of the overview report.

248. It is not known if the employer has a specific Domestic Abuse Policy for employees and customers or whether this policy was followed by E1 or any employee working at the company at the time.

## **Panel Conclusion from Analysis of Witness Statements<sup>13</sup>**

**Were family, friends and co-workers aware of abusive behaviours from the perpetrator towards the victim?**

249. The testimony from family, neighbours and work colleagues is of vital importance to the Review Panel as they appear to be the only individuals aware of, and witness to, domestic abuse between Adult A and Adult B between 2001 (when they met) and 2012.

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<sup>13</sup> This section summarises the conclusions of the Panel and the Independent Chair. Some conclusions are research based and are referenced accordingly. Others are conclusions derived from this DHR.

250. The juxtaposition between the eyewitness account of family, neighbours and co-workers and the testimony of the couple's friends FR1, FR2 and FR3 is consistent with the conclusions of the psychiatric assessment undertaken by Dr (Redacted), Consultant Forensic Psychiatrist in 2012 which identified that;

*'The abnormal behaviour pattern seems to be within the context of relationship within her family of origin and with partners and her children. Although there is some evidence of this abnormal behaviour spilling out into the relationships with neighbours, this clearly isn't pervasive of all of (Adult B's) relationships.....'*

*'..It is significant to note that (Adult B's) relationship with FR1 and FR2 has been at least 12 months duration with contact once or twice a week'.*

251. Dr (Redacted) concluded that Adult B was able to control and modify her behaviour with persons outside of the family unit. This provides one possible theory as to why the testimony of Adult A and B's friends differs significantly from other eye witness accounts.

252. This provides an interesting point of learning in that perpetrators of domestic abuse can often present as charismatic, charming and very plausible individuals. This can increase the isolation, fear and safety of victims as the perpetrator is able to effectively control and manipulate external relationships (including immediate family, close friends and professionals).

**Were there any barriers preventing family, friends and co-workers from reporting abuse or concerns?**

253. Many separate incidents of domestic abuse were witnessed by family, friends and co-workers leading up to the homicide of Adult A, including a *'frenzied assault'* witnessed by E1 and a glass bottle attack witnessed by N2.

254. The interesting and perhaps disconcerting question is why these individuals did not contact the authorities or report their concerns for Adult A or that of Adult B's youngest children (of which C5 would have been under the age of 16 from

2004 to 2009).

255. Applying the benefit of hindsight, it is likely that these individuals would have involved the relevant authorities had they known the subsequent outcome of the abuse, however this cannot be assumed. The behaviour witnessed is not uncommon for many families living in abusive households in the UK. With this in mind the Review Panel was keen to explore the threshold for public intervention;

256. The testimony of N1 may provide one insight into a perceived barrier to reporting concerns e.g. *“the arguments were never prolonged therefore I never felt the need to call the police”*.

257. The Review Panel considered the apprehensiveness of individuals to intervene or get involved in what may be considered a private matter. There are many reasons why people do not call the police when they witness a crime, including the belief that the incident does not warrant police or social services intervention.

258. The Review Panel recognised that high risk domestic abuse can be missed if each incident is considered in isolation. It is only when the cumulative incidents are pieced together that the picture emerges of sustained emotional and physical abuse. If the violence or threat to life is not overt, the public (and to some extent, professionals) may be reluctant to intervene on the off-chance that they may ‘get it wrong’, ‘waste valuable police resources’ or ‘make it worse for the victim(s)’. Neighbours and other eye witnesses may also fear retaliation.

259. E1’s and C5’s witness statements also provide an indication of a further perceived barrier that may impact on public intervention - Denial. Each witness believed that Adult A would deny the abuse if approached e.g. *“He was too private a person, and very protective of (Adult B). I believe that (Adult A) would have denied that the incident ever took place”* and C5’s testimony *“(Adult A) was reluctant on these occasions to admit what had happened”*.

260. Whether Adult A ever considered himself a victim of domestic abuse is unknown. He certainly never disclosed domestic abuse to professionals, close friends or relatives. It is known that C4 asked Adult A to leave on a number of occasions for his own protection, but he refused and said he wanted to stay.
261. Denial often occurs when a victim of abuse is unable to admit and acknowledge that they are being subjected to domestic abuse. A victim will not only avoid admitting the abuse to their friends and their family members, but they themselves will not acknowledge the violence that they are suffering from. They fail to recognise that there are any problems between themselves and their partner.
262. It is possible that Adult A did not realise that he was being subjected to domestic abuse. Until he reached a position whereby he acknowledged and confronted the abuse he was experiencing, it is unlikely that he would have accepted help from family, friends and neighbours, or sought the help and the protection he needed from professionals.
263. Adult A represents a cohort of male victims who do not acknowledge or disclose domestic abuse. The British Crime Survey highlighted the level of under reporting in 2011 with male victims being three times more likely **not to** report domestic abuse than their female counterparts<sup>14</sup>.
264. Many men are often too embarrassed to admit that they are being abused. Some suffer domestic abuse in silence because they are afraid that no one will believe them or take them seriously. Some believe that they will be mocked or ridiculed.
265. E1's witness statement provides some evidence that being mocked or ridiculed could have been a genuine concern and barrier for Adult A in the workplace e.g. *"I remember another time (Adult A) came to work with scratches around his face. These scratches appeared to have been caused by fingernails."*

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<sup>14</sup>British Crime Survey 2010/11 (page 88) Table 3.16 (page 111) - <http://tinyurl.com/7slnnom>

*I remember asking (Adult A) what had happened and he told me that he had been cutting a rose bush in his garden which had caused the cuts. A few weeks later I again saw (Adult A) with more scratches around his face and made a flippant joke that the rose bushes were taking some time to cut”.*

266. The Review Panel considered whether the flippancy of neighbours and colleagues towards Adult A’s masculinity and/or the fear of being mocked or ridiculed could have presented a barrier to reporting for Adult A.

267. Traditional gender assumptions also confuse the matter. Generalisations such as *‘men are aggressive’* and *‘women are passive’* or *‘real men are able to control their wives’* effectively undermine the multiplicity of gender and remain to be a common feature within the conventions of wider society.<sup>15</sup> The concept of male privilege and entitlement, reinforced by societal, cultural and institutional beliefs, supports the notion of a *‘real man, a breadwinner, a king of the castle’*. When men are abusive towards a partner, we ask what societal views reinforce his beliefs and abusive behaviour<sup>16</sup> however a woman’s use of violence does not receive the same societal scrutiny. In not behaving in the way that *‘society’*<sup>17</sup> expects of a real man’, Adult A’s unassuming nature became the focus of ridicule e.g. *“Some members of staff were derogatory...they were of the opinion that Adult B would ‘knock Adult A about’”*<sup>18</sup>.

268. Aside from the perceived embarrassment over admitting abuse, it may be possible that Adult A was aware of the perceptions of his peers and a wider society that in general would consider Adult A as *‘somewhat less of a man for “allowing” the abuse to occur’*.

269. This is reaffirmed in the contrasting views of Adults A’s friends who spoke of a *‘soft spoken, laid back and private man’* and the view of his neighbour who assessed the same character as *“a bit ‘wet’ really”*.

<sup>15</sup> Eckert & McConnell-Ginet, 2003, p.47.

<sup>16</sup> A book about the Freedom Programme ‘Living with a Dominator’ – Pat Craven

<sup>17</sup> As quoted throughout the Freedom Programme ‘living with a Dominator’ Book by Pat Craven

<sup>18</sup> Statement from Manager at Adult A and Adult B’s Employer

270. With this in mind, the Review Panel wished to explore whether the reversal of the *tradition gender roles* presented a further barrier for Adult A, family, neighbours and co-workers in reporting abuse or concerns. Although it is a very unconventional notion, the Review Panel considered whether the gender of Adult B (being female) was a mitigating factor which obscured the judgement of witnesses to decide to intervene or not.
271. Looking at this particular case, there is evidence that Adult B and her children, previous partners and some professionals attributed her violent and abusive behaviour to possible medical conditions such as premenstrual tension (PMT) or premenstrual symptoms (PMS).
272. This assumption is consistent with a study by Allen in 1998 that discovered a tendency to attribute female violent behaviour to some form of illness. Seeking an alternative explanation for female offending is a long-standing practice as society struggles to comprehend a female committing such crimes that break the rules which mark womanhood.<sup>19</sup>
273. Historically, the media have also encouraged this perception by labelling women who are aggressive or criminal as '*mad or bad*'. A '*mad*' portrayal will focus the public on the state of mind or past experiences of the criminal rather than her actions. A female who is '*mad*' is given the benefit of the doubt. While her actions are frowned upon, her state of mind is pitied more readily than that of the '*bad*' woman (who is deemed to be evil and manipulative).
274. It is conceivable that the violent behaviour and perceived threat of Adult B was neutralised by her female gender. As the bullying traits of Adult B's behaviour were not too dissimilar to the symptoms of severe PMT (e.g. aggression, mood swings, lasting irritability and anger that affects other people) family, neighbours and co-workers might have given Adult B's behaviour the '*benefit of the doubt*' and therefore justified not reporting her actions to the

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<sup>19</sup> As cited in Snider, 2003, p.355

authorities.

275. In this case, the perceived medical condition (PMT) may have obscured the complexity of her female offending and denied appropriate support and intervention for both Adult B and the people affected by her behaviour.
276. The Review Panel considers this point of vital importance. It would be reasonable to attribute particular behaviours to a medical condition such as PMT; however, other behaviours exhibited by Adult B towards Adult A are consistent with some of the characteristics of a domestic abuse perpetrator, and specifically an 'Intimate Terrorist' as defined by Professor Michael P. Johnson<sup>20</sup>. The key element to establishing if these behaviours were wrongly given the 'benefit of the doubt' (thus representing a barrier to reporting concerns) is determined by the presence of a power and control dynamic.
277. To establish if the power and control dynamic was evident in the relationship between Adult A and Adult B, the Independent Chair compared the witness statements with the characteristics/tactics of a domestic abuse perpetrator as defined by the Duluth Domestic Violence model developed in Minnesota, United States of America<sup>21</sup>, the Freedom Programme (UK)<sup>22</sup> and Professor Johnson's typology of Intimate Terrorism.
278. A brief description of the Duluth Model, Freedom Programme<sup>23</sup> and Professor Johnson's Typologies can be found at **APPENDIX C**.
279. Although Professor Johnson's typology of Intimate Terrorism, the Duluth Model and Freedom programme each identify the most common abusive behaviours as primarily male tactics employed to intentionally control and intimidate female victims, the Independent Chair used the models to establish

<sup>20</sup> A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (Northeastern University Press, 2008)

<sup>21</sup> <http://www.theduluthmodel.org/>

<sup>22</sup> <http://www.freedomprogramme.co.uk/>

<sup>23</sup> The Independent Chair recognises that the Duluth Model and Freedom Programme are only two of a number of programmes and research studies that document offender behaviour tactics. These programmes were selected based on local application and knowledge

whether Adult B adopted certain tactics of the ‘dominator/intimate terrorist’ during her adult life;

280. Table 280a: The Dominator/Intimate Terrorist

| <b>‘The Dominator’ Tactics</b> | <b>E.g. of Tactics used by ‘The Dominator’</b>                                                                                 | <b>Evidence of Adult B’s Behaviour</b>                                                                                                                                          | <b>Source of Evidence</b>                  |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| <b>The Bully</b>               | <i>Glares, shouts, smashes things, sulks, destroys property, threatens to use weapons, abuses pets or uses pets as weapons</i> | <i>...I have seen (Adult B) hold a knife to her own throat and she has also threatened partners with knives saying things like “Don’t come near me or I’ll use this”.</i>       | C4 Statement                               |
|                                |                                                                                                                                | <i>...I witnessed her both punch (Adult A) and throw things at him. Items thrown by (Adult B) included crockery, TV remote controls and lamps.</i>                              | C5 Statement                               |
|                                |                                                                                                                                | <i>...She would fly into a rage over the smallest matter like not doing the washing up properly or using the wrong polish.</i>                                                  | C1 Statement                               |
|                                |                                                                                                                                | <i>...”yeah we would shout and swear at each other and I would probably throw stuff across the room....”<br/>“Arguments would be about stupid things like being made coffee</i> | Adult B’s 1 <sup>st</sup> Police Interview |

|                   |                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                        |              |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
|                   |                                                                                                                                                                               | <i>instead of tea..."</i>                                                                                                                                                                                                                                                                              |              |
|                   |                                                                                                                                                                               | <i>She would shout and the dog would attack us. On one occasion I was being shouted at over something trivial and the dog attacked biting my back....she did nothing to assist and allowed the attack to continue which resulted in a permanent scar...</i>                                            | C2 Statement |
|                   |                                                                                                                                                                               | <p><i>'She threw a kitchen fork at me cutting my head deeply. She made me stand in the corner whilst the cut bled...'</i></p> <p><i>'She would scream and shout at us, smash up things; games consoles, TV's and even our school art work...If that didn't work she would resort to violence'.</i></p> | C2 Statement |
| <b>The Jailer</b> | <i>Tells you what to wear, stops you from seeing family or friends, seduces friends, family or work colleagues. Controls your movements, uses jealousy to justify actions</i> | <i>The arguments would almost always be about trivial matters, such as her not liking the jeans that he (Adult A) was wearing...</i>                                                                                                                                                                   | F3 Statement |
|                   |                                                                                                                                                                               | <i>'A few weeks before he</i>                                                                                                                                                                                                                                                                          | Adult A's    |

|  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              |
|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
|  |  | <p><i>died, Adult A posted a picture of himself on a social media website. He was wearing clothes that were very different to the clothes he normally wore. This was very out of character'.</i></p> <p><i>'I went to Adult A and Adult B's wedding but after that received only 2 or 3 phone calls and no other contact.</i></p>                                                                                                                              | Brother                      |
|  |  | <p><i>'The abnormal behaviour pattern seems to be within the context of her relationship within her family of origin and with partners and her children. Although there is some evidence of this abnormal behaviour spilling out into the relationships with neighbours, this clearly isn't pervasive of all of (Adult B's) relationships.....'</i></p> <p><i>'...Furthermore there is no evidence of any disharmonious attitudes and behaviour in her</i></p> | Forensic Psychiatrist Report |

|                       |                                                                                                                                                          |                                                                                                                                                                                                                                                     |                 |
|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
|                       |                                                                                                                                                          | <i>occupational history...'</i>                                                                                                                                                                                                                     |                 |
| <b>The Headworker</b> | <i>Puts you down, calls you names, humiliates you, says that you are too fat/thin, stupid, useless and weak. Plays mind games</i>                        | <i>I witnessed Adult B call Adult A "A fucking waste of space" and stating that he was "Useless".</i>                                                                                                                                               | N2 Statement    |
|                       |                                                                                                                                                          | <i>On one occasion I witnessed Adult B shout at Adult A "Fucking c**t" and "You're useless".</i>                                                                                                                                                    | N3 Statement    |
| <b>The Persuader</b>  | <i>Threatens to hurt or kill you, threatens to commit suicide, cries, says that they love you, threatens to report you or forces you to drop charges</i> | <i>"..She threatened to hurt herself as well. She held knives to her own neck and would also drive off in the car threatening to kill herself that way. I have seen (Adult B) hold a knife to her own throat...</i>                                 | C4 Statement    |
|                       |                                                                                                                                                          | <i>'She would threaten to crash the car and kill us all...'</i>                                                                                                                                                                                     | C2 Statement    |
|                       |                                                                                                                                                          | <i>"Adult B was preparing a joint of meat with a carving knife with a 12-15 inch serrated blade. She asked how much money I had been paid and when I mentioned that I was one day's wages down because I had taken a day off to take her to the</i> | Statement of H2 |

|                           |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                |              |
|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
|                           |                                                                                                                                                                                                           | <i>G.P's; she flew into a rage and came towards me with the knife. I went to hit her first but realised I had been stabbed in the left thigh through the artery. I staggered outside and neighbours applied a tourniquet and called an ambulance"</i>                                                          |              |
| <b>The Liar</b>           | <i>Minimises the abuse, lies about what happened, blames everything and everyone for their behaviour, blames drink, stress, unemployment, money, overwork and you</i>                                     | <p><i>"...She would say that she could not recall what had happened after a violent episode and would not believe it when told. She would be quiet for a while afterwards and then return to 'normal' and act as if nothing had happened".</i></p> <p><i>"...She blamed her behaviour on her hormones"</i></p> | C4 Statement |
| <b>King of the Castle</b> | <i>Makes you do menial tasks, treats you as an unpaid housekeeper or uses reverse tactics e.g. refuse to let you do anything because you are useless; controls all the money, makes all the decisions</i> | <i>"...he (Adult A) was always the one to feed the rabbits, put out the bins, hang out the washing...I could see into their garden and it would be Adult A getting the meal ready"</i>                                                                                                                         | N2 Statement |

|                          |                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                        |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
|                          |                                                                                                                                                                                                                                                      | <i>"If they needed to borrow anything it was Adult A that would be sent as 'the messenger'...he did not get a lot of rest"</i>                                                                                                                                                                                                                                                                                                                                                                                                   |                        |
|                          |                                                                                                                                                                                                                                                      | <i>'I learned how to cook, clean and look after babies before I learned how to play...'</i>                                                                                                                                                                                                                                                                                                                                                                                                                                      | C1 Statement           |
| <b>Sexual Controller</b> | <i>Won't accept no for an answer, uses persuasion, belittles you, rejects your advances, uses bribery and intimidation, is unfaithful or threatens to go elsewhere if you don't comply, forces you or pushes you to take part in degrading acts.</i> | <p><i>"(Adult B) promised sex from 7pm to midnight and when we got up stairs she didn't want it – she said she was joking..."</i></p> <p><i>"...I put up with taunts such as 'a 15 year old could make love to me better than you'"</i></p> <p><i>"(Adult B) says she wanted sex but didn't care who was on top of her..."</i></p> <p><i>"(Adult B) asked me if it would be alright if just her and (redacted) had sex upstairs in the bedroom for a couple of hours alone!"</i></p> <p><i>"(Adult B) still insisting on</i></p> | Extracts from H1 diary |

|  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
|  |  | <p><i>sex with who she fancies in bed”</i></p> <p><i>“I came home to find (redacted) and Adult B together on the sofa. She said if I had arrived home at 11pm she wouldn’t have had any clothes on...She said the only way to ‘cure’ her would be to go out at 7pm and leave them alone together (naked) in the bedroom until 11:30pm.... If I came back and they continued overnight she might give me permission to watch, or if I was lucky, join in...”</i></p> <p><i>“(At a party) (Adult B) wanted to make love in full view of everyone in a lit up room no holds barred”</i></p> |  |
|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

281. The behaviour of Adult B towards Adult A (and her children and previous relationships) appears to be consonant with elements of ‘the Dominator’ as developed by the Freedom Programme (and inspired by the Duluth Power and Control Wheel) and the ‘Intimate Terrorist’ as defined by Professor Johnson<sup>24</sup>.

<sup>24</sup> A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (Northeastern University Press, 2008)

Although the above comparison is not definitive, the Panel could surmise that the behaviour of Adult B was atypical of a female in that she did not appear to use fear and control in a distinctively different way to a male perpetrator of intimate terrorism.

282. Adult B's behaviour towards Adult A was motivated by the need to control him or punish him for non-compliance. Adult A did not resist the violence. The abuse was 'one way'. Adult A lived in fear of Adult B. Therefore the Panel could conclude that Adult A was a possible victim of intimate terrorism (as defined by Professor Michael P. Johnson's 'A Typology of Domestic Violence')<sup>25</sup> despite this research stating that '*intimate terrorism*' is perpetrated almost entirely by men, not women<sup>26</sup>.

283. Acknowledging Adult B as a female 'Dominant' or 'Intimate Terrorist' does not dismiss or disparage any contrary research, medical condition, childhood experience (endured or witnessed by Adult B) or the gender disparity of domestic abuse in general (e.g. 12.9 million incidents are committed against women each year compared to 2.5 million incidents against men<sup>27</sup>). It is an important consideration and reminder to professionals and the wider public to remain open to the possibility that abusive behaviours and tactics can be exhibited by females who may also pose a significant risk to intimate partners, children and family members. It is vital to acknowledge that, although the pattern of coercive control is largely perpetrated by men, it is not exclusively perpetrated by men.

284. With the number of women convicted of perpetrating domestic abuse in the UK quadrupling over the past seven years (from 806 in 2004/05 to 3,965 in 2010/11)<sup>28</sup>, Adult A's tragic death has highlighted the need for greater public awareness of female on male violence, the different forms of domestic abuse and

<sup>25</sup> A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (Northeastern University Press, 2008)

<sup>26</sup> A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (Northeastern University Press, 2008) page 2

<sup>27</sup> Walby & Allen, 2004, British Crime Survey 2003

<sup>28</sup> Parliamentary questions <http://tinyurl.com/73etslm> and <http://tinyurl.com/7rzzjy2>

the signs and symptoms of coercive control.

285. It is important that the general public and those responsible for protecting the public do not become distracted by statistics, gender assumptions, and societal perceptions alone. The impact of domestic abuse can be devastating and life changing regardless of the gender of the victim. It is vital that we do not become blinkered by traditional gender roles but instead seek to understand the context of violence within relationships and facilitate the most appropriate response, based on considered judgement. Our judgements should not be used to ‘frame’ a different conception of the female perpetrator; which is in contrast to the treatment of male perpetrators, if it can be established that the act of violence was used to gain control over another.

### **Adult B’s Participation in the Domestic Homicide Review**

286. On Monday 2nd December 2013, The Independent Chair and the Domestic and Sexual Violence Strategic Manager for Cornwall and the Isles of Scilly visited Adult B at HMP (*Redacted*) in (*Redacted*). Adult B was asked about her perception of professional support and agency intervention offered to her and her family during the period of the review (1963 – 2012).

287. Adult B could not remember many memories of her childhood but did recall being placed in care at 14 years old. She described having a few arguments with her mother but nothing compared to the arguments she had with her own daughters.

288. Adult B recalled her father being abusive and violent towards her mother. When they separated he remained in the home but was said to “*live in the dining room*”. He would attend work and return to the dining room where he had a bed, kettle, music and other living needs. Adult B said that her father remained at the house until he died at the age of 59.

289. Adult B had three children by the age of 21. She described this time as difficult and sometimes frightening. They had very little material goods and the

children had limited space to play, however she added *"things were okay when I had the boys"*. She recalled a few arguments with her first and second husbands but believed that her temperament changed considerably after the birth of her 4<sup>th</sup> child (Daughter - C4).

290. With the benefit of hindsight Adult B believes that she suffered with postnatal depression for the first year after the birth of C4. She remembers not being able to sleep or eat. She experienced panic attacks, constant headaches and thought that she was going to die.
291. Adult B said that she regularly spoke to her G.P and Health Visitor about her symptoms but they seemed powerless to help. She acknowledged that professionals were not as aware of postnatal depression 25 years ago. She remembers being prescribed Diazepam but that this made her feel worse. She also remembered being referred for a scan to find the cause of her headaches. Adult B described the whole year as *"horrendous"* and thought that, had it not been for H2 and a good support network of friends, she would not have got through it.
292. Following on from the perceived post natal depression, Adult B discussed her battle with severe pre-menstrual tension (PMT). She said *"I wanted two weeks of every month to go away. It wasn't me, I acted differently. Little things would make me snap. I ended up throwing things; I didn't know what I was doing. I didn't feel in control of what I did....I attacked a woman in her car....I attacked a painter working for the Council...."*
293. Adult B said that she begged her G.P to give her a hysterectomy for years, in the belief that this would end her outbursts. She felt angry at professionals for not helping her. She felt angry at herself for what she was doing.
294. When asked what 'help' Adult B would have liked, she was unable to provide a specific answer. She thought she needed a *"miracle"*.

295. Adult B received a hysterectomy in 2006 whilst residing in Cornwall with Adult A. She was disappointed when her PMT symptoms did not immediately cease. She complained of feeling worse and wished she had never had the operation. Instead of feeling uncontrollable for two weeks of every month, Adult B said that she felt angry and unpredictable every day.
296. With both Post Natal Depression and Pre-Menstrual Tension dismissed as the cause for her continued outbursts, Adult B was asked if she had considered any other non-medical cause for her rages. She was unable to think of any during the meeting and replied *"I just wanted it to stop"*.
297. Adult B said that she had two other relationships before Adult A but they both used her as a *"battering ball"*. Adult B admitted that each of these men resisted her rages with physical violence. She said that every month the smallest things would trigger her temper and she would throw things at them. They would respond with violence but not initiate violence. Thinking about Adult A, she added *"He would never argue back – he would try and talk to me"*.
298. When Adult B was asked about her relationship with Adult A, she replied *"He wasn't like anyone I ever met before, he was different. He was chilled, so relaxed. He could talk. It was my first caring relationship. We both had the same interests; we liked the same music, camping and bikes. We had more time for each other because the kids were older"*.
299. Adult B said that her relationship with Adult A had its *'ups and downs'*. During the down times, they would argue daily. She would often end up *"throwing anything and everything"*. He would generally walk away. She added *"I would follow or try and call. I went through so many mobile phones by throwing them at the wall....It was annoying when he wouldn't argue back"*.
300. When Adult B was asked *'What was different about the day of the incident?'* she recalled her version of the events and concluded that the argument leading up to the homicide was not any different to any other argument. She said *"I was*

*just throwing stuff...next thing, he was next to me, I caught him; that was it..."*

301. Adult B was asked if there was anything that any Professional could have done to prevent the outcome. She said that she tried to get help from her G.P. Apart from her G.P she did not know where else to go to get help. She reiterated *"I just wanted anything, I wanted it to stop"*.

## **Panel Conclusions of Adult B's Participation**

302. Adult B's participation in the Review provides an insight into the frustration she stated she experienced in trying to gain help for her behaviour. It also demonstrates her limited awareness of agencies and professionals, other than a G.P, who could have helped.
303. Likewise, Adult B's participation highlights the limitation of G.Ps and their knowledge of 'tools and services' available outside of the NHS to respond to patients who request help for abusive behaviours. An example of this would include the G.Ps involvement with Adult B when she was a child. Whilst the G.P responded with medication, there does not appear to be any consideration given to causes. Today, we would expect a G.P to consider possible non-medical explanations, including child abuse, sexual abuse, neglect or trauma. Given Adult B's father's propensity for violence, this would not have been unreasonable for a GP to consider, even in 1975.
304. Both of these issues raise the importance of improving awareness of, and accessibility to, specialist community services for both victims *and* perpetrators of abuse (for the general public and Professionals).
305. In particular, Adult B's contribution reaffirms the need for a greater focus on domestic abuse within the Healthcare Sector.
306. Although there were many inconsistencies in Adult B's recall of certain historical events during the meeting, she did not attempt to deny her behaviour towards others. She admitted that the violence she received from previous partners was often as a result of violent resistance to her behaviour. Adult B is

due to be released from prison by 2016/17. This is a relatively short period of time in which Adult B can engage with support to address this behaviour whilst in prison; therefore her rehabilitation plan should aim to reduce the level of risk she poses to others (including her own family) on release.

# SECTION FOUR

## ANALYSIS OF INDIVIDUAL MANAGEMENT REVIEWS

307. The focus for this section of the report will be an analysis of the response of **Services** involved with Adult A and Adult B and her children, why decisions were made and actions taken or not taken.

308. Any issues or concerns identified are a reflection of the evidence made available with the benefit of hindsight and the application of foresight.

### Hindsight bias

309. Hindsight bias can lead to grossly overestimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do the right thing. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and that looking back to identify lessons often benefits from such practice. That said, the Review Panel has made every effort to avoid hindsight bias and has viewed the case and its circumstances as it would have been seen by the individuals at the time.

310. The Review Panel has considered the way in which agencies and individuals responded to the family in the context of domestic abuse services accessible and available to victims during the period stated in the scope of the review.

311. All of the agencies involved in this review provided candid accounts of their involvement in order to identify lessons.

312. The Review Panel analysed each agency's involvement on a separate basis. The involvement of each agency covered different periods of time. Some of the contacts contained in the IMRs appear to hold more significance than others. The Review Panel has attempted to examine seemingly inconsequential contacts and cross reference them with other information held by statutory services at the time with the aim of establishing whether;

- a) The original contact warranted information sharing or further enquiry/investigation at the time;
- b) Information sharing principles at the time would have permitted the exchange of intelligence/information between parties;
- c) The accumulation of information would have increased the significance of the contact and necessitated a different response.

313. Other than witness testimonies from Adult B's children, neighbours and the employer, it is evident from the Individual Management Reviews that there was little or no agency contact with Adult A and no individual organisation was aware of domestic abuse within the relationship until the death of Adult A on the 13<sup>th</sup> May 2012.

314. This does not necessarily translate to no evidence of domestic abuse, only that there was no professed disclosure or incident that alerted professionals to enquire about domestic abuse. It was therefore important, for the Review Panel to consider whether front-line professionals possessed the skills and competence to identify signs and symptoms of domestic abuse and knew how and when to facilitate appropriate support.

315. The analysis of the Individual Management Reviews also includes an evaluation of the response by professionals to recognise the gender dynamic of a male victim and a female perpetrator.

## BEDFORDSHIRE POLICE INDIVIDUAL MANAGEMENT REVIEW

316. The IMR Author has undertaken an analysis and an unbiased critique of Bedfordshire Police involvement with Adult A and Adult B (and her family) and the key events in the period covered by this Domestic Homicide Review. It does not detail all contact or failed contact with key individuals and therefore does not reflect the entirety of the work carried out by Bedfordshire Police during the review period. Comprehensive information may be found in the tabular chronology. (**Appendix B**).

317. The appointed IMR Author is employed by Bedfordshire Police as a Review Officer. He is a retired Detective Inspector and has worked within the Major Crime Unit and the Professional Standards Department investigating complaints and cases of misconduct.

### Summary of Involvement with Bedfordshire Police

318. At 14:30 hours on the 20th June 1995, Bedfordshire Police Family Protection Unit received a telephone call from (*Redacted*) Junior School, Luton, reporting a possible non accidental injury on an 11 year old pupil, C3, by his mother, Adult B. The brief circumstances were that on the previous day, at 15:30 hours, a teacher had witnessed Adult B hitting C3 around the head and generally slapping him after he had been sent back into school after forgetting something and returning without it. The teacher who had witnessed this event was never identified.

319. On his return to school on the 20th June 1995, C3's teacher saw that C3 had a bruise to his left eye. When questioned about it, C3 stated that he had been kicked in the face at playtime. It was reported that C3 would get very worried if the school were to speak to his mother about anything he had done wrong.

320. It would appear from the records available to the IMR Author that Bedfordshire Police had very little information at the time that may have given rise to any concerns regarding Adult B's risk to other persons. However on the

20th June 1995 at 15:00 hours, officers from the Family Protection Unit attended a strategy meeting with Social Services where officers learnt of a long list of referrals relating to the family including other historical non-accidental injuries. Bedfordshire Police were not aware of this information and had no such previous records.

321. The information shared with Bedfordshire Police at the strategy meeting on the 20<sup>th</sup> June 1995 was as follows:

- In 1987, C3 had been referred to Social Services by the (*Redacted*) Hospital after he had been treated for lacerations to his penis. No further action was taken.
- Also in 1987 there had been concerns raised over the possibility of C3 and another sibling, again no action was taken.
- In 1987 Social Services were aware that Adult B had stabbed her husband, H2 in the left thigh, severing an artery but this was not reported to the Police. (*The Overview Report Author notes that there is an inconsistency between the view of Bedfordshire Police and the victim (H2) who recalls the police being called but refusing to make a statement. Bedfordshire Police has no such record*).
- In 1988 Adult B admitted trying to strangle C3. No further action was taken.
- In February 1990, Adult B allegedly stamped on C3's leg.
- In March 1990, there was a report to Social Services alleging cruelty to children where the father was involved.
- In June 1990, C3 suffered a bruised lip. He stated that he had fallen over.

322. Although Social Services had a record of all of these incidents, it would appear that none of them had been brought to the attention of the Police (*less the disputed incident involving H2 in 1987*).

323. The decision from the Strategy meeting was that the Police would contact Adult B with a view to asking her permission to interview C3 and carry out a

medical examination. Social Services were to make enquiries with the school in an attempt to identify the teacher who had witnessed the assault. On initial Police contact, Adult B was quite aggressive but agreed for C3 to be interviewed although she refused to allow him to be medically examined.

324. On the 21st June 1995, C3 was interviewed whilst at school and in the presence of a member of staff. C3 stated that his mother had remarried to a person called H2. C3 stated that he did not like his brother as he would beat him up. He also stated that the mark near his eye was as a result of being kicked by his friend. When asked about the incident outside the school, he said that he deserved to get hit because he had lost his hat. No further Police action was taken.

325. The next time Adult B came to the attention of Bedfordshire Police was in November 1995. By this time Adult B had changed her name due to marriage and she had also moved address. On this occasion she was the victim of domestic abuse, alleging that she had been assaulted by her new husband H3. Due to her change of name and address, neither this event nor the subsequent allegations against her over the years were linked to the information provided by Social Services in June 1995.

326. After this event, all subsequent dealings with Adult B by Bedfordshire Police were as a result of issues with C4, Adult B's eldest daughter. Between the 26th September 2000 and the 17th October 2002, C4 was reported missing from home on seven separate occasions.

327. On the 6th June 2001, at a strategy meeting between Bedfordshire Police and Social Services, it would appear that C4 was alleging that her mother had assaulted her and that she sometimes stayed away because she was fearful to go home. C4 said that her mother suffers from bad PMT and that her mother hits her when she is suffering from PMT. According to the strategy meeting notes, Social Services were going to discuss these issues with Adult B on the 8th June 2001. The Police were not involved in these discussions and the IMR Author can

find no reference to the outcomes.

328. As far as Bedfordshire Police are concerned, there are two incidents of assault on record where Adult B was the offender. Neither of these incidents fell within the definition of 'Domestic Abuse' at the time. The IMR Author accepts that other incidents of assault may well have gone unreported.

329. The first incident was an assault on a 19 year old male on the 14th January 2003. The circumstances of the allegation were that the victim, XY, had been to the cinema in Luton with C4 (aged 14 at the time) and five friends. They had got a taxi to the estate where they lived, arriving there at just after midnight. C4 and XY began to walk in the direction of their home when they were approached by Adult B in her car. The vehicle stopped and C4 got into the front passenger seat. Adult B then drove the vehicle towards XY and shouted, "*You had better watch your back*". XY continued walking and then he saw C4 get out of the vehicle. XY then saw that the car was being driven straight at him, causing him to have to jump out of its path. As he did so, the vehicle hit his right foot. XY was not injured but felt that it was a deliberate attempt to run him down.<sup>29</sup>

330. On the 10th February 2002 Adult B was interviewed and she admitted the incident. She was given a 'Caution'.

331. This incident may have highlighted Adult B's quick temper that was only evident to people she was in a close relationship with. Unless it had been raised during interview the Officer dealing with this case would almost certainly not have been aware of C4's history and the fact that she had been subject to case conferences with Social Services (By this time C4 had been reported missing no less than seven times).

332. The IMR Author can find no record of this case being referred to the Family Protection Unit. Bearing in mind C4's age, the time of the event and the age of the person C4 was with; this should have been a consideration by the responding

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<sup>29</sup> Crime file 04549-03

Officer.

333. The second incident was an allegation by C4 on the 2nd May 2003. C4 stated that she had been 'beaten up' by her mother and she was scared and very upset. This incident was recorded as a domestic incident and the response was graded as 'immediate'.
334. Officers arrived at 21:43 hours to find C4 had sustained bruising to an eye and marks to her hand. C4 was taken to an Aunts house and the case was referred to the Family Protection Unit.<sup>30</sup>
335. At 21:43 hours the same day Adult B was arrested at her home address and taken to (*Redacted*) Police Station where she was accepted into custody.
336. In the absence of the crime file which has now been disposed of, there is very little further information available. However, according to the custody record Adult B was released from custody at 23:44 hours, on Police bail pending further enquiries. Adult B was under a duty to answer bail on the 6th July 2003. She was released from her obligation to return to the Police station on the 2nd June 2003, and no further action was taken.<sup>31</sup>
337. According to the Family Protection Team, during interview Adult B stated that she acted in self-defence. There was insufficient evidence to proceed and no further Police action was taken. It was however referred to Social Services to provide on-going support<sup>32</sup>.
338. Bedfordshire Police took positive action from the start of this investigation. They immediately took steps to take the victim to a place of safety and the alleged offender was arrested. Some paperwork relating to the investigation still exists, and it would appear that officers carried out a detailed and diligent investigation. For example, C4's younger sister, C5, was also interviewed. C5

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<sup>30</sup> URN 375 of the 02/05/2003/DVU form ref. 201/03

<sup>31</sup> Custody Record DH/1657/3

<sup>32</sup> FPT form ref. D/106/03

stated that C4 had initially assaulted Adult B who in turn hit C4. This supported Adult B's account. C5 also indicated that this had not occurred before but when her mother got angry she would tell the children off. The crime report is closed as 'undetected'. C4 stated that she withdrew the complaint for fear that C4 and C5 would be removed from the home and separated. C4 wanted to protect C5 and therefore withdrew the complaint.

339. Bearing in mind the age of the victim, this incident did not fall within the definition of a domestic incident, but was referred to the Family Protection Unit who took responsibility for the investigation and recorded the incident on the Case Automated Tracking System (CATS)<sup>33</sup>. This meant that partnership agencies would also be included in an attempt to resolve the issues within the family.
340. In relation to the seven Missing Persons Reports made to Bedfordshire Police between 26<sup>th</sup> September 2000 and 17<sup>th</sup> September 2002, it was abundantly clear that the relationship between C4 and her mother was not harmonious, and on occasions Officers should have spent more time trying to understand the underlying problems resulting in C4's behaviour. The Police response to C4 being absent from home was slow. When she was located it would seem that Officers spent little time in trying to understand the reasons for her behaviour.
341. The IMR Author highlighted this and other issues as areas of practice that could have been dealt with more professionally by Bedfordshire Police. Practice that was acceptable in the past would not be acceptable today.
342. The shortcomings identified would be minimised today, due to new working practices. A summary of the key changes to working practices within the Police Service since 2002 are outlined in **APPENDIX D**, together with comments on whether such changes would anticipate a different outcome if a similar case was

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<sup>33</sup> 'CATS' was introduced into Bedfordshire in 2002 – 2003 and records all incidents of domestic, sexual and family abuse. The system allows officers within the Public Protection Unit to maintain a record of all Police contact with individuals, victims and suspects, a record of referrals, risk assessments and action taken.

presented today.

### **Review Panel Observations & Lessons Identified from Bedfordshire Police IMR**

343. The Panel received a thorough and comprehensive Individual Management Review (IMR) from Bedfordshire Police. The IMR Author provided a detailed chronology of their interactions with the family from 1995 to 2004, of which the Panel selected relevant information to support the Terms of Reference for this Domestic Homicide Review.
344. The Panel concludes with the IMR Author's comments and conclusions and is satisfied that working practices, policies and systems would have developed and improved significantly over the past two decades, however, the Panel also acknowledges the recent HMIC (Her Majesty's Inspectorate of Constabulary for England and Wales) Inspection (February 2014) which identified immediate steps to be taken by Bedfordshire Police to improve the force response to domestic abuse across the county.
345. Looking specifically at the Terms of Reference and applying the benefit of hindsight, the Panel can see a number of missed opportunities for professionals to enquire or raise concerns about domestic abuse in the household over the period of the review.
346. It is disappointing that no Police interactions from 1995 onwards were linked to the information provided by Social Services in June 1995. The Panel cannot speculate if this would have changed any of the subsequent Police decisions or actions, however the information shared at the strategy meeting in 1995 was sufficient enough to have warranted further enquiry and examination when the police were later involved with Adult B, C4 and XY.
347. The Panel are unable to comment on the decisions and actions of Bedfordshire Police in relation to the management of Adult B and any of the allegations/reports made against her. The Panel is aware that this review will

highlight some decisions that may not comply with child protection standards today e.g. no further police action in 1995 (following the witnessed assault at *(Redacted)* Primary School and the decision to seek consent from the suspected abuser for the medical examination of C3).

348. In response to the allegation of assault on C4 on the 2nd May 2003, the IMR Author states that *“by their very nature, domestic related incidents often provide little or no independent evidence to support the victim and if the offender states that they acted in self-defence, it can be difficult to prove otherwise”*. Whilst the Panel has considered the reasoning for this observation, it is important to recognise that Domestic Abuse is complex and extends beyond the criminal justice process and those that experience and/or witness domestic abuse may require additional support or intervention from non-police agencies, regardless of whether it can be established *‘who is to blame’*. As Domestic Abuse can also escalate, it is essential that these incidents are recorded to provide vital intelligence of the accumulative impact of seemingly ‘low-level’ incidents. This statement/observation should never be used as an excuse to do nothing.

349. The Panel considered whether there were opportunities for intervention in respect of Adult B that were missed by Bedfordshire Police. It certainly appears that the exchange of information between Officers and other agencies was made more difficult due to the frequent change of address and surname of key family members. This resulted in a ‘single incident approach’ whereby each report or allegation was viewed in isolation of the accumulative history, meaning that vital links were not, or could not, be made.

350. Adult B changed surname five times during the review period. C3 also changed his birth surname as a child. C1 and C2 have a different surname to C3 and C4. C5 has a different surname to all other family members.

351. As repeat perpetrators of domestic abuse (and other serious crimes) often avoid detection by using the tactic of moving and changing name, it is possible that Adult B purposefully changed identity and address frequently to avoid the links being made. The IMR Author highlights that this should be more difficult to

achieve today if children form part of the family unit, however this case evidences a weakness in the system when children change surnames too.

352. The opportunity 'to fall through the net' remains a concern for the DHR Panel.

Today's systems are only effective if professionals are appropriately trained and have the time and inclination to input quality data, share information and make the links between surnames, addresses and family members.

353. Unfortunately this case also highlights a shortcoming in an approach that relies heavily on child safeguarding procedures, and the presence of children, to identify and respond to adult domestic abuse. The children of Adult B were viewed as both a protective factor and an instigator of violence in this case. Adult B claimed that C4 and C5 were the cause of many of the arguments within the household and that the departure of C4 in April 2008 and C5 in March 2012 improved the harmony within the relationship. Conversely both C4 and C5 recall many occasions where they attempted to protect Adult A from Adult B's violent outbursts. Nonetheless, just 8 weeks after C5 moved out of the family home, Adult A was killed by Adult B.

354. This raises the vulnerability of victims of domestic abuse when children either grow up and leave the family home or are taken away from parents due to abusive relationships. If professionals believe that the presence of children will make it more difficult for victims and perpetrators to 'fall under the radar' then it must also be acknowledged that the risk to families without children are increased, unless professionals possess the same competency and practice standards for domestic abuse as exists for child safeguarding.

355. Although not mentioned within the narrative chronology, the Panel was notified within the tabular chronology (Appendix B) provided by Bedfordshire Police that Adult A held a firearms certificate for three shotguns owned between 2001 and 2006. The Panel asked the Police when considering an application for a firearms certificate, whether all members living in the household were vetted or just the applicant. The Panel was informed that only the candidate applying for

the application was vetted.

356. Although Adult A was fully entitled to own a firearms certificate, it is worrying that another member living in the household (Adult B) did have a criminal record and a history of violence. The Panel is concerned that the current vetting procedure for firearms certificates may be limited to the criminal history of the applicant and may not routinely uncover the potential risk of a firearm to others living in a domestic abuse household.
357. New Home Office guidance published on 31st July 2013 prohibits individuals with a history of domestic violence from possessing a firearm or shotgun. The change was introduced after a man from County Durham shot three members of his family and then himself in 2012. The perpetrator had been approved by police to own shotguns despite having received a warning because of previous incidents of domestic violence.
358. The DHR Panel welcomes the changes to the Home Office Guidance, which includes officers speaking confidentially to partners or other family members if there is intelligence or even a suspicion of domestic abuse.
359. However, the findings from this DHR could pose an interesting scenario for the new guidance, in that hypothetically the 'victim' (Adult A) would have been the applicant. Having no criminal history, Adult A would have passed this particular stage of the application. If officers did persist and speak confidentially to Adult B, they would have been talking to the possible offender, who could effectively manipulate the outcome if desired. Essentially, the Panel is still concerned that a victim, forced under duress to apply for a firearms certificate, could be exposed to significant risk or at worst homicide, by a loophole in the current guidance and application process that does not require the names or vetting of, all individuals living in the household.
360. If a similar case presented today, it is possible that the DASH (2009) risk assessment would identify 'access to weapons' as a high risk factor (even if the firearms vetting procedure did not identify a risk at the time), however, this is

reliant on the victim coming to notice of statutory agencies.

361. Given the complexities of this case in terms of the number of individuals involved (with different surnames), changes of address and the gender of the perpetrator; coupled with the absence of a common risk assessment framework available at the time and a victim who did not disclose abuse, the Panel can see how (with the benefit of hindsight) Professionals failed to accurately identify and assess high risk domestic abuse within the home or high risk factors (such as access to weapons) and their possible consequences.

## LUTON CHILDREN'S SERVICES - IMR

362. The Independent IMR Author commissioned by Luton Borough Council has considerable experience as a Children's Services Practitioner, Manager and Consultant.
363. Reference to "Luton" and "Luton Children's Services" are made in relation to events proceeding April 1997 and relate to the Luton office of Bedfordshire County Council Social Services Department which covered Luton prior to a Local Government Reorganisation in 1997 when Luton became a Unitary Authority.
364. As stated in 600 of Appendix A, there were no electronic records available at Luton Borough Council for the period of involvement relating to this IMR. Only two paper files were found and reviewed.
365. The two case files contain a total of one hundred and seventy nine (179) items. The case recording sheets by social workers, recording of referrals and the majority of documents are handwritten. Many of the recordings are difficult to read and the majority omit dates, names and status of the professional completing the recording. A minority of report copies are typed. Others are photocopied from the originals and the legibility has suffered in the process of duplication.
366. Luton Children's Services became a unitary authority in 1997. However the department appears to have continued to use the Bedfordshire County Council formatted referral records and templates until 2000. The majority of referrals do not specify which office, team and professional completed the referral. Therefore it is difficult to determine if a referral and/ or recording was completed by a Luton Professional or a Bedfordshire County Council Professional.
367. Additionally there appears to be insufficient documents present for the duration Adult B and her children were known to Luton and Bedfordshire County Council's Children's Services and the events recorded. For example there are no

assessments present and there are no case file chronologies present. Enquiries were made by Luton Borough Council and with Central Bedfordshire Council and Bedfordshire Borough Council as to whether they have any archived records related to any members of the family. The IMR Author was advised that no records are archived for Adult B or any of the other subjects within the scope of this DHR.

### Summary of Involvement with Luton Children's Services

368. Adult B was subject of a transfer summary between the then (*Redacted*) area offices within Bedfordshire County Council Children and Family Services (18.01.1985). This is the first reference to Adult B being in care as a child.

369. A non-dated nursery application in 1985 concerning C2 then aged 3 describes mother Adult B as being *"an aggressive and violent child at home and at school resulting in her being taken into care. Since leaving care Adult B has not been able to sustain a permanent relationship"*. The closure comments recorded by the social worker are *"No child concerns re parenting by mother but children are aggressive and behind in verbal and social milestones"*. This is the first and only reference to Adult B being violent as a child.

370. The case was re-opened at Bedfordshire County Council's Children's Service, Luton area during 1986 concerning an application by Adult B and H2 to adopt C3, aged 2. (Step-parent adoption). The registration and application to adopt continued through 1986- 1988. A case closure summary dated 28.02.1989 summarises the period of application and records that the process to adopt C3 was delayed due to the parents *"not thinking through their application, delays in submitting documents, delays by solicitors and marital disharmony"*.

371. The application to adopt C3 was withdrawn by Adults B and H2 on 05.09.1988. The allocated social worker recorded in the transfer summary a visit to the family and *'discovering mother Adult B, throwing all the clothing of H2 out of a window'*. Additionally the social worker discovered Adult B had also *'smashed all the crockery in the house'*. The social worker appropriately advised

the couple of withdrawing her support for the adoption application. There were no other records pertaining to this visit and observations.

372. On 24.04.1987 a referral to Luton Children's Services, Emergency Duty Team was received from the (*Redacted*) Hospital advising of a suspicious injury to the penis of C3, then aged 3. Parents were reported as being too casual and the injury did not appear consistent with the explanation of being caused by the toilet seat. The referring Ward Sister advised of intent to refer to a Paediatrician. No other recording relating to this incident could be located within case files one or two. The referral details were not recorded within the case closure summary of 29.02.1989.

373. On 10-11-1988 C3 aged 4 was seen by his infant's school to have a friction burn on his neck. C3 said that *"Mummy had strangled him"*. Mother, Adult B had also self-referred the incident to her allocated Health Visitor and admitted slapping C2, then aged 7 and knocking out his tooth. The allocated Health Visitor visited Adult B on 10-11-1988 but did not inform Luton Children's Services of the incident until the following day 11-11-1988.

374. A joint visit was completed by the allocated Social Worker and Health Visitor on 14-11-1988 where Adult B admitted to picking up C3 and throwing him on a sofa. There is no recording present relating to the incident or injury to C2.

375. During the joint visit Adult B reported to be suffering from a neurological condition which caused facial paralysis and blinding headaches. The condition was assessed at a London hospital by a Neurologist but the Social Worker's case record sheet documents there being no cause found for the symptoms. The closing case summary 28-02-'89 records;

*"Likely future contact to be:*

- Future marital strains*
- Possible further injuries to the children if Adult B is under stress again*

– *Schools may ring with concerns for the children*".

376. A foot note in the case closure summary 28-02-1989 documents a different Health Visitor having shared a press cutting relating to an incident of Adult B being taken into care after she had tried to strangle a relative.

377. A new referral was made to Luton Children's Services on 12-05-1989 by a paternal aunt who advised Luton Children's Services of H2 being stabbed by Adult B and of being taken to intensive care (*Redacted*) with a severed artery. The children were confirmed to be staying with the maternal grandmother in (*Redacted*) and the referral was closed on 15-05-1989 with a recording by a manager on the referral form "*as the matter appears to have resolved itself NFA*". There are no recordings present to confirm the children of Adult B were seen or a risk assessment completed. Details concerning maternal grandmother and her relationship with Adult B were also absent.

378. A notification/cause for concern was sent by a Health Visitor to Luton Children's Services on 08-06-1990 to advise of her referral of Adult B and children to Child and Family Guidance because of the level of violence within the family. Mother, Adult B and her children had failed to attend arranged appointments. Health Visitor records this notification being for '*Children's Services' information only*'.

379. On 18-06-1990 (*Redacted*) School made a referral by letter to a person named only as (*Redacted*) advising of C3, aged 6, attending school with a bruised lip of which the child alleged Adult B had hit him for not putting on a shirt quickly enough. C2, aged 8 had also attended school with a bruised eye which he claimed had been caused by an elder brother. The letter additionally refers to the children having four different home addresses and schools within the past three years and of mother, Adult B being described as '*aggressive and dangerous*' by a previous school.

380. At this time the family had a (*Redacted*) area home address. Four hand written social work record sheets report a joint visit by two Social Workers

completed on the 28-06-1990 to investigate reports of an injury to the lip of C3. All children were recorded as being seen. C3 was reported to have a one inch swelling on his lip. The Social Worker's record registers disbelief at the inconsistent explanation provided by mother, Adult B. A copy of the referral could not be located and referrer details appear absent.

381. A Professionals meeting was held at Bedfordshire County Council (*Redacted*) area office on 30-10-1990. The meeting appears to have discussed general concerns related to C2, aged 10 *"having difficulties at school due to his anger and has been excluded from some lessons and faces exclusion from school"*. The recorded decisions were: *"1: School to monitor C2; 2: other concerns of family are contained"*.

382. On 31-01-1991 H2, second husband of Adult B, self-referred to Bedfordshire County Council Children's Services, (*Redacted*) area office following an incident in which he assaulted Adult B by pushing her over. Children's Services established that Adult B was taken to hospital and sustained severe bruising to left side of face, neck, arm and hand. The Duty Social Work Team appear to have established the children were to be cared for by a maternal aunt and additionally advised Adult B to gain legal advice if concerned about a reoccurrence of violence. The children do not appear to have been seen. The referral was closed *"as no further involvement required"*.

383. An anonymous referral was received by Luton Children's Services on 18-12-1991 alleging Adult B to be frequently hitting C2 aged 10 because *'he resembles his father'*. Injuries are recorded as a bruised eye. There is no recording present confirming contact with the child or other family members. The referral was considered *"not adequate enough to merit a responsive visit."* The duty social worker wrote a letter 20-12-1991 to the Head teacher of (*Redacted*) School advising of the referral and requesting any future concerns to be referred.

384. During 19-06-1992 the new partner of H2 (now estranged from Adult B) attended Children's Services (unclear if Luton or Bedfordshire County Council or (*Redacted*) area office) alleging that C4, aged 4 had been hit by a partner (not

identified) of Adult B; and C4 is also neglected. The referrer advised if marks were not visible on C4 no action could be taken. Additionally the referrer was advised H2 should seek legal advice concerning custody issues of C4. The referral was considered to be *“a custody issue and NFA required. Case closed.”*

385. On 18-06-1993 A referral was received by Luton Children's Services from *(Redacted)* School reporting C3 aged 9 to have grazing around his right eye. C3 had said his mother, Adult B *“did it”*. C3 is later reported to have said he hurt his eye falling off a bike. He changed the explanation again and said another child had kicked him. A social work record sheet recorded *“the school informed that C3 becomes very worried if he thinks he will be in trouble when he gets home. Mother is a very violent woman”*. There are no apparent recordings of the family being contacted, the child being seen, completion of an assessment or consideration of service intervention concerning this referral.

386. On 20-06-1995 Children's Services Luton were advised by *(Redacted)* School during a telephone referral of school staff witnessing C3, aged 11 being beaten by his mother, Adult B in the school playground. Adult B was recorded as *“really laying into C3, slapping him and shoving him with her knee”*. C3 returned to school the following day with an additional bruise near his left eye. A strategy meeting was convened (date not recorded) where C3 was seen by a Social Worker and a Police Officer at school on 21-06-1995. The details of the explanation provided by C3 are absent. There are no recorded details of Adult B being interviewed.

387. Following the Strategy meeting, the Social Worker recorded that she and the Police Officer present had been dissatisfied with the account of the incident provided by C3 and Adult B. A recording on the strategy discussion advises that NFA should be taken: *“The established facts of witnesses were too far away to be reliable. Mother had hit child but not excessively. Despite previous concerns of the parenting by Adult B, the home environment is considered more stable. Adult B has remarried and would not welcome social work involvement; conversely it would add more stress”*.

388. Children's Services Luton was advised on 17-05-1996 by a school (not Identified in the referral) of a cut on the head of C4, then aged 8. The child said the cut was caused by her mother, Adult B hitting her with a shower head. The referral also included information of C4 being bruised on 13-01-1996 and her appearance being neglectful on 09-02-1996. The school advised Children's Services of not previously referring the latter incidents and concerns on the stated dates. The reasons for not previously referring the two concerns are not present within the case files.
389. A Social Worker recorded the School Nurse had refused to examine the cut on the head of C4 *"as it is the job of the Chief Medical Officer to do so"*. The Luton case files do not confirm if C4 received a medical assessment and treatment. A non-dated strategy document records the referral to be closed on the 24-06-1996 as the *"explanation C4 jumped up and hit her head on the shower head is plausible. If parent is lying it is too late to investigate"*.
390. Additionally the school advised of an incident of Adult B attacking another parent in the school playground. The school stated Police had been called and believed the Police to have notified Children's Services of the incident. There are no records within the Luton case files relating to the Police attending an incident concerning Adult B attacking another parent.
391. A (*Redacted*) School referral/cause of concern to Luton Children's Services on the 14-04-2000 advises of C4, then aged 12, being hit on the arm by Adult B resulting in bruising to her left arm. In Addition an Education Welfare Officer also referred C4 on 14-04-2000 for concerns of persistent truanting, behavioural problems at school and outside of school.
392. There is no apparent recording to verify whether C4 or any family member was seen in response to the above referrals on the 14-04-2000. Social Worker case recordings from 10-05-2000 to 31-10-2000 record the non-responses by Adult B to contact the Luton Children's Services Initial Assessment Team. It appears that Adult B and her children were resident at a different address when telephone contact was established on the 31-10-2000. (The details of new

address do not appear to be present within the case files). It is not apparent why Social Workers did not establish the home address of the family or visit the family within the six month period of the referral being open to Children's Services.

393. On the 22-05-2001 a referral was received at Children's Services Luton from an Education Welfare Officer at (*Redacted*) outlining concerns regarding the school attendance and behavioural problems of C4, then aged 13. The referral also recorded Adult B as '*not coping*'. A strategy discussion was held on 06-01-2001 and the meeting discussed the accumulative "*concerns for the safety of C4 going back to 26-09-2000*". Three actions from the strategy discussion are recorded;

- "*Speak to Mum, Adult B*
- *Contact Dad*
- *School check on C5, aged 7*"

394. However neither C4 nor any other family members appear to have been seen and spoken with. Correspondence was sent to the referring Education Welfare Officer on the 15-10-2001 advising of no contact with Adult B and "*the case file will be closed as it is presumed no social work input is required.*"

395. On the 17-01-2002 (*Redacted*) School again referred C4 aged 13 to Children's Services following complaints by C4 of being picked on by mum, Adult B. There were no recordings related to this referral located within case files. This was the last contact with Luton Borough Council's Children's Services concerning Adult B and her children.

### **Analysis of Involvement with Luton Borough Council**

396. There were eleven known or recorded occasions during the period 1985 to 2002 in which Luton Children's Services were informed of the children alleging to be, or reported by Professionals to have received, a non-accidental injury from

Adult B.

397. The children of Adult B were confirmed as being seen by Social Workers on four occasions of the eleven occasions they were injured.
398. It would be reasonable to expect confirmation within the case files of the commencement of a comprehensive assessment of the children, particularly in consideration of the specific and accumulative incidents involving their Mother, Adult B and the parenting they appear to have received.
399. It is disappointing to report that the case files do not evidence a single assessment.
400. In consideration of the available recordings it is very difficult to understand why no assessment was undertaken during the period of agency involvement or why the children had not been subject of a child protection case conference, particularly during the late 1980's and 1990's.
401. The incident relating to Adult B strangling C3 and knocking out the tooth of C2 is of particular concern. It is difficult to believe such incidents would not result in the children being discussed at a child protection case conference during any decade since the modernisation of Children's Departments in the 1950's.
402. The incidents pre date the introduction of the Children's Act 1989 and the focus upon significant harm provided by the Act. However, such was the severity of incidents / injury for both children it is difficult to understand why Professionals did not recommend the children to be discussed at an initial child protection case conference.
403. It is incomprehensible of there being no evidence of deliberation concerning the injuries to C2 and C3 or how the family could be supported when the children were clearly at risk. The lack of formal and informal interventions concerning the history of injuries to the children is alarming and it is difficult to accept there could have been a local culture of practice that considered injuries to the children

simply as resulting from the strains that Adult B found in coping with her environment and /or health issues.

404. The non-completion and standard of assessments and case recording/case file maintenance standards were both a national concern raised by the Department of Health (DOH) and the former Social Services Inspectorate (SSI) during the 1980's and 1990's<sup>34</sup>. It is speculative if the absence of assessments and the absence of other recordings and documents are due to non-completion, poor case file maintenance or both.
405. It is regrettable that no policies or procedures are archived at Luton Borough Council preceding 2002. Without access to historical policies and procedures, it is impossible to assess whether responses or interventions were within the expectations of practice at the time. The two case files held at Luton Borough Council do not evidence sufficient deliberation or clarity of the actions and outcomes that were completed concerning any of the recorded events.
406. Although policies and procedures would have been in place during the 1980's and 1990's concerning child protection related issues, it is apparent that the incidents of domestic abuse were responded to by Professionals within a culture of it being a '*private matter between the adults*'. It is possible that the limited interventions by Luton Children's Services during the period of involvement with Adult B and her children were not considered missed opportunities at the time and would only be considered retrospectively so.
407. The impact of adult violence upon children was not considered until a landmark case<sup>35</sup> in 2000, which provided evidence of the detrimental impact and consequences that domestic abuse can have on children. A number of studies followed which evidenced the co-occurrence of child abuse and adult domestic

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<sup>34</sup> (Child Abuse: A study of Inquiry Reports 1980-1989 DOH 1991) (recording with care: inspection of case file recording in social services departments SSI DOH 1999).

<sup>35</sup> (Re L; Re V; Re M; Re H (2002) FLR 334 (Re LVMH))

violence<sup>36</sup> and the psychological, behavioural and emotional effects that living with domestic abuse can have on children<sup>37</sup>.

408. The cumulative evidence of co-occurrence was recognised in new legislation in 2001 when the impact of *seeing or hearing* domestic violence was added as an amendment to the definition of harm in Section 120 of the Children and Adoption Act 2002. ACPO Guidance published in 2005<sup>38</sup> also recommended automatic screening for domestic violence in all child abuse cases, and vice versa.

409. The implementation of the Domestic Violence, Crime and Victims Act 2004 and successive government guidance since 2000 has developed professional attitudes, understanding and responses to incidents of domestic abuse. It is highly improbable today that Professionals would consider domestic abuse a *private matter* or not be compelled to consider the impact of an incident upon the child.

410. It is clearly evident that Adult B was considered to be an aggressive and physically violent woman. She was known to be physically violent during her childhood in the 1970's and as an adult during the 1980's and 1990's. The frequency and intensity of her violent episodes appear to have increased during the 1990's into 2000, with frequent recordings by Professionals of her being an '*aggressive and violent woman*'. Significantly none of the other male partners of Adult B were referred to as aggressive or violent within case files from 1985 - 2000.

411. Adult B's well-documented reputation for being aggressive and violent may have resulted in Professionals being reluctant to report her or raise concerns relating to her children for fear of how she would respond. It is also possible that Professionals were not clear about thresholds for referral to Children's Services

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<sup>36</sup> Walby and Myhill (2001) op. cit (Humphreys & Thiara, 2002; Mullender et al, 2002),

<sup>37</sup> Brandon, M. and Lewis, A. (1996) 'Significant harm and children's experiences of domestic violence', 1 Child and Family Social Work 33-42; Hester, M., Pearson, C. and Harwin, N. (1998) Making an Impact: Children and Domestic Violence: A Reader (London: Banardos/Department of Health); McGee, S. (1997) 'Children's experiences of domestic violence,' 2 Child and Family Social Work 13-23

<sup>38</sup> ACPO Guidance 2005: Identifying, Assessing and Managing Risk In the context of Policing Domestic Violence

or had a low expectation of the response and actions by Social Workers. There appears to have been an element of both being prevalent during the 1980's and 1990's and it remains speculative due to the limited information available in the case files. It is unlikely that there was any policy or practice guidance available at that time to assist practitioners working with difficult to engage families.

412. Adult B told Professionals that her behaviour towards her children was due to being ill from a neurological condition that caused facial paralysis and severe headaches. Professionals appear to have accepted this explanation as reasonable and do not seem to have taken any further action, even after no medical cause was found.

413. Worryingly, there does not appear to have been any overt linking during the 1980's and 1990's between Adult B's violent childhood and the subsequent injuries to her children. Although case closure summaries reference Adult B being placed in care after attempting to strangle a relative when she was a child, Professionals failed to link this to her strangulation of C3 in 1988. Today, strangulation, or any attempt to block an airway, would be considered a high risk factor of domestic/child abuse and would result in a multi-agency strategy discussion concerning the threshold of a Section 47 Enquiry (The Children Act 1989).

414. There are a number of occasions when there were delays in responding to a referral or a referral was not made at the time of the allegations (e.g. school concerns for C4) and of Professionals responding to the family without notifying Children's Services of involvement (e.g. Health Visitor responding to injuries to C2 on the 11-11-1988). The response by Luton Children's Services to many of these injuries were evidenced based on the child maintaining their allegation, whether the injuries were still visible and if the agency had responded quickly enough for the incident to be to evidential.

415. Responding to referrals regarding concerns for Adult B and her children was made more difficult by their constant moving around the areas of Bedfordshire. One might speculate that this was an avoidance tactic by Adult B to evade

contact with the local Children's Services in Central Bedfordshire Council and Bedfordshire Borough Council. It is not clear from the Luton case files why Social Workers did not make better attempts to locate, establish contact and visit the family at home and remained reliant on the responses from Adult B to written letters.

416. Disappointingly the case files do not substantially evidence information sharing despite the severity of incidents involving Adult B and her children being sufficient enough to justify sharing information and initiating a child protection conference.
417. A number of incidents pre-date the introduction of legal Acts that now underpin how information is shared in a secure and confidential manner and in accordance with the law (*e.g. Children Act 1989, Data Protection Act 1998, Human Rights Act 1998*). However three recorded contacts with Adult B at (*Redacted*) School from 2000-2002 occurred at a time when information sharing by Professionals was an implicit principle within the Framework for the Assessment of Children in Need and their Families (DOH 2000) and Working Together 2000 (DOH 2000).
418. A particular incident on the 12-05-1989 substantiates the Panel's concerns around information sharing decisions by Professionals at the time; When Luton Children's Services were advised that Adult B had stabbed H2 they were informed that the injury was sufficiently severe to result in H2 being admitted into intensive care with a severed artery. Children's Services were informed that H2 did not wish to press charges against Adult B although the Police dispute that they were ever called to attend the incident. Records appear to show that this information was not shared with Bedfordshire Police until the 20<sup>th</sup> June 1995 – almost six years after the incident. Despite this, the case was closed by Social Workers three days after the incident with a Managers comment *"This matter appears to have resolved itself, No Further Action (NFA)"*.
419. Whilst it is apparent a specific domestic abuse risk assessment would not have been completed during the period of the stabbing (The incident pre-dated

the SPECCS 2005 Risk Assessment) there should have been a risk assessment completed concerning the children who had been traced to the home of a maternal grandmother.

420. It is highly unlikely that a similar incident occurring during 2014 would not result in a Police arrest, thorough investigation, risk assessment and a referral for multi-agency intervention - even if H2 refused Police intervention and insisted on withdrawing support for a prosecution.

421. Since the implementation of the Domestic Violence, Crime and Victims Act in 2004, serious offences (for example, where children or young people are present, or where there is considerable violence, or where there is the real and continuing threat to the victim or children), can still be prosecuted by the Crown Prosecution Service (CPS) in the public interest, even if the victim says that they do not wish to press charges or asks for charges to be dropped.

422. For the safety of Adult B's children and others, it would be common practice today to establish the reason for H2 not wanting Police intervention or withdrawing his complaint. Many reasons exist as to why victims retract statements including the victim being reconciled with the defendant or having concerns about being responsible for the defendant receiving a criminal record. It may be that the H2 experienced feelings of embarrassment or a fear of being ridiculed. Conversely he may have been pressured, coerced, intimidated or blackmailed into withdrawing the complaint.

423. The reasons for H2 not pursuing Police involvement is not known, however the Crown Prosecution Service would today consider the evidence and testimony of other witnesses, including Adult B's children, to determine whether fear and intimidation was a factor. In such cases, a multi-agency strategy for supporting the victim and the children would be essential through the galvanisation of local safeguarding and domestic abuse protocols.

## Conclusion of Luton Children's Services IMR

424. In consideration of the established chronology of allegations and injuries to some of the children; partners, and other adults (e.g. parent in the school playground); it is clear that Adult B was known to be a risk to others. With reflection of the available records, even by the standards of that time, it is evident that the known risks appear to have been understated and overlooked. It would be reasonable to expect there to have been evidence of completed assessments and interventions concerning the specific and accumulative concerns relating to the standard of parenting provided by Adult B to her children.
425. From the recorded information concerning Adult B it is debatable if Luton Children's Services did promote the welfare of Adult B and her children. That said, the issues are historical and cannot be verified by case records without sight of the policy and procedures, or interviews with staff that were in post at the time of involvement.
426. The standard of practice located within the Luton case files are not comparative with the evidence based practice, present day structure of Luton Children's Services or the national service standards and expectations of proficiency that Social Work Practitioners are obligated to achieve today.
427. The implementation of 'Working Together to Safeguard Children 2013' now guides Professionals to consider the impact of prolonged or regular exposure of children to domestic abuse<sup>39</sup>. With children being directly abused in over 50% of known domestic violence households<sup>40</sup>, this case highlights that no agency or service provider to children should become complacent about overcoming the challenges of safeguarding children exposed to adult violence and abuse.
428. It is vital that all Professionals working with children have the skills and competency to identify the co-occurrence of domestic abuse and child abuse. Furthermore Professionals should know when and how to raise a safeguarding

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<sup>39</sup> ( Working Together 2000 2.21 DOH)

<sup>40</sup> NSPCC (1997) found a 55% overlap; Farmer & Owen (1995) found 52% overlap

alert **and** a simultaneous multi-agency domestic abuse referral.

429. Further progress is also required on a national basis to ensure that the evidence-based link between child abuse and domestic violence is parallel with practice on the ground. The competency of professionals varies dramatically from area to area depending on the quality of training; which has an impact on the consistency of response to domestic abuse across England and Wales. The topic of domestic abuse has commonly been covered (in brief) as a component within broader, mandatory child safeguarding training programmes however the level and intensity of this 'component' is not regulated or evaluated.

430. The Panel would welcome minimum national standards of training for domestic abuse for all Professionals working with children. This would assist in providing a benchmark for local authorities and ensure that any 'commitment to improve workforce knowledge' is quantifiable.

**CORNWALL AND ISLES OF SCILLY PRIMARY CARE TRUST IMR <sup>41</sup>**

431. The IMR Author for the Primary Care Trust (PCT) is a qualified General Practitioner and Senior Medical Advisor to Cornwall and Isles of Scilly Primary Care Trust.
432. On behalf of the PCT, the IMR Author carried out a detailed independent review of the medical records of Adult A from 01.01.04 to 13.05.12 and Adult B from 26.09.63 to 13.05.12. Interviews were undertaken with staff at (*Redacted*) Surgery, (*Redacted*), Cornwall.
433. Adults A and B were registered with (*Redacted*) Surgery shortly after moving from Bedfordshire to Cornwall on 29<sup>th</sup> of June 2004
434. The clinicians at (*Redacted*) Surgery who provided care for Adult A held no suspicions that he was a victim of domestic abuse prior to the homicide and although he suffered from multiple and complex medical conditions they did not consider him to be a vulnerable adult/adult at risk, under the definition of No Secret DH 2000. From a detailed review of his case notes there is no information to suggest that he was at risk of or a victim of domestic abuse.
435. The case notes of Adult B contain multiple references to violent behaviour and several references to physical attacks against a previous partner which were documented in correspondence dating back over many years. Apart from references to 'PMT' and a referral for 'family therapy' which appeared in the medical summary of her case notes, the references to violence were contained within a very large volume of letters and printouts of computer records from previous surgeries.
436. The documented violent episodes pre-dated Adult B's move to Cornwall and these episodes had not been included in the medical summary of her case notes. The clinicians interviewed as (*Redacted*) Surgery were not aware of Adult B's history of violence.

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<sup>41</sup> CIOSPCT was abolished on 31 March 2013 as a result of the Health and Social Care Act 2012. The responsible authority for future GP IMRs is NHS England Devon and Cornwall Area Team.

437. At previous surgeries this history was known about and documented, but does not always appear to have been acted upon.
438. The medical case notes of Adult B contain references to violent behaviour dating back to 1975 when she was 11 years old. Her grandmother and mother were quoted in letters requesting help and her mother expressed her fear that one day Adult B would *'end up murdering someone'* (letter from Education Welfare Officer dated 17.03.1978).
439. Adult B was referred to a Psychiatrist, Social Services and the Education Welfare Service between 1975 and 1978 from the age of 11 following violent and aggressive outbursts including physical attacks against her mother and a teacher, smashing furniture and an episode of intentional medication overdose. According to the letter authorised by the Consultant Psychiatrist dated 28<sup>th</sup> February 1977 *"(Adult B, aged 14 at the time) had swallowed a token overdose of tranquilisers prescribed for her and that she had thrown yet another tantrum in the house during which furniture had been broken. Her mother locked her out of the house and the police had been involved after which (Adult B) had been talked to at the police station"* It appears that she did not engage with the GP or Psychiatric Services and it is not clear what support the family received.
440. Adult B's mother was cited as being inconsistent in her requests for help with Adult B's violent behaviour and this inconsistency appears to have been a barrier to receiving help despite the possibility that she may have been intimidated by her daughter's presence (letter from Consultant Psychiatrist 28.02.1977, and Education Welfare Officer 17.03.1978).
441. Adult B's mother would probably be viewed as a vulnerable adult/adult at risk today under the definition of No Secrets DH 2000, being a self-reported victim of domestic violence and being physically handicapped following a childbirth-related stroke which left her with residual speech difficulties. She was the carer for her three children, one of her other daughters having a learning disability and behavioural problems, and her husband is described as living like a lodger in the family home.

442. There is no record in Adult B's medical case notes of further involvement by agencies following Adult B's pregnancy at the age of 15.
443. It would be normal practice today for the family to receive support despite Adult B's non-engagement as per HM Government Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, March 2013 *"If parents and/or the child do not consent to an early help assessment, then the lead professional should make a judgement as to whether, without help, the needs of the child will escalate. If so, a referral into local authority children's social care may be necessary."*
444. The welfare of Adult B's unborn child would warrant referral for risk assessment today due to her history of impulsive violent outbursts.
445. In 1984 the handwritten GP record notes that Adult B was *'pregnant with third child...deserted...living unsupported in squalor. Frightened'*. There is no correspondence to indicate any further social services referral or involvement which would be normal practice today in these circumstances.
446. In 1988 a Health Visitor filed a Cause for Concern Report relating to the four eldest children of Adult B after she informed the Health Visitor that she had attempted to strangle her son (C3, aged 4 years at the time) by *'putting her hands around his neck, she picked him up by his neck...'* *'She had also smacked (C2, age 7 years at the time) and knocked a loose tooth out...'* It was noted that Adult B *'is under considerable stress from an unknown illness.'* (This illness involved referral to a Neurologist with headaches – a CT head scan was subsequently reported as normal).
447. The above incident was reported to Social Services by the Health Visitor and the local school. A joint visit was performed by the Health Visitor and Social Worker. Case note reads: *'It was decided that no further action would be taken by Social Services but intensive support would be offered by myself, and (Social Worker) would visit as necessary'*.
448. In 1989 the family were referred by a different Health Visitor to the Child and Family Psychiatric Department, (*Redacted*), Luton for family psychiatric support. The entry states: *'Son (C1 age 9 years at the time) having problems at school –*

*'aggressive and disruptive' and difficulties at home. 'I feel that many of the family's problems are caused by (Adult B's) mental state and vulnerability to stress. She has a long psychiatric history and there have been two incidents of violence in the last six months...I am concerned about the risks her intermittent and unpredictable violent outbursts pose to the children...'*

449. There is no correspondence in the medical records of Adult B regarding the outcome of this referral, nor any indication of the duration of the support provided for the family from either of these referrals. This level of communication would be unacceptable today and close supervision of the children's welfare would be recommended with multi-agency collaboration.
450. It is possible that frequent changes of GP practice and house moves may have impeded communication reaching the case notes of Adult B, or perhaps correspondence was filed in the children's case notes. This is an on-going problem for child protection teams which may be alleviated with the roll out of a national clinical portal to provide a single view of medical data from different health systems. The introduction of a clinical portal would improve the basic exchange of information between agencies when patients move home or register at a new GP surgery.
451. Between 1996 and 2008 there are numerous records in the case notes of Adult B detailing mood swings, bad temper, PMS/PMT and depression.
452. In 1996 the GP notes record Adult B's account of having *'stabbed the 1st husband in the leg 5 years ago...'* and on a separate date in 1996 *'full-fledged fight with husband last week. (pre period)...'* On 10.08.1999 Adult B attended surgery and multiple bruises to her face and abdomen were recorded with 'finger-shaped bruises'. A referral was made to see a Consultant Psychiatrist in 2000 but Adult B failed to attend and there is no record of a further referral being made.
453. In 2001 Adult B failed to attend a date for hysterectomy for PMT. She was referred again to a Gynaecologist in 2003 and the referral letter details: *'During the discussion about her PMT (Adult B) became aggressive...she told me that she had stabbed a previous partner as a result of PMT...and that he*

*subsequently died on the operating table...'. A Hysterectomy and removal of ovaries was performed in August 2006.*

454. Adult B stated that her premenstrual tension symptoms improved after the Hysterectomy. However after a period of time the mood swings returned and she was prescribed a variety of different formulations of HRT. Whilst receiving HRT Adult B states that *'her moods returned to as bad as they were before the operation'*.

455. The IMR Author interviewed Adult B's G.P following the homicide of Adult A and the conclusion of the criminal justice process. The GP stated: *"during consultations (Adult B) never mentioned or hinted at a history of violence...she was moody with me, grumpy, nothing was ever good enough. She wanted me to sort out her moods – said she was flying off the handle all the time. Then things started to improve and her mood stabilised 18 months to two years before it (the homicide) happened."*

456. Adult B's G.P felt that he had been *'very proactive in managing her moods'* that she had *'made progress'* and that she was a *'different person'* in the past two years.'

## IMR ANALYSIS

457. The IMR Author identified several local and national implications for practice that could be improved for future victims of domestic abuse. These issues relate to:

- a. Case note summarising
- b. Routine screening for domestic abuse
- c. Follow-up of psychiatry referrals
- d. Evading detection through frequent changes of medical practice
- e. Information sharing between agencies

458. An analysis of each concern is addressed individually below;

### Case note Summarising

459. The clinicians at (*Redacted*) Surgery were not aware of Adult B's previous history of violence because this had not been detailed on her case note summary. Although Adult B's case notes were reviewed and summarised by administrative staff at (*Redacted*) Surgery, information pertaining to her violent past was not highlighted (despite staff reviewing original letters and not relying on previous practices' summaries for information).
460. It is the responsibility of each new GP practice to review the Lloyd George summary cards (from previous surgeries) and cross-reference information from letters and correspondence to identify risks or behaviours that may be a cause for concern. If necessary and appropriate, an 'Aggressive Behaviour' READ code can be applied and the person responsible for summarising the records can bring any significant history or cause for concern to the Doctor's attention.
461. In the case of Adult B, letters detailing violence dated back several years and were contained within a large volume of correspondence generated by computer records being printed out as hard copies each time Adult B moved to a new surgery. Multiple changes of GP practice, and inadequate clinical record summarising failed to highlight episodes of reported violent behaviour, thus no 'Aggressive Behaviour' READ code was ever applied.
462. The IMR Author did discover notes to suggest that Adult B's children may have been at risk from her aggressive and violent outbursts over many years; however, this information was only identified following a comprehensive analysis of all records pertaining to Adult B and was not contained within any previous summary sheets.
463. The Review Panel cannot speculate as to why Adult B's notes were not flagged with a READ code or summary sheet and brought to the attention of her registered GP. If her history of violence had been more clearly identifiable in the case note summary, it is possible that her treatment plan may have differed e.g. During the DHR interview with Adult B's G.P, he stated; *'Had I known about the violent history of (Adult B) when she was presenting with PMS symptoms*

*between 2006-2008 I would have involved the mental health team 'more aggressively'.*

464. The application of an 'Aggressive Behaviour READ Code' and a summary sheet outlining Adult B's propensity for violence may have also presented an opportunity to flag and assess Adult A as a potential victim of abuse; however, this would be dependent on the GP making the link between husband and wife and being conversant with safeguarding principles.
465. The IMR Author discussed the reliance and appropriateness of case summaries being written by administrative staff rather than qualified and trained clinicians. The clinicians at (*Redacted*) Surgery felt that note summarising by clinicians would be more likely to pick up and highlight relevant important information; however, this would require a major investment of clinicians' time and would not be feasible due to the financial costs and the demands on clinician/patient time.
466. Clinicians at (*Redacted*) explained that the target for summarising the medical records of newly-registered patients is within 8 weeks from receipt of records from the Primary Care Trust; however this target was removed on 1<sup>st</sup> April 2013 due to changes in the NHS Quality and Outcomes Framework (QOF). The clinicians at the practice raised concerns that this change may lead to a substantial increase in the time it takes for many practices to process records i.e. a significant drop in this standard; impeding timely and efficient communication of essential patient information between GP practices.
467. The importance of implementing thorough and detailed summarising of case notes with quality control has been highlighted as an issue which applies to all general practices in the UK and which could have altered the risk management in this case, although it is uncertain whether any intervention by clinicians would have altered the outcome.
468. The Panel was unable to establish if the QOF indicator for case summaries would be replaced in the future. Confusion amongst clinicians at a local level as to whether the summarisation of medical histories would still be required has raised further questions about the effectiveness of READ codes for aggressive

patients. If this standard slips, there is a danger that aggressive patients with a history of violence will not be identified in a timely manner, placing clinicians, primary care staff, family members and children at significant risk of harm.

469. In the absence of a national QOF standard for case note summaries, the Panel has raised questions about local quality assurance measures and how NHS England intends to ensure that medical histories are summarised and coded appropriately for new patients to prevent a similar oversight, as identified with Adult B's case notes, from occurring again in the future.

470. The removal of the case summary performance indicator from the Quality Outcomes Framework in 2013 raised further Panel discussion around the realistic expectations of clinicians to identify signs of, or enquire about, domestic abuse with a patient;

### Routine Screening for Domestic Abuse

471. The DHR Panel notes the absence of any reference to screening for domestic abuse within the 2013/14 General Medical Services (GMS) Contract Quality and Outcomes Framework (QOF) Guidance for GMS contract 2013/14.

472. With an estimated 12.9 million incidents of domestic abuse against women and 2.5 million incidents against men in England and Wales each year<sup>42</sup> and a cost of £1.2bn to the NHS each year<sup>43</sup> dealing with physical injuries alone, it is surprising to the DHR Panel that domestic abuse is not included as a performance indicator within the NHS Quality Outcomes Framework.

473. If clinicians are not required to routinely ask about domestic abuse in the same way that they are required to ask about other health issues such as smoking or depression, the Panel questioned whether our current expectation of clinicians to identify and respond to domestic abuse is realistic.

474. If domestic abuse was prioritised by the NHS and included as an indicator within the Quality Outcomes Framework, clinicians at (*redacted*) Medical Practice may have been more inclined to enquire about non-medical explanations for

<sup>42</sup> The British Crime Survey (2009/10)

<sup>43</sup> Department of Health 'Responding to domestic abuse: a handbook for health professionals' 2005

Adult A's symptoms of exposure to domestic abuse and Adult B's reoccurring propensity for violence.

475. For example, it has already been identified that Adult A had complex and challenging health problems. Some of his symptoms included tiredness, weight loss and dizziness. In 2007 and 2008 Adult A was twice referred to the eye infirmary for corneal abrasions to his eye – a possible sign of non-accidental injury. As only 4% of male victims tell a health professional<sup>44</sup> that they are being abused, it may have been more viable for Adult A's GP to enquire whether the eye injuries were linked to a non-accidental injury. Professionals are encouraged to consider non-medical explanations for children as part of their safeguarding obligations, yet the same does not seem to apply to adults.

476. Adult B also attended the surgery on approximately 25 occasions for symptoms associated with Premenstrual Tension (PMT). She blamed this condition for her mood swings, irritability, anger and aggression and even misled her G.P into believing that she had once killed an ex-partner to demonstrate the power of her rages. Unfortunately even after a full hysterectomy, these symptoms did not diminish.

477. Although the IMR Author is confident that staff at (*Redacted*) Surgery were trained to be aware of indicators of domestic abuse, it would appear from the above examples that opportunities were missed to identify or enquire about domestic abuse with both Adult A and Adult B. To offset the risks associated with personal interpretation, the Panel would recommend that routine screening for domestic abuse is added as a performance indicator within the NHS Quality Outcomes Framework.

### Follow-up of Psychiatry Referrals

478. The IMR identified that Adult B and her family did not attend an appointment at the Child and Family Psychiatric Department in 1989. Adult B also failed to attend an appointment with a Consultant Psychiatrist in 2000. The medical records fail to mention whether these appointments were followed up by Adult B's

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<sup>44</sup> British Crime Survey 2010/11 (page 88) Table 3.16 (page 111) - <http://tinyurl.com/7slnnom>

G.P when she failed to attend. No follow-up discussions are recorded and no further referrals were made. There is no information available to the Panel to indicate whether mental health treatment would have helped the patient.

479. This appears to be a rather passive response from the G.Ps. As Adult B never received the on-going expert support and intervention from a psychiatrist, it cannot be determined whether this specialist input would have had a positive impact on her future relationship with Adult A.

480. The Panel is keen to raise awareness of the need for medical practitioners to be more robust in their follow up of missed appointments for psychiatry referrals, especially where the consequence of non-attendance could have an impact on others (e.g. child/public protection). It is vitally important that medical practices have systems in place to ensure that notifications of missed appointments are shared with the referring G.P and appropriate safeguarding or follow-up checks are made.

### **Evading detection through frequent changes of medical practice**

481. This Domestic Homicide Review has raised the loophole of abusive and neglectful parents who mask their behaviour by moving between different healthcare services. The Review Panel conservatively estimates that Adult B and her children moved home between twelve to twenty occasions during 1985-2002. This often involved a change of G.P Surgery. The constant moving of address meant that important information (including up-to-date contact details) were lost within an ever-expanding volume of medical records.

482. The problem was compounded by the children having different surnames. No care orders were in place during the review period, therefore no child protection alerts were attached to the children's case notes. This made it almost impossible for medical staff to link the children with the adults and respond to the potential risks.

483. This problem was highlighted again in 2012 by the Royal College of Paediatrics and Child Health. The College identified that professionals had difficulty knowing whether a child was already listed as being 'at risk' or if children

had been repeatedly seen in different GP surgeries, emergency departments or urgent care centres under different names and with suspicious injuries or complaints, which may indicate abuse.

484. A new system, introduced from 2013 should help to address the concerns of the College and the current loophole of evading detection by constantly changing name and address. The new, national 'Child Protection - Information System' known as "CP-IS" will record all names, previous names and addresses of children at risk, which should increase the opportunity for healthcare professionals and social care staff to make the links and act accordingly. A description of this proposed service can be found at **APPENDIX E**.

485. Although the CP-IS system and the recommendations resulting from Domestic Homicide Reviews will go some way to improving how healthcare professionals respond to the co-occurrence of domestic abuse and child abuse in the same families, the Review Panel is still concerned that CP-IS is only effective for children identified as 'at risk' or subject to a child protection plan. In this case, Adult B's children were never assessed as 'at risk' (although they should have been) therefore it is questionable as to whether CP-IS will prevent similar cases 'falling through the net' in future.

486. Adult B's constant moving highlights the dangers of transient families who avoid being assessed as 'at risk' due to their transitory lifestyles. This may present one plausible explanation as to why professionals in this case did not appear to act on, or share information consistently, specifically between healthcare settings, educational establishments, children's services and the police.

### Information Sharing Between Agencies

487. There is no evidence in Adult B's case notes of cross-boundary communication between Bedfordshire and Cornwall, nor are there any indicators of effective cross-agency information sharing principles between the various GP practices and other statutory agencies. Given the self-reported acts of violence

towards an ex-husband (stabbing), and the documented history of violence towards two of her children, it is surprising to find no GP referral to Children's Services or the Police for an assessment of her risk towards others.

488. It is possible that vital links were not made between social care records, medical records and police reports due to a lack of national guidance and local protocols available at the time. A number of incidents pre-date the introduction of legal Acts that now underpin how and when professionals should share information in a secure and confidential manner and in accordance with the law (*e.g. Children Act 1989, Access To Health Records Act 1990, Access to Medical Reports Act 1998, Data Protection Act 1998, Human Rights Act 1998, Health Act 1999, Common Law Duty Of Confidence and Caldicott Principles*)
489. In particular, the NHS experienced a number of reforms during the 1980's and 1990's and it is conceivable that the family G.P was not required, approached or encouraged to engage in multi-agency intervention and information sharing in the same way as would be expected in the present day.
490. Today, the welfare of the child is paramount, and GP's must share information with Social Services even if it means disclosing confidential information about the parents. Guidance from the General Medical Council states *"that health professionals may consider disclosing confidential patient information where there is a possibility of death or serious harm to patients or others, or where disclosure may assist in the prevention, detection or prosecution of a serious crime. There are also exceptions where the public interest in disclosing information outweighs the patient's rights to confidentiality"*.<sup>45</sup>
491. The General Medical Council recognises the vital role that G.P's, Health Visitors, Midwives and other Healthcare Professionals play in the early identification of child abuse and domestic violence. Whereby historically, patient confidentiality created a barrier to healthcare professionals engaging wholeheartedly in the partnership response to domestic abuse; information sharing is now considered 'expected practice' and fundamental to the safety of

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<sup>45</sup> <http://www.medicalprotection.org/uk/gp-registrar/medical-records/keeping-medical-records-confidential>

others and the prevention of crime and disorder.

492. The problem seems to exist between 'expected practice' in theory and its actual application on the ground. In 2009 The Care Quality Commission carried out a review of arrangements in the NHS for safeguarding and information sharing procedures. They found that the average proportion of eligible staff with up-to-date training at level one (intended for all those working in healthcare) was worryingly low at just 54%. The proportion of eligible GPs who were not up to date on training at level 2 was even more perturbing at 35%.
493. The findings of the Care Quality Commission are particularly concerning for the Panel given that the majority of domestic abuse training for healthcare professionals is incorporated within mandatory child safeguarding training. If the percentages of those eligible for safeguarding training are a cause for concern for the Care Quality Commission, it is unlikely that healthcare professionals are competent and up-to-date on domestic abuse training.
494. This Domestic Homicide Review demonstrates that there is still work to be done to improve how GPs and Healthcare Professionals identify domestic abuse and share information to protect adult victims and children. It is imperative that all care professionals continue to develop and maintain their practice in accordance with developing legislation (resulting from a culmination of UK-wide lessons identified) and regular audited mandatory training, supervision and management.

## CORNWALL EDUCATION DEPARTMENT - IMR

495. The DHR Panel decided to request an IMR from Cornwall's Education Department in the hope to access some educational records pertaining to C5, the only one of Adult B's children required to attend school when the family moved to Cornwall in 2004.

496. Given the history of violence demonstrated by Adult B towards her other children during the 1980's and 1990's, the Review Panel was keen to ensure that vital signs and symptoms of abuse were not missed by educational professionals responsible for C5 in Cornwall.

497. The IMR Author is a Senior Officer for the Cornwall Local Authority, Children, Schools and Families Department. The education records for C5 were reviewed by the IMR Author from 1998 to 2004 (whilst residing in Bedfordshire) and from 2004 until 2010 when C5 left state education.

498. Unfortunately very limited information was available for C5 from her schooling in Bedfordshire. Basic transfer records show no indications of abuse or neglect and no existing concerns about the welfare of C5.

499. The form tutor of C5 (from 2005 to 2010) provided a statement to the Panel, which read;

*"I feel I got to know C5 well. I did her tutor interviews and monitored her progress. C5 never disclosed anything to me or made any suggestion that she was suffering physical abuse at home. Her behaviour in school was consistent and she didn't change dramatically at any time which could be attributed to issues at home. I also never observed any bruising on C5. I would see her on a daily basis and didn't see anything. I also never noticed that she was wearing long sleeve tops or anything to try and cover herself up. I met C5's mother on four occasions when we held our annual review day. Her mother always attended these with C5 but they did not*

*have any other adult with them e.g. step dad. C5's mother was always polite and interested in what I had to say. She wanted C5 to do well. On one occasion they arrived arguing, shouting at each other as they came down the corridor. I cannot remember what was being said and the argument did not spill into the room I was conducting the interviews in. On no occasion would I have suspected any form of abuse was taking place towards C5 or that her mother was violent".*

500. C5's attendance rates during her school years in Cornwall were fairly acceptable until her last four terms at school (2009 –2010), with an average absence rate of 31.88% compared to 3.81% for the previous year.
501. During this period of absences, four letters were sent to Adult B requesting reasons for C5's non-attendance at school (17/11/09, 19/11/09, 04/01/10 and 18/01/10). On two of these occasions, Adult B provided the school with a written response outlining reasons for C5's non-attendance. The School Information Management System (SIMS) recorded reasons for the remaining absences.
502. This was also a period whereby C5's behaviour became notably more challenging for her teachers. Between 2009 and 2010, 10 student referral forms were completed for inappropriate behaviour in class. The incidents included verbally abusing teachers, use of foul language, rudeness, truanting and walking out of school mid lesson.
503. The IMR does not provide any information or clarification on whether this behaviour was considered normal or acceptable for students attending the school at this time. Although C5's behaviour was reported to the Head of Year on 11 occasions, the school does not appear to have raised C5's behaviour with Adult B. (The Panel acknowledges that C5's behaviour is not uncommon amongst young people of this age and therefore accepts that many of these behaviours are monitored and managed effectively by schools without the need to involve parents or guardians).

504. The statement provided by C5's tutor could be misleading as it is worded in such a way that it does not allow a reader to ascertain whether her behaviour was consistently poor or consistently good e.g. *her behaviour in school was consistent and she didn't change dramatically at any time which could be attributed to issues at home.*
505. This may appear to be a trivial point, however, it is clear that C5 exhibited challenging behaviour throughout her secondary education in Cornwall, therefore a teacher looking for a dramatic 'spike or shift' in behaviour (as a sign of abuse) would not necessarily identify someone who is 'consistently challenging' or 'consistently compliant/quiet' due to long-term exposure to abuse.
506. The statement from the Tutor provides the Panel with an insight into a common misunderstanding of domestic abuse insofar as when asked if she was aware of domestic abuse in the household, she replied "*I never observed any bruising on C5....I also never noticed that she was wearing long sleeve tops or anything to try and cover herself up*".
507. The emphasis on a physical act of abuse is not an uncommon misconception of domestic abuse amongst many professionals. It is imperative that professionals also remain vigilant to emotional, sexual, psychological and financial abuse as defined by the cross-government definition of domestic abuse (2013).
508. The Panel has a number of concerns connected to the IMR provided by the Education Department. These relate to;
- a. The transfer of records and the sharing of information between all of the attended schools have been exceedingly poor for all of Adult B's children.
  - b. C5's accumulative and consistent 'low-level' behaviour did not prompt Education Professionals to routinely or periodically query or consider potential external factors or influences.

- c. C5's Form Tutor was not alerted to the possible signs and symptoms of long term exposure to abuse due to a limited understanding of domestic abuse.
- d. Previous educational records from C5's schools in Bedfordshire (identifying Adult B as a dangerous and violent woman with a long history of abusing her own children) were not shared with the Cornwall Education Department; preventing C5's school from accessing the risk of Adult B authorising absences from education (2009 & 2010).
- e. The level of training provided to educational professionals at the time was basic and did not cover domestic abuse in detail.

509. Under Section 175 (157 if an Academy or Independent school) of the Education Act 2002 all staff in schools are required to undertake basic safeguarding awareness training every 3 years. It is one of the areas that schools have to provide information on in their annual Section 175 Returns. Each school is responsible for sourcing, facilitating and/or commissioning this training, which can result in varying degrees of quality in terms of materials, content and delivery.

510. The panel was informed that the Local Safeguarding Children's Board (LSCB) training, which is currently a 1 day introduction followed by a 2 day advanced course does make reference to domestic abuse both in terms of it being the most common risk factor present in families and what they might see if children are experiencing domestic abuse, however the course does not cover domestic abuse 'in any great depth'.

511. The LSCB have commissioned 'Reconstruct' to deliver Safeguarding and Child Protection Training. The Review Panel considers this to be a good opportunity to review and audit the content of the course and consider the benefits of adding modules on the DASH Risk Assessment and MARAC process.

512. The need for Educational Professionals to be DASH trained and know how to refer into the MARAC process is especially relevant given the new age reduction to the 2013 definition of domestic abuse (from 18 years old to 16 years old and

above), the new government requirement for all young people to remain in education or training until 18 years of age and the prioritisation of teenage relationship abuse within the UK.

513. The Panel would welcome national, mandatory, minimum standards of training for all Teachers and Education Welfare Officers in line with the Government's commitment to end violence against women and girls. As educational settings can provide a 'safe haven' for young victims of abuse, it should be considered a compulsory safety measure for both professionals and young people to have appropriately trained individuals in place to respond immediately, effectively and efficiently to disclosures or reports of abuse within education and training establishments.

# SECTION FIVE

## OVERALL CONCLUSIONS

514. The content of this section will address the case specific Terms of Reference identified in Section One of this Overview Report (13-25). To reduce repetition in answering the issues raised some terms of reference have been combined.
515. The overall conclusions encapsulate the main findings of the Individual Management Reviews. Principle lessons identified from this DHR follow and focus on what, if anything should have been done differently and changes required today to prevent a similar tragedy happening again.
516. The final section will record all appropriate recommendations about what actions are required by individual Agencies to address the findings of this review. The Panel has also made recommendations regarding any implications for national policy arising from the case.

## TOR CONCLUSIONS

Was the incident in which Adult A died a ‘one off’ or was there any warning signs that would indicate that more could have been done to protect him?

517. The most concerning feature of this case is the reference in 1978 that “*One day, Adult B would end up murdering someone*”. This was the belief and fear of Adult B’s mother who pleaded for support with her increasingly ‘*volatile, violent and destructive child*’ from 1966 until 1978 when Adult B was eventually placed in the care of Bedfordshire County Council.
518. Adult B was reported to have used weapons against ex-partners during the 1980’s. H1 reported that Adult B had thrown darts at him and stabbed him in the

hand with a carving knife in 1981. H2 was also stabbed with a carving knife in 1989 severing an artery in his leg.

519. Adult B sought help from her G.P on approximately 25 occasions for violent outbursts and severe mood swings during her adult life. She had a self-professed history of throwing objects whilst in a fit of rage. When C4 was notified by C5 that Adult A had been stabbed by their mother, she stated that she “*was not surprised*” and later expressed to Professionals that it “*was only a matter of time...*”

520. With the presenting evidence of a history of violent outbursts, throwing random items in violent rages and Adult B’s previous use of weapons against ex-partners, the Panel would conclude that Adult A’s death was not a ‘one off’ in so far as ‘luck’ played a part in averting the death of others. In particular, the fatality of H2 was prevented in 1989 by immediate life-saving medical intervention.

Were family, friends, key workers or colleagues (including employers) aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons), prior to the homicide?

521. The testimony from family, neighbours and work colleagues demonstrates that they were the only individuals aware of, and witness to, domestic abuse between Adult A and Adult B between 2001 and 2012.

522. Many separate incidents of domestic abuse were witnessed by family, friends and co-workers leading up to the homicide of Adult A, including a ‘*frenzied assault*’ witnessed by E1 and a glass bottle attack witnessed by N2.

523. Unfortunately none of the witnessed abuse was reported to authorities.

Were there any barriers experienced by the family/ friends/colleagues in reporting any abuse or concerns in Cornwall, Bedfordshire or elsewhere?

## Did the victim, family, friends, neighbours or co-workers know how to report domestic abuse had they wanted to?

524. The Panel cannot speculate on why family, neighbours and work colleagues did not report the incidents of abuse they witnessed between 2004 and 2012, however the Panel is aware of a general apprehensiveness of individuals to interfere or get involved in what can still be regarded as a *'private matter'*.

525. Personal thresholds for intervention appear to have created a barrier for reporting abuse. The belief that the individual incidents did not warrant Police or Social Services intervention was conveyed within N1's testimony: *"the arguments were never prolonged; therefore, I never felt the need to call the police"*.

526. There was also a belief that Adult A would deny the abuse if approached as he appeared to be protective of Adult B. Until Adult A reached a position whereby he acknowledged and confronted the abuse he was experiencing, bystanders may have withheld concerns until he was deemed more *'accepting'* of help from family, friends and neighbours.

527. It is possible that the reversal of the traditional gender roles presented a further barrier for Adult A, family, neighbours and co-workers in reporting abuse or concerns. There is evidence that Adult A was ridiculed in the workplace and community with colleagues and neighbours mistaking his passive resistance as a sign of *'immasculinity'*. It is possible that the gender of Adult A (being a male victim) could have been a mitigating factor which obscured the judgement of witnesses to decide to intervene or not.

528. It is also conceivable that the violent behaviour and perceived threat of Adult B was neutralised by her female gender, in that international studies looking at the typologies of domestic abuse conclude that *'intimate terrorism'* – or one-way abuse where one partner uses violence to gain control over another, *"is perpetrated almost entirely by men"*<sup>46</sup>. The gender theory that intimate terrorism

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<sup>46</sup> Johnson 2006 -

in heterosexual relationships is primarily a matter of men abusing women is based on the principle that the use of violence requires a credible threat of a damaging violent response to non-compliance<sup>47</sup>. Feminist theorists deduce that this threat is more credible coming from a man than a woman simply because of the size difference in most heterosexual couples<sup>48</sup>. It is feasible that witnesses were dissuaded from reporting abuse because they were subliminally influenced by the conventional perception of domestic abuse (i.e. males perpetrating against females). In order to report a crime, the witnesses first needed to perceive that a crime had taken place.

529. It is not possible to hypothesise on whether individuals knew how to report abuse had they wanted to. C4 had previously contacted Bedfordshire Police on the 2<sup>nd</sup> May 2003 alleging that she had been 'beaten up' by Adult B at her home address. This would indicate that C4 at least knew how to report abuse to the Police. Equally, C1, C2, C3 and C4 had each informed Teachers independently of injuries sustained at the hands of their mother.

530. This provides an interesting insight into the principle of disclosure and highlights the advantages of direct questioning. No adult involved in this case ever reported their concerns to a Professional (other than Adult B), yet the children, despite being scared, answered questions honestly when asked specifically about incidents they had witnessed or injuries they had sustained.

531. Intriguingly when the adult witnesses were questioned by the Police as part of the criminal justice investigation, they were able to recall specific incidents, dates and events with clarity, even dating back a number of years. This would suggest that the barriers to reporting abuse for adult witnesses at the time may have been attributed, in part, to internal struggles with reasoning and decision-making. Had the adult witnesses been asked specifically by a Professional about a particular incident (perhaps as a result of a Police call out) they may have found it easier to share concerns as the need for personal decision-making would have been

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<sup>47</sup> M. A. Dutton & Goodman, 2005

<sup>48</sup> <http://www.personal.psu.edu/mpj/2012%20VAW%20General%20Surveys.pdf> p. 7

removed.

532. With this in mind, the Panel would welcome further national research on the effectiveness of public awareness campaigns that address the threshold for public intervention such as the NSPCC “Don’t wait until you’re certain” National Television Campaign in 2013. The findings of such research may help to establish if such campaigns have a positive impact on the public reporting of suspected abuse.

533. Even if the abuse of Adult A had become apparent, the Panel is not entirely confident that either Adult A, any witness or (more alarmingly) some non-Police Professionals would have known where to access appropriate support.

534. Adult A was a male victim of domestic violence during a time when specialist support services for men were less accessible than services for females. This was a consequence of a society that did not actively recognise domestic abuse towards men (by their female partners) as a widespread problem; therefore dedicated services were scarce which may have added to the reluctance of males, like Adult A, coming forward and seeking help. This subsequently created an unrepresentative understanding of prevalence and a misleading demand for comparable services.

535. In summary, it is possible, due to the shortage of specialist support services available at the time, that Adult A (nor witnesses and non-Police Professionals) would not have known where to access non-Police support had he/they wanted to report domestic abuse.

### Were there any opportunities for Professionals to enquire or raise concerns about domestic abuse in the household?

536. Adult B disclosed violent behaviour, aggressive outbursts, mood swings and rages towards intimate partners during frequent attendances to General Practitioners (G.P’s) over three decades. The G.P medical notes even record a disclosure of the stabbing of H2 in 1989 (G.P reference on the 16/12/2003) yet it

appears that no attempt was ever made by a G.P during any decade to routinely enquire about the name and whereabouts of the 'partner' Adult B was referring to at the time. This may have been an opportunity to 'link' information between patients to enquire confidentially about safeguarding and the welfare of Adult B's partners with the aim of facilitating appropriate support or intervention as necessary.

537. It is apparent there were many missed opportunities for Professionals to share information during the 1980's and 1990's that would have helped to develop a cumulative portrayal of a violent and dangerous woman who presented a risk to immediate family members. Disappointingly, it is also apparent when information was shared there is no evidence of services responding to the information in a timely and consistent way, or with the considerations to actions and interventions that is conversant with custom and practice in 2014.

538. The co-occurrence of child abuse and adult domestic violence and the psychological, behavioural and emotional effects that living with domestic abuse would have had on Adult B's children was certainly a missed opportunity by Children's Services, Education and Health Professionals.

539. Although many of the incidents preceded changes in legislation and our professional understanding of the co-occurrence of child abuse and domestic abuse, the Panel acknowledge that the information contained within this report will be painful and upsetting for those directly involved with the case. In particular the children of Adult B would be justified in feeling let down by the very agencies that existed to protect them.

540. In relation to the seven Missing Persons Reports made to Bedfordshire Police between 26<sup>th</sup> September 2000 and 17<sup>th</sup> September 2002, it is clear that the relationship between C4 and her Mother was not harmonious, and on occasions Officers should have spent more time trying to understand the underlying problems resulting in C4's behaviour. The Police response to C4 being absent from home was slow and when she was located, Officers never enquired about abuse. Since the missing person reports involving C4, numerous reviews have

been conducted in relation to the policy and procedures for dealing with missing persons. These incidents would now be viewed by Police as a strong indicator of domestic abuse within the family and Officers would seek to understand the underlying reasons for C4's frequent absconding.

541. The Panel would also conclude that opportunities were missed by Education Professionals to explore the underlying reasons for C5's behaviour in School between 2009 and 2010. There is a risk within busy school environments for significant warning signs of abuse to be wrongly misinterpreted as *'normal teenage behaviour, learning disabilities or just plain naughtiness'*. It is important that Teachers are equipped with the knowledge to identify symptoms of abuse and know how to respond to concerns appropriately and in a timely manner.

**Did the perpetrator have any previous concerning conduct or a history of abusive behaviour and was this known to any agencies?**

542. There was evidence of Adult B's aggressive nature throughout her life. Historically Adult B was known to be physically violent during her childhood in the 1970's and as an adult during the 1980's and 1990's. The frequency and intensity of her violent episodes appear to have increased during the 1990's into 2000, with frequent recordings by Professionals of her being a *'physically violent woman'*.
543. Adult B's history of abusive behaviour is evidenced by individual comments documented by Professionals within various case records over a number of years;

| Professional or Agency                                        | Date       | Comments                                                                                         |
|---------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------|
| Bedfordshire County Council Children's Department – Letter to | 06-02-1975 | <i>'Violent and destructive behaviour which regularly occurs within this family and which is</i> |

|                                                                       |            |                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| G.P.                                                                  |            | <i>seen as being initiated by (Adult B)...</i>                                                                                                                                                                                                                                                                                                    |
| Bedfordshire County Council Education Welfare Service – Letter to G.P | 17-03-1978 | <i>'...mother pleads for help with (Adult B)... telling me of (Adult B's)... violent temper and her own fears for the two younger children. Even saying to me "(Adult B)... will end up murdering someone"'</i>                                                                                                                                   |
| Health Visitor<br><i>(Redacted)</i> Clinic, Luton                     | 26-05-1989 | <i>. 'I feel that many of the family's problems are caused by (Adult B's)... mental state and vulnerability to stress. She has a long psychiatric history and there have been two incidents of violence in the last six months...I am concerned about the risks her intermittent and unpredictable violent outbursts pose to the children...'</i> |
| Unidentified Social Worker – <i>(Redacted)</i> Area Office            | 18-06-1990 | <i>"There is a worrying background and the stories about this injury are inconsistent. Seems like a family to watch"</i>                                                                                                                                                                                                                          |

|                                                                                                     |             |                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Unidentified Teacher at<br>(Redacted) School                                                        | 18-06-1993  | <i>"Mother, Adult B is very violent and C3 becomes very worried if he thinks he will be in trouble when he goes home".</i>                                  |
| Social Worker -<br>Bedfordshire County<br>Council Children's<br>Services. (Redacted)<br>Area office | 20-06 -1995 | <i>"...Mother had hit child but not excessively. Despite previous concerns of the parenting by Adult B the home environment is considered more stable".</i> |

544. Notably, the G.P Lloyd George records contain the most references to Adult B's history of violent outbursts dating back to 1966 and continuing throughout her child, adolescent and adult years until 2008. Details of each individual G.P appointment for anger issues are provided within the full chronology at Appendix B.

545. It is evident that Adult B's long history of violence was well documented within records retained by statutory agencies; however this does not translate to Adult B's history of aggression *'being known'*. The information was undoubtedly available but individual Professionals did not always 'make the link' with historic records and/or understand the dynamics of abusive behaviour. There appears to have been a culture of responding to the presenting issue rather than the accumulative pattern of power and control. This 'blinkered' approach prevented agencies from understanding and assessing the collective risk of Adult B's violence towards her children and partners.

546. Communication between agencies was hindered further by Adult B's frequent change of home and name. The Review Panel conservatively estimates that Adult B and her children moved home between twelve to twenty occasions during 1985-2002 (which could be perceived as an attempt to avoid detection). Her

constant moving and name changes caused Adult B and her immediate family members to 'fall through the net' as local agencies were unable to link Adult B's previous violent history with new presenting issues.

Were there opportunities for agency intervention in relation to the perpetrator (e.g. aggression, mental health issues or child protection arrangements) that were missed?

547. In consideration of the available recorded information concerning Adult B it is debatable if *any* service fully understood the risk she posed to others.

548. Various agencies were involved/had contact/or had referrals with Adult B throughout her life from Education Welfare Officers, Social Workers and Consultant Psychiatrists to Police Officers, Teachers and General Practitioners. Although child protection concerns were identified on many occasions by multiple independent Professionals, no risk assessment was ever undertaken during any period of the review and the children were never discussed at a child protection case conference.

549. Adult B's mental health was referenced on only a few occasions. In 1998 a Health Visitor made a referral for family psychiatric support due to '*Adult B's mental state and vulnerability to stress*'. She added '*I am concerned about the risks her intermittent and unpredictable violent outbursts pose to the children...*'

550. Adult B was also treated for a '*depressive illness*' by her G.P intermittently throughout her adult life, however, much of her low mood, depression and irritability was attributed to severe premenstrual tension.

551. It appears that Adult B coveted professional intervention for her behaviour and this is evidenced by the number of appointments she made to see her doctor for help with severe mood swings and unpredictable outbursts. There is confirmation that on at least one occasion Adult B appeared frustrated with her G.P for '*palming her off with tablets, rather than helping*'.

552. Despite having a full hysterectomy in 2006, Adult B's symptoms of aggression continued. Once the long standing 'medical cause' for her behaviour was eliminated, there is no evidence of further exploration for the root cause of her aggression. This could be perceived as a missed opportunity for professionals to promote the welfare of Adult B and others living with Adult B.

553. There is no information available to the Panel to determine whether any professional involved with Adult B during the scope of the review actually asked her what help she thought she needed.

Could more be done to raise awareness of services available to victims and perpetrators of domestic violence?

Was there any evidence that Adult A or Adult B were directly or indirectly discriminated against by any agency based on the nine protected characteristics of people who use services under the Equality Act 2010 e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation?

554. These questions have been combined and answered within the context of this case and will, therefore, focus on whether more could be done to raise awareness of services available to *male victims* and *female perpetrators* of domestic abuse, and if Adult A or B were directly or indirectly discriminated against by any such service.

## Male Victims

555. In brief, this review identified that more could be done to raise awareness of services for male victims. However, whilst it would be beneficial to increase public awareness of domestic violence against men, it would be irresponsible to encourage reporting unless appropriate services are in place and professionals are able to differentiate between the different types of abuse.

556. The British Crime Survey highlighted the level of under reporting in 2011 with male victims being three times more likely **not to** report domestic abuse than their female counterparts;<sup>49</sup> however, this figure does not distinguish between the different typologies of abuse<sup>50</sup>. For example, it is unlikely that male victims of intimate terrorism will ever report in high numbers. That said, women are equally capable of using violence within a conflict-ridden relationship (where violence is used through frustration rather than as an act of control), therefore it is important that services not only exist for male victims but that the support and intervention offered, is appropriate according to the presenting typology.

557. The issue of commissioning accessible service provision for men cannot be determined by statistics alone, and whether men make up 5% or 50% of reported domestic abuse. It would be unacceptable to say that male victims do not report in high numbers, therefore, services should be prioritised for women and girls (who do report in higher numbers). This rationale would have discriminated against Adult A – a male whose life was ultimately taken by a high risk, serial, female domestic abuse perpetrator.

558. We must remember that reporting figures do not take into account the extremely complex nature of domestic abuse or the context of the violence and abuse within the relationship. In order for appropriate services to exist, and to achieve better outcomes for victims and perpetrators, it is vital that we differentiate between the presenting types of abuse and cater services to meet the specific needs of individuals.

## Female Perpetrators

559. In much the same way as male victims are underrepresented, the same can be said for female perpetrators who fall into a similar minority subgroup that does not appear to command the prevalence to warrant dedicated support services.

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<sup>49</sup> British Crime Survey 2010/11 (page 88) Table 3.16 (page 111) - <http://tinyurl.com/7slnnom>

<sup>50</sup> Professor Michael Johnson's Typologies of Domestic Abuse: Intimate Terrorism, Violent Resistance and Situational Couple Violence

560. As this Review has highlighted, many Professionals pursued or accepted medical explanations for Adult B's abusive behaviour. At no stage throughout her adult life was Adult B identified or acknowledged by any Professional as a domestic abuse perpetrator; therefore she was never offered the opportunity to access specialist support i.e. perpetrator treatment programs.
561. A concerning conclusion from this review is that Professionals appear to have been distracted by the female gender of the perpetrator and afforded her 'the benefit of the doubt'. If Adult B had been a male, it is doubtful that no professional would have suspected domestic abuse at any point during the scope of this review.
562. If Professionals justify female intimate terrorism in contrast to the treatment of male intimate terrorism, there is a risk that female perpetrators, like Adult B, will remain undetected or receive a string of unsuitable 'treatments' that will not address the root cause of their offending. Conversely we are in danger of indirectly discriminating against female perpetrators of intimate terrorism by denying them access to services that would address their perpetrating behaviour.
563. Unless Professionals possess the skills, knowledge and broad-mindedness to identify the context of female violence, and whether it is used in frustration, self-defence, as a means of control or as a desperate act; it is unlikely that the true prevalence of female intimate terrorism or situational couple violence will be realised.
564. For both male and female offenders, the context of the violence within the relationship remains crucial to how services should respond. Whilst Adult B used violence to punish or control Adult A, other women resort to violence when faced with a direct threat to themselves or their children. These two forms of violence should not be treated the same and the professional response should differ significantly.

**Are there any training requirements necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county?**

565. Many of the training issues raised in this review are historical and are no longer applicable to the present evidence-based practice or the national standards of proficiency that present day practitioners are obligated to reach and maintain.

566. That said, the Panel identified the following specific training requirements to address the lessons identified from this review and to help prevent similar tragedies happening again in the future;

567. Adult B was able to avoid detection as a suspected domestic abuse perpetrator because Professionals (especially Healthcare Professionals), did not possess the skills and knowledge to identify high risk signs of domestic abuse. This was evidenced in the failure to apply an Aggressive Behaviour 'READ' code to the medical case notes of Adult B despite staff reading, interpreting and summarising them for the General Practitioners (GPs).

568. Equally various GPs throughout Adult B's life failed to make the links between her own disclosure of abusive behaviour and the welfare of the partner(s) she was referring to. This would suggest that the GPs struggled with the balance between patient confidentiality and the sharing of information in the interest of protecting others from significant harm.

569. Whilst many Professionals are now competent and confident to share information to safeguard children and vulnerable adults, the Review Panel identified through this DHR, that Professionals were far less confident and knowledgeable about how and when to share information, proportionately, appropriately, legally and ethically, in the interest of public protection and for the prevention of crime and disorder. This is an area that still has a significant and detrimental impact on the effectiveness of sharing information and intelligence between agencies and must be addressed to assist in the management and

tracking of dangerous, serial perpetrators.

570. This Review also highlighted the variance in the quality and take-up of mandatory child safeguarding training. This was particularly worrying for the Panel as the majority of agencies purported within their IMR's that staff received domestic abuse training as a module within child safeguarding courses. As the Care Quality Commission reported a national 35% attendance rate for GP safeguarding training the Panel remain unconvinced that local Healthcare Professionals possess the level of knowledge and skill envisaged or recommended as a result of this review.
571. The Individual Management Review undertaken by the Education Department demonstrates a limited understanding of domestic abuse which is a cause for concern for young people who are encountering abusive relationships. It is vital that all Education Professionals have a minimum standard of training in relation to the signs and symptoms of domestic abuse and know how to refer for a risk assessment. Ideally each designated school Child Protection Officer should be equipped and skilled to assess and manage disclosures of abuse using a common risk assessment framework e.g. DASH (2009) for young people 16 years and above.
572. During the course of this review, the Panel became aware of a lack of knowledge of the DASH (2009) Risk Assessment Checklist. This was found across the board of non-police agencies (not including specialist domestic abuse services) and validated concerns that Professionals responsible for the safeguarding of children and young people, perpetrators and the general public do not have a cohesive understanding of risk in order to identify domestic abuse and *activate* the commissioned domestic abuse pathway/response.
573. Whilst almost all Professionals were clear on how to initiate a child safeguarding alert, the Panel was surprised to find that many Professionals, including Social Workers and School Teachers, did not know how to complete (or refer for) a DASH Risk Assessment or initiate a MARAC referral.

574. The Panel concludes that the training content of both child/adult safeguarding and domestic abuse courses at a local level should be reviewed to ensure that there is a consistency of content that includes mandatory components of learning.
575. In particular, the training program for domestic abuse should include the learning from this Review in terms of raising awareness of male victims, female perpetrators, typologies of abuse, the power and control dynamic, abusive tactics, high risk factors, information sharing, pathways and professional referrals.

# SECTION SIX

## LESSONS IDENTIFIED<sup>\*51</sup>

### **What lessons have been identified from the domestic homicide regarding the way in which local Professionals and organisations worked or work, individually and together to safeguard victims?**

576. It is important to acknowledge that the majority of issues, omissions and concerns highlighted within this Review are historical. There have been significant changes and advancements in legislation, government guidance, evidence base practice, quality assurance and governance since the 1980's and 1990's. Partnership working in particular has progressed considerably since the last agency contact with Adult B and her children in 2002.
577. Although the Panel was fairly certain that modern day legislation and practice is fundamentally superior than at any time during the scope of the Review, its Members were not comfortable in making an assumption that no lessons could be identified from reviewing the case as far back as 1963. As a mark of respect to Adult A and the families involved, the Review Panel decided to '*leave no stone unturned*' in ascertaining whether more could be done to prevent similar tragedies happening again in the future.
578. This section will summarise the key lessons identified from this Domestic Homicide Review (DHR). The number in *Column One* is the reference to the paragraph(s) within the main body of the report that describes the issue in full. The number in *Column Six* is a reference to the corresponding recommendation (if applicable) within Section 7.

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<sup>51</sup> The Chair has chosen to avoid the term 'lesson learnt'. Lessons cannot be learnt until they are acted upon.

579. (Table 579a)

| 1                                                | 2                                                                                                                                                                                         | 4                                                                                                                                                                                                                                                                                                   | 5                                                                                                                                                                                                                                                                                                                                                              | 6                        |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Para.<br>Ref                                     | LESSON IDENTIFIED                                                                                                                                                                         | What changes are required to practice, policies and procedures?                                                                                                                                                                                                                                     | What needs to change in order to reduce the risk of the incident happening again in the future?                                                                                                                                                                                                                                                                | Rec.<br>Ref              |
| <b>Bedfordshire<br/>Police IMR<br/>353 - 354</b> | There cannot be an over reliance on child safeguarding procedures to identify adult domestic abuse in a household. Domestic abuse also happens in families where no children are present. | <p>Child safeguarding policies need to cross reference local domestic abuse policies and protocols, and vice versa to address the co-occurrence of child/domestic abuse.</p> <p>A separate training strategy for domestic abuse should be developed separate to, but in conjunction with, Child</p> | <p>Child Safeguarding Training should not be classed as adequate domestic abuse training. A 'segment' on Domestic Abuse is not exhaustive enough to equip Professionals with the competency and confidence to identify high risk factors of domestic abuse.</p> <p>Domestic Abuse should not be considered as a 'bolt-on' to child protection or any other</p> | <b>Rec. 3<br/>and 11</b> |

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|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                            |                                                                                                                                                                                                              | <p>Safeguarding Training.</p> <p>There should be a local policy agreement for mandatory domestic abuse training for specified Professionals who work with high risk or vulnerable groups.</p>                                                                                  | <p>type of crime. Its consequences necessitate an undivided focus as an autonomous issue.</p> <p>Domestic Abuse training needs to be encompassed within the University/College courses syllabus at the point that students are qualifying for their chosen profession e.g. Teachers, Social Workers, Midwives, Doctors and Police Officers.</p> |                      |
| <p><b>PCT IMR</b><br/><b>480 - 479</b></p> | <p>Professionals need to follow up on referrals and missed appointments especially where the failure to attend could have a consequence on others e.g. Psychiatric Appointment/Child and Family Guidance</p> | <p>Local policy should be reviewed and communicated to local healthcare providers that 'DNA's (Did not attend) should be followed up by both the agency receiving the referral and the referring agent. The expectations of Professionals should be made abundantly clear.</p> | <p>Professionals need to be reminded of the importance of following up on missed appointments and the potential consequence of not doing so.</p> <p>Employers need to hold Professionals to account for passive or apathetic management of referrals.</p>                                                                                       | <p><b>Rec 13</b></p> |
| <p><b>Conclusions</b></p>                  | <p>Agencies should ensure that all staff know how and when to share</p>                                                                                                                                      | <p>Local policies on confidentiality need to contain examples within Acts and</p>                                                                                                                                                                                              | <p>All Professionals working in the Public and VCS sectors need to understand their</p>                                                                                                                                                                                                                                                         | <p><b>Rec 3</b></p>  |

|                                                                                                    |                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| <b>569</b>                                                                                         | information and intelligence proportionately, legally and ethically in the interest of public protection and the prevention of crime and disorder       | <p>Legislation that permit the legal sharing of information when consent is not obtained.</p> <p>Policies need to extend beyond 'safeguarding' guidance and include other circumstances where it is appropriate to breach confidentiality e.g. Data Protection Act and Human Rights Act.</p> <p>Domestic Abuse Training must contain a learning outcome on information sharing, intelligence gathering and confidentiality.</p> | <p>obligation to share proportionate information without consent to protect the wider public or prevent crime and disorder.</p> <p>Professionals need comprehensive training to ensure that lives are not put at risk because of a narrow understanding of the law.</p> <p>Agencies need to be held accountable for their decision-making where it has been proven that the appropriate training or guidance has not been provided to employees.</p> |              |
| <b>PCT IMR</b><br><br><b>417,419, 479, 486 and 487</b><br><br><b>Conclusions</b><br><br><b>568</b> | Healthcare Professionals need to know when to breach patient confidentiality without consent or know where to refer to a Caldicott Guardian for advice. | <p>Local policies and guidance exist throughout the UK however it would be good practice to undertake a regular audit of policies to ensure that Healthcare Professionals comprehend the policy and apply it to everyday practice e.g. Are they confident around information sharing? Do they know who the Caldicott Guardian is and how to refer for advice?</p> <p>The local adult and child safeguarding</p>                 | Too much of Adult B's history of violence was contained within medical records – this information was never shared with other agencies to protect partners or children of Adult B. Healthcare Professionals need to be confident around patient confidentiality versus the obligation to share (proportionate) information in the interest of public protection, prevention of crime and disorder, national security and the safeguarding of others. | <b>Rec 3</b> |

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|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
|                                            |                                                                                                                                                                                                                | training should be audited to ensure that it covers domestic abuse in enough depth to equip Healthcare Professionals with the confidence and competence to address domestic abuse disclosures. If it is not fit for purpose, local Healthcare Organisations should commit to providing adequate domestic abuse/DASH training to protect and support staff and service users. |                                                                                                                                                                                                                                                                                                                                                                         |                          |
| <b>Bedfordshire<br/>Police IMR<br/>617</b> | Local systems or protocols need to ensure that first response Practitioners are able to access historic information on individuals that have been the subject of a strategy meeting, MARAC or case conference. | Local protocols need to be reviewed to ensure that Professionals such as First Response Police Officers or On-Call G.P.s know how and where to access multi-agency information pertaining to the family/victim/perpetrator.                                                                                                                                                  | Professionals need to step back from taking a 'blinker' single incident approach and consider whether there is other information available to help assess the cumulative risk of the situation. This would be relevant to frequent child absconders, police call-outs, mental health assessments, regular truanting of young people and other child protection reports. | <b>Rec. 8</b>            |
| <b>Witness<br/>Statements</b>              | Professionals need to be more alert to female perpetrators and                                                                                                                                                 | Local policies and procedures relating to domestic abuse should be careful to use                                                                                                                                                                                                                                                                                            | Professionals need to be open-minded to the possibility that abusive behaviours and power                                                                                                                                                                                                                                                                               | <b>Rec 1 &amp;<br/>2</b> |

|                                                                 |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |
|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <p><b>283-285</b></p>                                           | <p>the different types of domestic abuse.</p> <p>Professionals should be aware of the common characteristics and manipulative tactics of a domestic abuse dominator/intimate terrorist and be open to the notion that, on rare occasions, women can be intimate terrorists too.</p> | <p>gender natural terms and avoid stereotyping the perpetrator as a male and the victim as female.</p> <p>Local training courses for domestic abuse and child protection should include content and case studies on different types of domestic abuse.</p> <p>Supervisors responsible for supporting frontline practitioners should be trained to challenge stereotyping and the tendency to rationalise female offending (where it has not been appropriately considered).</p> <p>Professionals should be made more aware of the typologies of domestic abuse and understand the patterns of power and control dynamics.</p> | <p>and control tactics can be exhibited by females.</p> <p>How we view female offending needs to change. We need to establish the context of the violence within the relationship and respond appropriately and sensitively to each scenario.</p> <p>A non-biased, considered approach is required to domestic abuse households to limit false assumptions on 'who is to blame'.</p> <p>Professionals need to be more effectual at identifying different types of violent perpetrators and facilitating the appropriate response/support.</p> |                     |
| <p><b>PCT IMR</b></p> <p><b>489</b></p> <p><b>Education</b></p> | <p>There needs to be a greater focus on information sharing across boundaries – Professionals need to be proactive in tracking records</p>                                                                                                                                          | <p>Establishing if information exists in other counties within the UK and/or chasing absent records should be considered routine practice and incorporated as part</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p>Professionals need to be aware that serial perpetrators move around, therefore, there is a possibility that information will exist elsewhere in the UK.</p>                                                                                                                                                                                                                                                                                                                                                                                | <p><b>Rec 7</b></p> |

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| <b>IMR</b><br><b>498</b>         | that may exist in other counties.                                                                                                                                                                                                            | of every agency's referral/intake process.                                                                                                                                                                                                                                                            | Educational Professionals who use the school2school secure internet system for transferring pupil information (as per the Department for Education's Children Missing from Education Guidance 2013) are more likely to <i>make the links</i> , identify high risk families and improve how local decisions are reached                 |                     |
| <b>PCT IMR</b><br><b>459-474</b> | The process of case note summarising when a patient changes practice is currently unreliable due to staff not having the time, resource or skill to interpret and condense extensive medical histories (which may include a risk to others). | The local policy for case note summarising needs to be reviewed to ensure that important information recorded in the clinical records is not missed or obscured.<br><br>The training for Case Note Summarisers in Bedfordshire and Cornwall needs to be audited to ensure that it is fit for purpose. | In the absence of a national QOF standard for case note summaries, Healthcare Professionals need alternative national benchmarks to ensure that medical histories are summarised and coded appropriately for new patients to prevent a similar oversight, as identified with Adult B's case notes, from occurring again in the future. | <b>Rec 5 and 15</b> |
| <b>PCT IMR</b><br><b>459-474</b> | The unreliability of case note summarising has resulted in an ineffective READ code system for patients with a history of domestic                                                                                                           | The national policy for case note summarising for applying 'Aggressive Behaviour READ codes' needs to be reviewed to ensure that patients with a                                                                                                                                                      | Any patient with a history of domestic abuse, child abuse, violent or aggressive behaviour needs to have a READ Code applied to                                                                                                                                                                                                        | <b>Rec 15</b>       |

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|                                                        | abuse and who pose a risk to other patients and Healthcare Professionals.                                                                                             | <p>history of violence are routinely and consistently identified, coded and risk assessed.</p> <p>Healthcare Professionals need to be able to access a policy, guidance or support to know what to do once a READ code has been applied e.g. What happens next?</p>                                                               | <p>medical records.</p> <p>Professionals need to act on this information so that it does not become a meaningless process. Patients with a READ Code should be risk assessed to identify the level of risk to Healthcare Professionals and others. Information should be shared if applicable and appropriate action taken.</p>                               |              |
| <p><b>Witness Statements</b></p> <p><b>251-256</b></p> | The general public are still reluctant to report domestic abuse. There is a widespread apprehensiveness to get involved for fear of getting it wrong or overreacting. | <p>Overarching Local Domestic Abuse Strategies need to include specific communication and marketing strategies that identify what the barriers are and how they can be overcome to increase third party reporting of domestic abuse.</p> <p>A budget should be allocated to support the communication and marketing strategy.</p> | <p>There needs to be a greater focus on tackling people's fears by clarifying the threshold for intervention.</p> <p>National campaigns such as the NSPCC television campaign 'Don't leave it until you're certain' should form the basis of other interconnected issues where under reporting exists e.g. domestic abuse, animal abuse and sexual abuse.</p> | <b>Rec 1</b> |
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| <b>Witness Statements</b><br><br><b>254-256</b>   | <p>Society still seems to struggle with 'what constitutes domestic abuse?'</p>                                   | <p>Local Domestic Abuse Strategies should include awareness raising campaigns for the general public and Professionals to highlight the definition of domestic abuse, including a focus on age, gender, family members, sexuality and the different forms of abuse. This should be linked with the communications and marketing sub-strategy.</p> | <p>The stereotypical image of domestic abuse (being a physical act of violence committed by a man against a female) needs to be challenged.</p> <p>All members of society need to be able to recognise domestic abuse in its many varying forms.</p>                                                               | <b>Rec 1 and 2</b>    |
| <b>Witness Statements</b><br><br><b>265 - 274</b> | <p>There is a risk that gender stereotyping will preclude male victims from coming forward and seeking help.</p> | <p>In addition to local publicity and awareness raising campaigns aimed at increasing male reporting, local policies and domestic abuse training courses should challenge common misconceptions and myths e.g. <i>Men should be able to fight back, or there must be provocation...</i></p>                                                       | <p>Less emphasis should be placed on statistics and more on context and behaviour.</p> <p>The Government need to improve on how they view and support male victims within the UK as many agencies use the Government's focus on 'Violence against Women and Girls' as justification for gender discrimination.</p> | <b>Rec 1 and 3</b>    |
| <b>Witness Statements</b>                         | <p>We should not apply a 'mad or bad' label on female perpetrators.</p>                                          | <p>Public Sector Professionals working with at risk groups need to possess a basic understanding of the different typologies</p>                                                                                                                                                                                                                  | <p>We need to understand the context of the violence within relationships and make distinctions between those that use violence</p>                                                                                                                                                                                | <b>Rec 1, 2 and 3</b> |

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| <p><b>273-274</b></p>                                    | <p>It is vital that we understand the context of the violence being used and its role within the relationship.</p> <p>Unless the violence used by a female is as a means of self-protection, we should not make allowances for female offending that is in contrast to our tolerance of male offending.</p> | <p>of domestic abuse and the common characteristics of domestic abuse perpetrators.</p> <p>Local Domestic Abuse Policies should take account of the context of male and female offending and make distinctions between the different forms of domestic abuse and the distinctly different responses they should receive.</p> | <p>to control another person or as an act of self-protection or through frustration.</p> <p>Offender management or treatment programmes should respond to the context of the violence – a ‘one size fits all’ response is not appropriate or effective.</p>                                                                                                                                                                                                                                                                                         |                     |
| <p><b>Witness Statements</b></p> <p><b>243 - 246</b></p> | <p>Domestic Abuse in the workplace needs to be taken more seriously.</p>                                                                                                                                                                                                                                    | <p>Domestic Abuse in the workplace should be incorporated into wider health and safety and/or HR employee welfare policies. Every employer and employee should know how to manage a disclosure (or incident) of domestic abuse (for staff or service users/clients).</p>                                                     | <p>Very few public and private sector organisations have a specific domestic abuse policy. As the workplace can be a place of safety and respite for victims, it can also pose a threat to the perpetrator – therefore it is not uncommon for the workplace (or work colleagues) to become a focus within the abuse. To protect employees and the general public, it is imperative that we progress towards mandatory domestic abuse policies within the workplace (possibly incorporated into CHAS or other Health and Safety accreditations).</p> | <p><b>Rec 4</b></p> |

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| <p><b>Bedfordshire<br/>Police IMR</b></p> <p><b>355</b></p> | <p>Many Professionals do not know how to identify high risk domestic abuse and therefore form/make ill-informed decisions/opinions that place others at risk.</p> | <p>All Public Body and relevant VCS organisations should retain a cohort of staff that has received specialist domestic abuse training including modules on identifying high risk factors of domestic abuse.</p> <p>A multi-agency domestic abuse programme should be commissioned to increase the number of professionals who are confident and competent to identify, assess and manage high risk domestic abuse, stalking and harassment and honour based violence.</p> <p>Professionals working within Healthcare and Educational settings should receive a minimum level of training to ensure that domestic abuse symptoms are not attributed solely to health complaints and/or challenging behaviour.</p> | <p>DASH Risk Assessment Training should be a mandatory requirement for all Professionals accountable for making informed decisions that impact on the safety of others, e.g. Fire Arms Application Officers, CAFCASS Professionals (for unsupervised access to children), Social Workers, Police Officers, Child Protection Teams/Managers, Probation Officers, Magistrates and Education Welfare Officers.</p> <p>Domestic Abuse should be included as an Indicator within the NHS Quality Outcomes Framework to ensure that it is identified and acknowledged in line with other health concerns e.g. obesity, smoking and depression.</p> <p>The government should champion national minimum occupational standards of domestic abuse/DASH training for identified professions working with at risk groups, at the point of learning the profession (post graduate awards).</p> | <p><b>Rec 3,<br/>7, 12<br/>and 17</b></p> |
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### If a similar case presented today, could we expect a different outcome?

580. This Domestic Homicide Review has highlighted a number of weaknesses in our coordinated response to domestic abuse. Although the Panel cannot speculate on whether the outcome would have been different if any of these shortcomings had of been addressed earlier, the Panel can consider the likeliness of a similar outcome if a comparable case presented today.

581. To answer this question, the Panel focused on the principle shortcomings of the case and asked whether future or current victims are more vulnerable as a result;

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| If we continue to rely on our child safeguarding procedures to help identify adult domestic abuse, could childless families/victims remain undetected?              | Yes |
| Is there a chance that Professionals will not know how to identify, assess and manage domestic abuse if minimum standards of training are not agreed?               | Yes |
| Are male victims less likely to seek help if intimate terrorism is perceived as a gender-based crime perpetrated almost entirely by men against women and children? | Yes |
| If service provision for male victims remains as it is, will male victims be at greater risk?                                                                       | Yes |
| Is there a risk that Professionals will misinterpret or miss female offending if the learning from this DHR is not realised?                                        | Yes |
| Is there a risk that manipulative, serial, repeat perpetrators could avoid detection by moving and changing name?                                                   | Yes |

582. **Given the answers to the above questions, the Panel conclude that a similar case presenting today *could* result in the same tragic consequences.**

# SECTION SEVEN

## OVERALL RECOMMENDATIONS <sup>52</sup>

This Domestic Homicide Review has identified a number of recommendations for local, regional and national practice. For ease of reading, the recommendations have been separated into the following headings;

- Cornwall Recommendations
- Cornwall & Bedfordshire Recommendations
- Bedfordshire & Luton Recommendations
- National Recommendations

## CORNWALL RECOMMENDATIONS (1-6)

**RECOMMENDATION 1:** Following four consecutive Domestic Homicide Reviews involving male victims in Cornwall in 2012/13, the Safer Cornwall Partnership should seek to understand if this recurrence of male victims is an unfortunate happenstance or a ‘chink in the chain’ of support for males. In response to the sequence of unrelated DHRs, the Safer Cornwall Partnership will need to raise public and professional awareness of male victimisation,<sup>53</sup> and seek to dispel gender assumptions by focusing on the context of violence within relationships.

### Addressing Recommendation 1; Action 1, 2 and 4

**RECOMMENDATION 2:** The Review Panel recommends that the Safer Cornwall Partnership commissions academic research to better understand how existing

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<sup>52</sup> Recommendations are linked to actions (to achieve the recommendations) – See SMART Action Plan

<sup>53</sup> Male victims are not a homogenous group and include victims of heterosexual , LGBT and intra- familial abuse

theories such as Professor Michael P. Johnson's Typologies of Domestic Abuse<sup>54</sup>, and the Duluth Domestic Violence Model<sup>55</sup> impacts on service design and efficiency of support in Cornwall, including the appropriateness of our partnership, community and criminal justice response to the different forms of abuse.

### Addressing Recommendation 2; Action 5

**RECOMMENDATION 3:** This Domestic Homicide Review has identified that victims of Domestic Abuse in Cornwall are still reluctant to TELL; Professionals are still reluctant to ASK, and too many Practitioners do not possess the knowledge to IDENTIFY signs of abuse, ASSESS the level of risk and REFER to the Domestic Abuse Pathway.

The Independent Chair recommends that the Safer Cornwall Partnership develops a culture that encourages individuals to TELL, ASK and REFER.

This should be achieved through the commissioning of a Multi-Agency DASH Risk Assessment Training Programme that is linked to the launch of REACH<sup>56</sup> and the communication strategy to increase public awareness of Domestic Abuse (See Action 3).

### Addressing Recommendation 3; Action 3

**RECOMMENDATION 4:** The Panel recommends a phased strategy (2014 – 2015) by the Safer Cornwall Partnership to encourage, promote and assist public and private sector organisations to introduce specific domestic abuse policies for employers/employees in the workplace. This could be achieved by linking into Cornwall Council's Healthy Workplace Award Scheme.

### Addressing Recommendation 4; Action 6

**RECOMMENDATION 5:** The Review Panel recommend that aspects of this report which relate to the omission of the history of violent attacks and domestic violence

<sup>54</sup> A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (Northeastern University Press, 2008)

<sup>55</sup> <http://www.theduluthmodel.org/>

<sup>56</sup> REACH is a multi-agency HUB developed to provide a single gateway for Risk Assessment, Evaluation and Coordination of Help for Domestic Abuse. The HUB is due to open in Truro on the 1<sup>st</sup> March 2014 and will implement a phased launch to Professionals and the Public. It will facilitate 'the right support at the right time' accordingly to the level of risk.

from the medical case note summary of Adult B should be shared with the note summarisers and clinicians at (*Redacted*) Surgery in order to emphasise the importance of this work and the lessons identified from this DHR.

### Addressing Recommendation 5; Action 7

**RECOMMENDATION 6:** The Panel does not know if the medical case notes of Adult B have been appropriately summarised for future clinicians. When Adult B is released from Prison in 2017 her care will transfer from the prison authority to the General Practitioner in the area of her residence. To ensure Professionals are fully informed on the risk that Adult B poses, the Panel recommend that the Probation Service facilitate communication with Prison Services and MAPPA to ensure Adult B's medical records are appropriately summarised to include a record of her previous behaviour leading up to the homicide. MAPPA will need to ensure that this information is considered as part of her risk management plan.

### Addressing Recommendation 6; Action 8

## CORNWALL & BEDFORDSHIRE RECOMMENDATIONS (7-9)

**RECOMMENDATION 7:** Education staff in Cornwall and Bedfordshire responsible for the administration and supervision of school transfer records should be made aware of the lessons from this DHR and reminded of the importance of using school2school<sup>57</sup> for the secure transfer of pupil information (for families who frequently move between local authority areas) in line with the Department For Education's 'Children Missing Education' Statutory Guidance for Local Authorities (2013).<sup>58</sup>

Addressing Recommendation 7; Action 9 however Safer Cornwall cannot implement an action plan on behalf of Bedfordshire Education

**RECOMMENDATION 8:** This Domestic Homicide Review has identified an immediate recommendation to review how information from Strategy Group Meetings can be disseminated to first response and investigation officers within

<sup>57</sup> <http://www.education.gov.uk/researchandstatistics/datatdatam/s2s/a0064650/school-to-school-s2s>

<sup>58</sup> Department for Education - 'Children Missing Education' Statutory Guidance for Local Authorities (2013) p8.

Bedfordshire Police and Devon and Cornwall Police to ensure officers have *all* available information to inform the appropriate response to individuals.

In addition, Devon and Cornwall Police should explore the feasibility of ‘flagging’ repeat Domestic Abuse victims, perpetrators and missing persons on the Unify System. Devon and Cornwall Police to feed back to the Sexual Violence Domestic Abuse Strategic Group.

**Addressing Recommendation 8; Action 10** however Safer Cornwall cannot implement an action plan on behalf of Bedfordshire Police

**RECOMMENDATION 9:** All Police Officers and Staff within Bedfordshire Police and Devon and Cornwall Police need to be reminded immediately of the requirement to submit a form 745 Child at Risk Report (or 121a for Devon and Cornwall Police) following any event involving a vulnerable child or where there is concern for a child’s welfare.

Officers within Devon and Cornwall Police should be reminded that a separate safeguarding alert must to be raised **in addition** to a 121a where there is a significant concern of risk for a child living in a domestic abuse household. Officers should consistently use existing, formal procedures for referral to the Multi Agency Referral Unit (MARU).

**Addressing Recommendation 9; Action 11** however Safer Cornwall cannot implement an action plan on behalf of Bedfordshire Police

## **BEDFORDSHIRE & LUTON RECOMMENDATIONS (10 – 11)**

**RECOMMENDATION 10:** The Children’s Service Records pertaining to Adult B’s children C1, C2, C3, C4 and C5 should be revisited and organised in chronological order to ensure that records are decipherable and accessible should any dependent of Adult B chose to request access to personal information.

**Addressing Recommendation 10; Safer Cornwall cannot implement an action plan on behalf of Bedfordshire or Luton Children's Services**

**RECOMMENDATION 11:** The Panel recommends that Bedfordshire and Luton Children's Services undertake an audit of the current Safeguarding training for Social Workers to ensure that the course contains a domestic abuse specific module to equip Practitioners with the knowledge to make informed decisions about the care and level of intervention for children living in domestic abuse households. Specifically, the Panel recommends that ACPO DASH Training is included, or offered in addition to, Child Safeguarding Courses.

**Addressing Recommendation 11; Safer Cornwall cannot implement an action plan on behalf of Bedfordshire or Luton Children's Services**

## **NATIONAL RECOMMENDATIONS (12-17)**

**RECOMMENDATION 12:** Early Intervention is pivotal in recognising domestic abuse before it becomes high risk. It is inconceivable to think that Domestic Abuse Training, and specifically DASH Risk Assessment Training, is not considered a mandatory component within University or College Courses for Community Development, Public Sector, Criminal Justice, Social Care or Healthcare Professions.

The Review Panel recommends that the Government works with the UK Commission for Employment and Skills to explore the possibility of including Domestic Abuse Risk Assessment Training within National Occupational Standards for Professions that routinely respond to Domestic Abuse, Stalking, Honour Based Violence, Child Abuse, Sexual Abuse and Animal Abuse.

**Addressing Recommendation 12; Safer Cornwall cannot implement an action plan on behalf of the Government**

**RECOMMENDATION 13:** NHS England should review the non-attendance policy for appointments to ensure that G.P's are clear on their obligation and accountability to

follow-up referrals made to specialist services/treatment, especially where non-attendance could have a significant impact on the safety of patients or others e.g. *Psychiatric Assessment Referral*.

Commissioners should review non-attendance policies and feedback to Contract Management.

**Addressing Recommendation 13; Safer Cornwall cannot implement an action plan on behalf of NHS England**

**RECOMMENDATION 14:** The Review Panel recommends a review of the Firearms Licence Application Process to ensure that all individuals in a household are vetted in addition to the named applicant.

**Addressing Recommendation 14; Safer Cornwall cannot implement an action plan on behalf of the Home Office**

**RECOMMENDATION 15:** Adult B's violent history was not highlighted in case note summaries produced by several G.P surgeries prior to, and during, Adult B's relocation to Cornwall. This could be evidence of a systemic problem in the process of case note summarising which might place health Professionals and other patients at risk of harm. Healthcare Professionals need to have an awareness of the level of risk when presented with someone with a history of violence.

The Panel recommends that NHS England carry out a review of the current system for case note summarising to ensure that it is safe and fit for purpose.

**Addressing Recommendation 15; Safer Cornwall cannot implement an action plan on behalf of NHS England**

**RECOMMENDATION 16:** Adult B disclosed her violent outbursts towards other family members, to a number of G.P's during her adult life. Despite the whole family

being registered at the same surgery, there is no evidence of a G.P making a routine enquiry about the welfare of the said family member(s). The Panel was informed that this was not feasible because the national electronic care record does not have the capability to enable surgeries to link family members (with different or same surnames).

The Panel recommends that NHS England investigates the attainability of upgrading the national electronic care record to include the facility of linking family members and coding dangerous domestic abuse perpetrators.

**Addressing Recommendation 16; Safer Cornwall cannot implement an action plan on behalf of NHS England**

**RECOMMENDATION 17:** The DHR Panel would like to see domestic abuse recognised within Primary Care for G.Ps through the addition of a National QOF Indicator for routine enquiry and the maintenance of a domestic abuse register (similar to a register for patients with hypertension or diabetes).

**Addressing Recommendation 17; Safer Cornwall cannot implement an action plan on behalf of NHS England**

**NOTE:** *The Safer Cornwall Partnership has no jurisdiction over the Government, NHS England or any other Local Authority outside of Cornwall and the Isles of Scilly. Although recommendations have been suggested for Bedfordshire, Luton, NHS England and Central Government, the Safer Cornwall Partnership cannot enforce their application. It is for individual agencies/political parties to decide whether to accept and action specific recommendations in order to learn lessons and prevent further tragedies.*

# SECTION EIGHT

## SMART ACTION PLAN<sup>59</sup>

| No. | S                                                                                                                                                                                                                                                                                                                                                         | M                                                                                                                                                                                                                                               | A                                                                                                                                              | R                                                                                                                                                                               | T                                                                                                                                                                                        | R.A.G                                                         |
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|     |                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                 |                                                                                                                                                |                                                                                                                                                                                 |                                                                                                                                                                                          | Red = Not complete<br>Amber = In progress<br>Green = Complete |
|     | Specific                                                                                                                                                                                                                                                                                                                                                  | Measurable                                                                                                                                                                                                                                      | Assignable                                                                                                                                     | Realistic                                                                                                                                                                       | Time-Bound                                                                                                                                                                               | Status                                                        |
| 1.  | The Safer Cornwall Partnership should aim to readdress the gender imbalance for specialist domestic abuse and sexual violence services available across Cornwall and IoS for male victims by considering future commissioning contracts/tenders and the feasibility of including 'equitable provision for male and female victims' as a contract outcome. | Record current number of DASV contracts that do not include 'gender equality' as a contract outcome.<br><br>(Where appropriate and feasible) aim to increase the number of contracts with gender equality as a contract outcome and/or increase | The Domestic Abuse & Sexual Violence Strategic Manager to evidence consideration to male victims when renewing or commissioning new contracts. | Where it is unethical to mix male and female support services (such as refuge accommodation), the commissioner should consider how male victims can access equivalent services. | To form part of the Domestic Abuse & Sexual Violence Strategic Group work plan<br><br>On-going and as contracts are renewed or new contracts are commissioned.<br><br>Review April 2016. |                                                               |

<sup>59</sup> The dates suggested within the SMART Action plan are based on the principle that the Home Office will approve the report by the 31<sup>st</sup> March 2014. Dates may be subject to change if the Home Office is unable to approve the report by the 31<sup>st</sup> March 2014.

|    |                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                               |  |
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|    |                                                                                                                                                                                                                                                                                                        | <p>support hours to male victims by 5% over by 2016 (end of current contracts).</p> <p>Report performance to the Domestic Abuse &amp; Sexual Violence Strategic Group on a quarterly basis.</p>                                                                                                                           |                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                               |  |
| 2. | <p>The Domestic Abuse Sexual Violence Strategic Manager for Cornwall and the Isles of Scilly should liaise with all DASV providers, through a providers group, to develop a work plan that aims to increase the confidence and competence of Professionals to identify and respond to male victims</p> | <p>The DASV Providers Group should produce a work plan by January 2015.</p> <p>Aim to increase the referral rate of male victims to specialist services by 5% by 2016.</p> <p>Aim to increase the identification and assessment of female perpetrators of intimate terrorism and situational couple violence by 5% by</p> | <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager to feedback learning and recommendations from this DHR to the DASV Providers Group and support them to create a working plan 2015 – 2018.</p> <p>The DASV Providers Group to ensure the Working Plan includes goals/outputs that</p> | <p>Ensure that males who are victims of abuse at the hands of a partner, ex-partner or family member are afforded the same opportunity as females to seek help and access victim support services (if it can be determined that the act of violence exhibited by the female/partner was not an act of self-protective violent resistance to intimate</p> | <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager to work with the DASV Providers Group to develop a Working Plan by January 2015.</p> <p>Working Plan to be written and presented to DASV Strategic Group by March 2015</p> <p>Outputs within Working Plan to be time-bound.</p> |  |

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|    |                                                                                                                                                                                                                                                                                                                                                                                                     | 2016.                                                                                                                                                                                                                                                                                                                            | address the imbalance between accessible services for male and females, and raise awareness of domestic abuse typologies.                                                                                                                                                                                                | terrorism).                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                   |  |
| 3. | <p>Create a Culture of TELL, ASK and REFER by;</p> <ul style="list-style-type: none"> <li>– Raising awareness of Domestic Abuse in the Community to encourage increased reporting to REACH<sup>60</sup></li> <li>– Ensuring the newly commissioned provider delivering LSCB Safeguarding Children Training includes a Domestic Abuse Specific module including the DASH Risk Assessment.</li> </ul> | <p>A culture of TELL will be achieved through the implementation of the Communication Strategy.</p> <p>A culture of ASK will be achieved by providing all professionals with access to Domestic Abuse and DASH Risk Assessment Training – and equipping them with the knowledge to feel competent and confident to ASK, Risk</p> | <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager to table the recommendations of this Domestic Homicide Review as an agenda item at the next Sexual Violence &amp; Domestic Abuse Strategic Group (following permission to publish from the Home Office).</p> <p>The Chair of the Sexual Violence &amp;</p> | <p>Training will need to be consistent across agencies to ensure that there is a cohesive understanding of risk between Professionals.</p> <p>All Domestic Abuse training should be underpinned by Good Practice Guidance to support and guide Practitioners through the Domestic Abuse Pathway and expected</p> | <p>Table the recommendations and actions from this Domestic Homicide Review at the Domestic Abuse &amp; Sexual Violence Strategic Group within one-month of Home Office approval to Publish.</p> <p>Commission a Multi-Agency Domestic Abuse Training Programme by July 2014.</p> |  |

<sup>60</sup> REACH is a multi-agency HUB developed to provide a single gateway for Risk Assessment, Evaluation and Coordination of Help for Domestic Abuse. The HUB is due to open in Truro on the 1<sup>st</sup> March 2014

|  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   |  |
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|  | <ul style="list-style-type: none"> <li>– Including a specific Domestic Abuse DASH module on the Safeguarding Adults Board Training</li> <li>– Ensuring all Designated Child Protection Officers working for the Cornwall Education Authority attend DASH training as part of enhanced Child Safeguarding Training.</li> <li>– Commission Domestic Abuse &amp; DASH Training for Multi Agency Practitioners including the Voluntary Community Sector, Probation, Mental Health, Drug &amp; Alcohol Services and the Health Sector.</li> <li>– Provide DASH Training to all Special Constables, First Response Officers, Supervisors (including Communication staff), Call Handlers and Sexual Offences Domestic Abuse</li> </ul> | <p>Assess and REFER.</p> <p>A culture of REFER will be achieved by making it easier for the Public and Professionals to refer cases to REACH for Information, advice, risk evaluation and access to specialist Domestic Abuse Services.</p> <p>A measure of progress will be;</p> <ul style="list-style-type: none"> <li>– The Commissioning of a Domestic Abuse Training Program by July 2014;</li> <li>– The number of Professionals attending Domestic Abuse Training;</li> <li>– The number of</li> </ul> | <p>Domestic Abuse Strategic Group to delegate and hold representatives to account for the implementation of the actions.</p> <p>All trained professionals will be required to include a copy of the DASH Risk Assessment when referring a client to REACH. This will provide the Domestic Abuse &amp; Sexual Violence Strategic Manager with evidence of DASH completion, adherence to guidance and effectiveness of training.</p> | <p>standards of practice.</p> <p>Domestic Abuse Training should include as a minimum;</p> <ul style="list-style-type: none"> <li>– The Definition of Domestic Abuse (2013)</li> <li>– The Prevalence of Domestic Abuse</li> <li>– Typologies of Domestic Abuse</li> <li>– Risk of Gender Stereotyping</li> <li>– Signs and Symptoms of Domestic Abuse (Adults and Children)</li> <li>– Barriers to Leaving Abusive Relationships</li> <li>– The Cycle of Abuse</li> <li>– Coercive and</li> </ul> | <p>Set a time frame for individual agencies to implement actions and report back to the DASV Strategic Group.</p> |  |
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|    | Investigation Teams.                                                                                                           | <p>new DASH Forms accompanying referrals to REACH;</p> <ul style="list-style-type: none"> <li>– The number of Non-Police Professionals referring cases to MARAC</li> <li>– A year on year increase in the identification and overall reporting of Domestic Abuse</li> </ul> |                                                                                              | <p>Controlling Behaviours</p> <ul style="list-style-type: none"> <li>– High Risk Factors of Serious Harm and Homicide</li> <li>– DASH Risk Assessment (Including Stalking &amp; HBV)</li> <li>– How and when to Share Information</li> <li>– New Domestic Abuse and Stalking Legislation</li> <li>– The Domestic Abuse Pathway (Inc. REACH &amp; MARACs).</li> </ul> |                                                                               |  |
| 4. | This case has highlighted the need to increase public awareness of domestic abuse and address barriers to reporting for under- | Create a Communication Strategy (2015 – 2018) linked to the phased launch of the                                                                                                                                                                                            | The Domestic Abuse & Sexual Violence Strategic Manager should liaise with the DASV Providers | The Communication Strategy will need to be realistic in its desired outcomes for 2015-2018. Any                                                                                                                                                                                                                                                                      | Prioritise and agree outcomes for the Communication Strategy by January 2015. |  |

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|  | <p>represented groups</p> <p>A public communication and marketing strategy should be developed to increase public confidence to report concerns by;</p> <ul style="list-style-type: none"> <li>– Educating the Public on what constitutes abuse;</li> <li>– Highlighting all forms of Domestic Abuse and the signs and symptoms of coercive and controlling behaviours;</li> <li>– Educating the Public on when and how to intervene/report concerns;</li> <li>– Advertising a single point of contact for all concerns.</li> </ul> | <p>new Domestic Abuse HUB (REACH)<sup>61</sup> by January 2015.</p> <p>Record annual figures from 2014 – 2018 for;</p> <ul style="list-style-type: none"> <li>– The number of Public reports, enquiries or concerns made to the HUB for a third person;</li> <li>– The number of self-disclosures or reports to the HUB;</li> <li>– The number of male victims assessed by the HUB;</li> <li>– The number of alleged female perpetrators and</li> </ul> | <p>Group and the HUB to agree and prioritise key outcomes for the Communication Strategy (To be agreed by January 2015)</p> <p>For example;</p> <p><i>Increase male reporting by ....</i></p> <p><i>Or,</i></p> <p><i>Increase third party (witness) reporting by....</i></p> | <p>marketing and communication campaign to increase public confidence takes time to build awareness and achieve desired results.</p> <p>The strategy will need to encompass short, medium and long-term objectives.</p> | <p>Write Communication Strategy by January 2015.</p> <p>Share Communication Strategy with DASV Strategic Group and Working Group by end of March 2015.</p> <p>Start implementation of Strategy within timescales set for each objective.</p> |  |
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<sup>61</sup> REACH is a multi-agency HUB developed to provide a single gateway for Risk Assessment, Evaluation and Coordination of Help for Domestic Abuse. The HUB is due to open in Truro on the 1<sup>st</sup> March 2014 and will implement a phased launch to Professionals and the Public. It will facilitate 'the right support at the right time' accordingly to the level of risk.

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|    |                                                                                                                                                                                                                                                                                                                                                         | <p>the context of violence used.</p> <ul style="list-style-type: none"> <li>– The gender of perpetrators and the type of case [IPV/ Intra-familial], age and sexual orientation.</li> </ul> <p>Compare figures against comparable data held for 2012/13 to establish progress.</p> |                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                         |                                                                                                                                                                 |  |
| 5. | <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager should liaise with specialist academic researchers within the field of Domestic Abuse to explore a commissioned research proposal to evaluate how the typologies of Domestic Abuse (as defined by Professor Michael P. Johnson<sup>62</sup> and the Duluth Model<sup>63</sup> relates</p> | <p>The hypothesis will be agreed with the Research Group by October 2014.</p> <p>The research will be an original piece of work and will be of benefit to the Cornwall Domestic Abuse Pathway.</p>                                                                                 | <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager to obtain an estimated cost to support the hypothesis.</p> <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager to identify a means to undertake the</p> | <p>The field of Domestic Abuse is expansive. There is a risk that the research outcomes will be lost unless the hypothesis is specific and the outcomes address the learning from this DHR and are beneficial to the Domestic Abuse</p> | <p>Agree hypothesis for research by October 2014.</p> <p>Identify Budget and Commission Research by November 2014</p> <p>Commence Research by no later than</p> |  |

<sup>62</sup> A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (Northeastern University Press, 2008)

<sup>63</sup> <http://www.theduluthmodel.org/>

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|    | <p>to the design and delivery of the new Domestic Abuse Pathway in Cornwall (Including REACH<sup>64</sup>).</p> <p>The outcome of the research should determine the design and commissioning of domestic abuse services for victims and perpetrators from 2016 onwards</p>                                                                                    | <p>The research will be reviewed by academic peers and published within academic journals.</p> <p>Quarterly updates of the findings will be shared with the DASV Strategic Group.</p>                                 | <p>research e.g. Budget, University, Academic Researchers and Accountable Organisation.</p> <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager to lead on the commissioning of the research.</p>              | Pathway in Cornwall.                                                                                                                                                                                                                                   | <p>January 2015</p> <p>Draw on the outcome of research to lead service redesign &amp; commissioning of domestic abuse services from 2016 onwards (if applicable)</p>                                                       |  |
| 6. | <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager to facilitate discussions with Cornwall Council's Healthy Workplace Award Scheme to organise a domestic abuse workshop to assist and support all existing members (100 +) to adopt and implement a domestic abuse policy.</p> <p>Share the Overview Report and Lessons identified from this</p> | <p>Record the number of existing members (of the Healthy Workplace Award Scheme) with a Domestic Abuse Policy.</p> <p>Aim to report baseline data for 2015/16 as to the number of employees disclosing DASV. This</p> | <p>The Domestic Abuse &amp; Sexual Violence Strategic Manager and the Coordinator of the Cornwall Council's Healthy Workplace Award Scheme should create a work plan on how to increase the number of domestic abuse</p> | <p>The workshop should introduce the lessons from this DHR and outline the benefits of adopting a workplace domestic abuse policy for employees.</p> <p>The adoption of a domestic abuse policy should be made easy by providing employers with an</p> | <p>Arrange a meeting between the Domestic Abuse &amp; Sexual Violence Strategic Manager and the Coordinator of the Cornwall Council's Healthy Workplace Award Scheme to agree a partnership work plan by January 2015.</p> |  |

<sup>64</sup> REACH is a multi-agency HUB developed to provide a single gateway for Risk Assessment, Evaluation and Coordination of Help for Domestic Abuse. The HUB is due to open in Truro on the 1<sup>st</sup> March 2014 and will implement a phased launch to Professionals and the Public. It aims to facilitate 'the right support at the right time' accordingly to the level of risk.

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|    | <p>DHR with the Employer of Adult A and B and extend an invitation to be part of the Healthy Workplace Award Scheme in Cornwall.</p> <p>Change the criteria for future annual 'Healthy Workplace Awards' and stipulated that nominated companies must possess a domestic abuse policy.</p> | <p>data will be utilised to establish Performance Indicator with target from 2016 onwards</p>                                                                                                                                                                                                                          | <p>policies adopted by private and public sector organisations across Devon and Cornwall.</p>                                                                                                                                                                                                        | <p>example policy, including guidance on how to TELL, ASK &amp; REFER.</p>                                                                                                                                                                                                                                         | <p>Facilitate the first workshop by March 2015.</p> <p>Change the criteria for the Healthy Workplace Awards for 2015 by January 2015.</p>                    |  |
| 7. | <p>NHS Kernow should share this report with staff at (<i>Redacted</i>) Surgery to ensure that lessons can be learnt from this DHR relating to the importance of medical case note summarising.</p>                                                                                         | <p>Staff at (<i>redacted</i>) Surgery should sign to evidence perusal.</p> <p>Staff should explore opportunities to improve the system for summarising medical case notes.</p> <p>Suggestions for improvements should be fed back to the Domestic Abuse &amp; Sexual Violence Strategic Manager in order that good</p> | <p>The Practice Manager should identify practice lessons and share these with NHS England to assist with implementation if necessary.</p> <p>The Practice Manager should identify any training requirements for staff at the Surgery and liaise with NHS England and/or the Domestic Abuse &amp;</p> | <p>The Panel is unable to implement actions on behalf of NHS England however the Domestic Abuse &amp; Sexual Violence Strategic Manager will record all Practice discussions and communicate the risk to patients and primary care staff if the recommendations and actions from this DHR are not implemented.</p> | <p>NHS Kernow should share this report with staff at (<i>Redacted</i>) Surgery within three-months of the authorisation to publish from the Home Office.</p> |  |

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|    |                                                                                                                                                                                                                                        | practice can be shared with other Surgeries and family members can be assured of changes to prevent future tragedies.                                                                                                                                                                    | Sexual Violence Strategic Manager to facilitate access to such training.                                                                                                                      |                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                              |  |
| 8. | Devon and Cornwall Probation Trust should facilitate communication with the Prison Services to ensure Adult B's medical records are appropriately summarised to include a record of her previous behaviour leading up to the homicide. | Devon and Cornwall Probation Trust to provide the DASV Strategic Group with written confirmation that the medical records of Adult B have been suitably summarised to enable future Primary Care Trust Professionals to easily identify Adult B's previous history of violent behaviour. | Devon and Cornwall Probation Trust to liaise with the Medical Unit at HMP <i>(Redacted)</i> to request that Adult B's medical records are suitably summarised in preparation for her release. | Given the extensive history of Adult B's violent behaviour, Devon and Cornwall Probation Trust may wish to consider sharing the Health Section of this DHR Overview Report with the Prison Service to help the Summariser select key information provided within the narrative chronology. | Devon and Cornwall Probation Trust to liaise with the Prison Service before Adult B's release in 2016/17.<br><br>Devon and Cornwall Probation Trust to provide written confirmation of the summary of Adult B's medical case notes to the DASV Strategic Group by June 2015. |  |
| 9. | The Senior Manager for Social Inclusion and SEN Support Services will identify a means of sharing the lessons of this Domestic Homicide Review with Education Personnel                                                                | The Senior Manager for Social Inclusion and SEN Support Services will provide evidence that these actions have been                                                                                                                                                                      | The Senior Manager for Social Inclusion and SEN Support Services will remind all schools to use the school2school secure                                                                      | The Senior Manager for Social Inclusion and SEN Support Services will ensure that the Department For Education's                                                                                                                                                                           | The Senior Manager for Social Inclusion and SEN Support Services will identify a means to share lessons of this DHR                                                                                                                                                          |  |

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|     | <p>throughout Cornwall and the IoS responsible for the administration and supervision of school transfer records.</p> <p>The Senior Manager for Social Inclusion and SEN Support Services will reiterate the importance of securing transfer records for pupils in line with the Department For Education's 'Children Missing Education' Statutory Guidance for Local Authorities (2013).</p> | <p>completed by reporting back to the DASV Strategic Group by December 2014.</p> <p>All schools will use the School2School<sup>65</sup> secure internet system for transferring pupil records when a child moves.</p> | <p>internet system for transferring pupil information.</p> <p>School Personnel responsible for the administration and supervision of pupil transfer records will be reminded of the importance of chasing missing/delayed records.</p> | <p>'Children Missing Education' Statutory Guidance for Local Authorities (2013) is disseminated to all schools in Cornwall and the IoS with a summary of the lessons identified from this DHR.</p> <p>Schools will be individually responsible for adhering to the Department For Education's 'Children Missing Education' Statutory Guidance for Local Authorities (2013).</p> | <p>with Education Personnel by December 2014.</p> <p>The Department For Education's 'Children Missing Education' Statutory Guidance for Local Authorities (2013) will be disseminated to schools with a summary of lessons identified from this DHR by December 2014.</p> <p>The Senior Manager for Social Inclusion and SEN Support Services will report back to the DASV Strategic Group by January 2015.</p> |  |
| 10. | Devon and Cornwall Police should review the protocol for the dissemination of Strategy                                                                                                                                                                                                                                                                                                        | The force-wide protocol for the dissemination of                                                                                                                                                                      | The Public Protection Unit Lead for Cornwall will direct                                                                                                                                                                               | The Public Protection Unit Lead for Cornwall will need to be                                                                                                                                                                                                                                                                                                                    | The Public Protection Unit Lead for Cornwall to complete                                                                                                                                                                                                                                                                                                                                                        |  |

<sup>65</sup> <http://www.education.gov.uk/researchandstatistics/datatdatam/s2s/a0064650/school-to-school-s2s>

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|  | <p>Group discussions for vulnerable adults, children, MARAC, MAPPA and Missing Persons to ensure that they are recorded and accessible to First Response Officers.</p> <p>Devon and Cornwall Police should seek to identify whether the current challenges associated with the accessibility and dissemination of Strategy Group discussions are due to individual performance or an insufficient policy.</p> <p>Devon and Cornwall Police should explore the possibility of 'flagging' repeat victims and perpetrators of Domestic Abuse on the Unify System.</p> | <p>information from Strategy Group discussions should be reviewed to see if it is fit for purpose.</p> <p>Devon and Cornwall Police to report the outcome of the review to the DASV Strategic Group.</p> <p>If the protocol is fit for purpose, Devon and Cornwall Police should identify a means for quality assuring the application of the protocol and an avenue by which Partners can raise concerns about individual performance.</p> | <p>the review on how Strategy Group Discussions are made accessible to First Response Officers. He will also lead the research into the feasibility of adding a flagging system for repeat domestic abuse victims &amp; perpetrators.</p> <p>The Public Protection Unit Lead for Cornwall to feedback the outcome of both actions to the SVDV Strategic Group.</p> | <p>satisfied that the protocols for sharing Strategy Group discussions are consistently applied and are workable and effective at an operational level.</p> <p>A time frame will need to be agreed for the flagging of repeat Domestic Abuse victims and perpetrators e.g. <i>how long will they be flagged for and how will this be monitored?</i></p> <p>Devon and Cornwall Police will need to agree the purpose and benefit of flagging victims and perpetrators and how (or if) this information will be shared with partners for intelligence purposes.</p> | <p>the review and feedback the outcome of both actions to the DASV Strategic Group by January 2015.</p> |  |
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| 11. | Devon and Cornwall Police should send out an immediately reminder to all Officers on the process of raising 121a's and separate child safeguarding alerts. | <p>Devon and Cornwall Police to dip sample 10 (or 5%) Domestic Abuse cases each month for a period of 12 months to ensure that 121a's are consistently completed and separate safeguarding alerts raised to MARU (In Cornwall) for significant child welfare concerns.</p> <p>Results of Dip Sampling to be reported to the SVDV Strategic Group on a monthly basis.</p> | <p>The Public Protection Unit Lead for Cornwall should undertake the dip sampling on behalf of Devon and Cornwall Police or nominate a representative who will act on his behalf.</p> <p>The Public Protection Unit Lead for Cornwall will escalate any concerns about individual or systemic practice in line with formal Devon and Cornwall Police escalation processes.</p> | <p>Dip Sampling should provide the Public Protection Unit Lead with an indication of the effectiveness of the Force Policy for 121a's and Child Safeguarding Alerts.</p> <p>A reminder of the protocol/policy for 121a's and Child Safeguarding Alerts, together with knowledge of a dip-sampling process should refresh Officers and encourage consistent practice.</p> | <p>Send out reminder to all Officers within one month of Home Office approval of the Report.</p> <p>Start Dip Sampling from December 2014.</p> <p>Report first set of results to DASV Strategic Group by January 2015.</p> |  |
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## APPENDIX A: CONTEXT OF AGENCY INVOLVEMENT

Documented evidence of agency involvement during each key time period

### 1963 – 1980

583. During the period 1963 -1980 the Review Panel has seen documented evidence to suggest involvement from;

- ***Education Welfare Services;***

584. A letter from an Education Welfare Officer was sent to Adult B's G.P on the 10<sup>th</sup> April 1978 following pleas from Adult B's Mother for help controlling Adult B's temper. This contact was recorded within medical records and reviewed under the Cornwall and Isles of Scilly Primary Care Trust IMR.

- ***G.P Services;***

585. The medical case notes of Adult B contain references to concerning violent behaviour dating back to 1975 when Adult B was 11 years old. Between 1975 and 1979, Adult B was seen on 14 separate occasions for issues relating to aggression. This contact was recorded within medical records and reviewed under the Cornwall and Isles of Scilly Primary Care Trust IMR.

- ***Consultant Psychiatrist;***

586. A letter was sent to Adult B's G.P on the 28<sup>th</sup> February 1977 by a Consultant Psychiatrist outlining a two-year period of involvement with the family to address Adult B's 'temper'. This contact was recorded within medical records and reviewed under the Cornwall and Isles of Scilly Primary Care Trust IMR.

## 1980 – 2004

587. During the period between 1980 -2004 there is documented evidence of involvement from;

- ***Health Visitor;***

588. A Health Visitor (KR) sent a letter to the G.P, Social Services and the local school on the 2<sup>nd</sup> December 1988 in relation to a serious assault on C2 and an assault on C3 by Adult B. This contact was recorded within medical records and reviewed under the Cornwall and Isles of Scilly Primary Care Trust IMR.

- ***Bedfordshire County Council;***

589. Bedfordshire County Council Children's Social Care had brief involvement with Adult B and C4 in 1999 and subsequently in 2003. Central Bedfordshire Council became a unitary authority in April 2009. The extent of the information available from Bedfordshire County Council Children's Social Care to undertake this review was limited. A review of the available information

in the form of a paper file has been undertaken and the previous electronic databases employed by the legacy Council (Bedfordshire County Council) have been accessed.

– ***Bedfordshire Police;***

590. Bedfordshire Police were involved with the family from 1995 (following a report of assault on C3 by Adult B at *(Redacted)* Junior School, *(Redacted)*) until the last recorded contact on the 22<sup>nd</sup> June 2004. During the period from 1995 – 2004, Bedfordshire Police recorded (18) separate incidents with the family.

591. Bedfordshire Police has accessed all available electronic and paper records relating to the family including crime reports, incident logs, family protection reports, custody records, the Case Automated Tracking System (CATs) and the Compact computer system for missing persons.

– ***(Redacted) Junior School, Luton;***

592. Luton Children's Services received a referral from *(Redacted)* school reporting an alleged assault on C3 by Adult B on 18<sup>th</sup> June 1993.

593. *(Redacted)* Junior School made a further report of assault to Bedfordshire Police on the 20<sup>th</sup> June 1995 after a teacher witnessed an assault on C3 by Adult B in the school playground.

594. Children's Services Luton were advised on 17<sup>th</sup> May 1996 by a school (Not Identified in the referral) of an alleged assault on C4 by Adult B and also an assault on another parent in the playground by Adult B. It is not known if this referral was received from (*Redacted*) Junior School or (*Redacted*) High School (see below) or another unidentified school.

– (*Redacted*) **High School, Luton;**

595. A referral was received from (*Redacted*) High School to Luton Children's Services on the 14<sup>th</sup> April 2000 advising of an alleged assault on C4 by Adult B. In Addition an Education Welfare Officer also referred C4 on the same day for concerns due to persistent truanting, and behavioural problems at school and outside of school.

596. A further referral was made by the Education Welfare Officer on the 22<sup>nd</sup> May 2001 for accumulative concerns for the safety of C4 going back to 26<sup>th</sup> August 2009.

597. **Note:** The Review Panel were unable to secure any records or request an IMR to cover educational referrals or concerns as they were unavailable. It is thought that a school fire may have destroyed paper records linked to the family.

– **Luton Borough Council;**

598. The case was opened in Luton Borough Council (Luton B.C.) resulting from an agreement by Luton to accept case responsibility from Leighton Buzzard following a move in accommodation by Adult B on the 18-01- 1985. Luton and Leighton Buzzard were both localities within the former Bedfordshire County Council (Beds C.C.).

599. Luton B.C became a unitary authority on the 01-04-1997. The remainder of Beds C.C. became the unitary authorities of Bedford Borough Council (Bedford B.C.) and Central Bedfordshire Council (C.B.C) on the 01-04-2009.

600. There are no electronic records available at Luton Borough Council for the period of involvement relating to this IMR. Therefore paper files only were reviewed. Two case files were reviewed;

601. *Case File One* contained 127 items comprising of referral forms, Case recordings/report sheets, summaries, strategy meetings, child protection documents (including health visitor reports and investigation forms) and non-child protection documents, letters, forms and telephone message slips. Case File One has the names of C1, C2, C3, C4, C5, H3 and Adult B.

602. *Case File Two* contained 52 items relating to C4. The file consists of loose paper records including referrals, transfer and closure summaries, case recordings and report sheets, strategy meetings, child protection documents and letters.

603. From 1985 – 2002, Luton Borough Council received 17 separate referrals to Children's Services regarding the welfare of Adult B's children, of which, 11 were reports of the children alleging to, or reported by professionals to have, received a non-accidental injury from Adult B. The last contact with Luton Borough Council Children's Services concerning Adult B and her children was the 17<sup>th</sup> February 2002.

## 2004 – 2012

604. During the period 2004 – 2012 there is documented evidence of involvement from;

– ***G.P Services;***

605. (Redacted) Surgery, (Redacted) provided General Medical Services to Adult A and Adult B who both registered with the practice on 29.06.2004. Their registered GP was Dr (Redacted).

606. The IMR Author undertook a detailed review of the medical records of Adult A from 01.01.04 to 13.05.12 and Adult B from 26.09.63 to 13.05.12 in line with the scope of the review. Staff at (Redacted) Surgery were also interviewed.

– ***Local Authority Education Services (Cornwall);***

607. Child 5 (C5) of Adult B attended (Redacted) Community Primary School (from 14/07/2004 to 26/07/2005), (Redacted) School and Community College (from 05/09/2005 to 19/01/2011) and (Redacted) College (Redacted) (from 30/08/2011 to 29/06/2012).

608. The Education IMR Author has reviewed all attendance records, key stage results, school reports, Frameworki electronic records, annual reports, assessment records, student referral forms (for behaviour concerns), student response forms and letters to and from Adult B. C5's form tutor (from 2005 – 2010) was also interviewed.

## APPENDIX B – Full Chronology

| Date        | Source of Information | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                            | Actions taken/Decisions made | Comments                                                                                                                                                                                                                                                                   |
|-------------|-----------------------|----------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10 May 1966 | Cornwall PCT > GP     | Perpetrator's mother                         |                           | Lloyd George record - handwritten                                                         |                              | Irritable, screaming fits                                                                                                                                                                                                                                                  |
| 06 Feb 1975 | Cornwall PCT > GP     |                                              |                           | Fragment of a letter addressed to GP ( <i>Redacted</i> ) from Bedfordshire County Council |                              | Letter states that Mrs S (Adult B's grandmother) expressed concerns about the 'violent and destructive behaviour which regularly occurs within this family and which is seen as being initiated by (Adult B)...' <i>the rest of the letter is torn and indecipherable.</i> |
| 22 Feb 1975 | Cornwall PCT > GP     |                                              |                           | Lloyd George medical record - handwritten                                                 |                              | Record of letter from Child Guidance Clinic – original letter is not contained in the medical records                                                                                                                                                                      |

| Date        | Source of Information | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                            | Comments                                                                                                       |
|-------------|-----------------------|----------------------------------------------|---------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| 04 Sep 1975 | Cornwall PCT > GP     | Perpetrator's grandmother                    |                           | Lloyd George record - handwritten                              |                                                                                                                         | 'Mrs S reports she is still very bad-tempered and...' ( <i>indecipherable</i> ).                               |
| 02 Apr 1976 | Cornwall PCT > GP     | Perpetrator's mother                         | No                        | Lloyd George medical record - handwritten                      | Medication prescribed Valium 2-4mg daily x 100. Valium is a benzodiazepine prescribed for anxiety states and agitation) | '(Adult B) Has scratched and hit her teacher. Is violent at home and breaks the doors.                         |
| 21 May 1976 | Cornwall PCT > GP     | Perpetrator's mother                         | No                        | Lloyd George medical record - handwritten                      | Repeat prescription of valium 2mg twice daily x 100 tablets                                                             |                                                                                                                |
| 06 Jul 1976 | Cornwall PCT > GP     | Perpetrator's mother                         | No                        | Lloyd George medical record - handwritten                      |                                                                                                                         | '(Adult B) is playing up again. Won't take her tablets. Kicks her mother. To be sent down to see me.'          |
| 02 Oct 1976 | Cornwall PCT > GP     | Home visit                                   | No                        | Lloyd George medical record - handwritten                      |                                                                                                                         | '(Adult B) attacked her mother today and smashed banisters. Child quite ok now and has gone out to do shopping |

| Date        | Source of Information | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                         | Comments                                                                                                                                                                     |
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|             |                       |                                              |                           |                                                                |                                                                                                                      | so could not be interviewed.'                                                                                                                                                |
| 31 Jan 1977 | Cornwall PCT > GP     | Not stated                                   | No                        | Lloyd George medical record - handwritten                      | Prescribed largactil tablets 25mg twice daily x 60. (Largactil is an anti-psychotic medication – a 'tranquilliser'.) | '(Adult B) uncontrollable again today despite Val ( <i>valium</i> ) 2x2 bd. Won't come down here. Mother has been down to ( <i>Redacted</i> ) but "they can't do anything".' |
| 15 Feb 1977 | Cornwall PCT > GP     |                                              | No                        |                                                                | 'Write to Dr ( <i>Redacted</i> ) requesting further appt.' (Consultant Psychiatrist)                                 |                                                                                                                                                                              |
| 16 Feb 1977 | Cornwall PCT > GP     | Home visit to Adult B                        | No                        |                                                                |                                                                                                                      | 'taken Val 2, disprins etc. Not drowsy. No action.' ( <i>?medication overdose</i> )                                                                                          |
| 17 Feb 1977 | Cornwall PCT > GP     |                                              | No                        | Lloyd George record - handwritten                              | Telephone call to social services                                                                                    | 'Discussion about Adult B's temper tantrums. Is taking the largactil (says no side-effects noticed... increase dose if necessary.'                                           |

| Date        | Source of Information                                 | Contact with or by the Victim or Perpetrator                       | Contact with the Children | Communication (identify if within agency or to another agency)         | Actions taken/Decisions made                                                                                                                                                                                             | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| 28 Feb 1977 | Cornwall PCT > Dr (Redacted), Consultant Psychiatrist | Perpetrator's mother attended but Adult B refused to attend clinic |                           | Letter from Dr (Redacted), Consultant Psychiatrist – outpatient clinic | <p>Further appointments were offered on request but (Adult B's)... mother 'made it clear she saw no point in this'.</p> <p>A home visit was planned to meet (Adult B)... – unclear by which agency? social services.</p> | <p>Letter details that ((Adult B)... had 'swallowed a 'token' overdose of tranquilisers...thrown yet another tantrum ...during which furniture had been broken...the police had been involved...(Adult B)... had been 'talked to' at the police station.' The clinic letter details that the mother of (Adult B)... had alleged in February 1975 that she was the victim of domestic violence at the hand of her husband (Adult B)'s father). The mother of (Adult B)... is detailed as having suffered a stroke 10 years previously with resultant left-sided weakness and speech problems. She is detailed as being solely</p> |

| Date | Source of Information | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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|      |                       |                                              |                           |                                                                |                              | <p>responsible for the management of their three children, her husband having little involvement despite sharing the home 'as a lodger'. (Adult B)... being the eldest child, the second daughter is described as 'mentally handicapped probably as a result of birth injury' and 'often throws temper tantrums'.</p> <p>'...over a two year period and having heard about the family from...school..., from the Health Visitor and the family doctor and now from the Department of Social services I have pieced together a picture of a grossly dysfunctional family where it is possible</p> |

| Date        | Source of Information                                                | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                                          | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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|             |                                                                      |                                              |                           |                                                                |                                                                                                                                       | to build up a rather fragmentary picture of multiple problems but not to work with them in any constructive way.'                                                                                                                                                                                                                                                                                                                                                |
| 17 Mar 1978 | Cornwall PCT > Bedfordshire County Council Education Welfare Service |                                              |                           |                                                                | 10.04.78 Education Department intended to take (Adult B)... to court for poor school attendance and to request an Interim Care Order. | Letter from Education Welfare Officer to GP requesting information about sickness and school non-attendance. Details: 'I have visited the home on a number of occasions when mother pleads for help with (Adult B)... telling me of (Adult B's)... violent temper and her own fears for the two younger children. Even saying to me "(Adult B)... will end up murdering someone"'... Social Services have not been able to do much on (Adult B)'s behalf because |

| Date                | Source of Information                            | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made | Comments                                                                                                                                                 |
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|                     |                                                  |                                              |                           |                                                                |                              | mother retracts her statements when in the company of (Adult B)..., and Dr (Redacted)' help too has been thwarted because of mother's non-co-operation.' |
| 02 Mar 1979         | Cornwall PCT > GP                                | Adult B                                      |                           | Lloyd George record - handwritten                              |                              | Home visit – 'Psychological – distant girl – wants to marry at 16 – boy (18) who knocks her about.'                                                      |
| (Redacted) May 1980 | Cornwall PCT > DHR review – information provided | Adult B                                      |                           |                                                                |                              | Birth of son                                                                                                                                             |
| (Redacted) Sep 1981 | Cornwall PCT > DHR review – information provided | Adult B                                      |                           |                                                                |                              | Birth of son                                                                                                                                             |
| 18 Sep 1983         | Cornwall PCT > GP                                | Adult B                                      |                           | Lloyd George record - handwritten                              |                              | Pregnant with third child. Husband/partner                                                                                                               |

| Date                   | Source of Information                                         | Contact with or by the Victim or Perpetrator                                 | Contact with the Children                                         | Communication (identify if within agency or to another agency)                                                           | Actions taken/Decisions made                                                                                                                                                                                               | Comments                                                                                                                                        |
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|                        |                                                               |                                                                              |                                                                   |                                                                                                                          |                                                                                                                                                                                                                            | deserted 1 month ago. Living unsupported in squalor. Frightened...'                                                                             |
| (Redacted)<br>Mar 1984 | Cornwall PCT > DHR review – information provided              | Adult B                                                                      |                                                                   |                                                                                                                          |                                                                                                                                                                                                                            | Birth of son                                                                                                                                    |
| 01 Jan 1985            | Luton Council > Beds C.C. Children Services-Luton Area Office | Application for a sponsored full time nursery placement concerning C2 aged 4 | Hand written Nursery application. Descriptive of behaviours only. | Luton Area Bedfordshire children's services application to (Redacted) Nursery.                                           | Application states Adult B was received into care for being violent at home and school. The children C1 and C2 are recorded as "exhibiting aggressive behaviours and considerably behind on verbal and social milestones". | First description of the reason Adult B had been taken into care. Case file one.<br><br>This dates appears to be - exact date not known in 1985 |
| 18 Jan 1985            | Luton Council > Beds C.C.. Children's Services                | Internal /inter area Transfer summary<br><br>Case transfer from (Redacted)   | First record of family in Luton. Moved into Luton December        | One page typed transfer summary<br><br>Notification Adult B had been in care of Bedfordshire County Council on full care | Background family history Information records concise outline of the care order concerning Adult B. Her children C1 and C2 were                                                                                            | Case transfer accepted by Luton Children's Services 18-01 1985 Via an internal email from an area manager.                                      |

| Date        | Source of Information                                            | Contact with or by the Victim or Perpetrator | Contact with the Children                                | Communication (identify if within agency or to another agency)                                            | Actions taken/Decisions made                                                                                                                                                                                                                                          | Comments                                                                                                                                                                             |
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|             |                                                                  | to Luton                                     | 1984.<br>Contact with children not recorded              | order aged 13-18.<br><br>Adult B had three children<br><br>C1 aged 5. C2 aged 4<br><br>C3 aged ten months | recorded as having speech delays<br><br>Transferring Social Worker considered Adult B to be providing adequate parenting with a requirement for minimal support from social services in counselling and assistance with the Department of Health and social security. |                                                                                                                                                                                      |
| 12 Apr 1985 | Luton Council > Beds C.C. Children's services. Luton Area office | Internal/ closure summary                    | Closure summary only. Contact with children not recorded | Closure summary only                                                                                      | Case closed. Future needs of Adult B and her children were considered to require assistance with be financial support only.                                                                                                                                           | The closure summary is the only reference to the children being offered nursery support. There is no recording of the work undertaken with the developmental delays of the children. |
| 15 Sep      | Luton Council > Beds C.C.                                        | Referral opened concerning                   | Self- referral only relating                             | Self-referral only .No                                                                                    | The Application by Adult B and H3 to adopt C3 was                                                                                                                                                                                                                     | The step parent application was open to                                                                                                                                              |

| Date                          | Source of Information                                            | Contact with or by the Victim or Perpetrator                            | Contact with the Children                                                    | Communication (identify if within agency or to another agency)                                                                                                                                | Actions taken/Decisions made                                                                | Comments                                                                                                                                                             |
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| 1986                          | Children's services. Luton Area office                           | application by Adult B and H2 to adopt C3 aged 2 (step parent adoption) | to step parent adoption application                                          | contact with child.                                                                                                                                                                           | open until September 1988.                                                                  | Luton B.C. for two years due to delays in submitting court documents and difficulties in identification of the biological father of C3.                              |
| 24 Apr 1987                   | Luton Council > Beds C.C. Children's services. Luton Area office | Referral from <i>(Redacted)</i> A +E                                    | Referral to Emergency Duty social worker from Ward Sister of A+ E department | Hospital reports a suspicious injury to the penis of C3 aged 3<br><br>Parent H2 reported as being too casual and explanation of injury being inconsistent of being caused on a lavatory seat. | Referral records intention of ward sister arranging for child to be seen by a paediatrician | No other recordings related to this referral could be located on case files one or two. The referral states child is known and not on the child protection register. |
| <i>(Redacted)</i><br>Jan 1988 | Cornwall PCT > DHR review – information provided                 | Adult B                                                                 |                                                                              |                                                                                                                                                                                               |                                                                                             | Birth of daughter                                                                                                                                                    |
| 01 Aug 1988                   | Luton Council > Beds C.C. Children's                             | Incident between Adult B and H2                                         | Incident recorded in a closure                                               | Recorded within internal closure summary after the event                                                                                                                                      | Social worker records visiting family on a non-dated day in August 1988                     | The application to adopt C3 was withdrawn following a visit by a                                                                                                     |

| Date | Source of Information       | Contact with or by the Victim or Perpetrator | Contact with the Children                                                                    | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                                                                                                                       | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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|      | services. Luton Area office |                                              | summary 28-02-'89 Case recording of incident could not be located in case files one and two. |                                                                | to discuss the progress of step parent adoption. The social worker witnessed Adult B throwing all clothing of H2 out of a window. Additionally upon entering the home discovered all the crockery had been smashed | <p>Luton Social worker to the family home during August 1988.</p> <p>It was not possible to locate any other recording concerning the incident. The summary states the social worker advised Adult B and H2 of withdrawing support for their step parent adoption application.</p> <p>The application to adopt C3 was withdrawn by the parents during September 1988.</p> <p>No other recordings related to this referral could be located on case files one or two. The referral states child is</p> |

| Date        | Source of Information                               | Contact with or by the Victim or Perpetrator                                                                      | Contact with the Children                                                                      | Communication (identify if within agency or to another agency)                                                                            | Actions taken/Decisions made                                                                                                                                                                                                                                                                                                                            | Comments                                                                                                                                                                                                                                                                                                                                                                              |
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|             |                                                     |                                                                                                                   |                                                                                                |                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                         | known and not on the child protection register.                                                                                                                                                                                                                                                                                                                                       |
| 03 Nov 1988 | Cornwall PCT > GP                                   | Adult B                                                                                                           |                                                                                                | Lloyd George record - handwritten                                                                                                         | Referred to Neurologist at UCH. Head CT scan result – normal.                                                                                                                                                                                                                                                                                           | 3/11/1988 –20/01/1989<br><br>'Headaches...feels depressed.'                                                                                                                                                                                                                                                                                                                           |
| 10 Nov 1988 | Luton Council > South Bedfordshire Health Authority | Referral /Cause for concern by allocated Health Visitor concerning injuries to C3 aged 4 and C2 aged 7,by Adult B | Children seen by Health Visitor on 10-11-'88 and joint visit by Luton S W and H V on 14-11-'88 | Written accounts provided to Luton Children's services by H V ( 02-12-'88 ) and also ( <i>Redacted</i> ) school (Nursery unit ) 25-11-'88 | The Health Visitor had been informed by mother, Adult B, of the incidents concerning C2 and C3 and visited Adult B without notifying Children's services of the incidents and visit until the following day 11-11-'88.<br><br>A Joint visit by a social worker and health visitor on 14-11-'88 is the only account located in case files one and two of | Adult B asked the Health Visitor to visit and advised of strangling C3 by picking him up and throwing on a sofa. Additionally Adult B Informed the health visitor of slapping C2 and knocking out a tooth.<br><br>The nursery had noticed a friction burn 3"x ½ inch on the neck of C3. The recorded information by the nursery was not received at Luton Children's Services until 2 |

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|      |                       |                                              |                           | .                                                              | action being completed       | <p>weeks after the incident.</p> <p>The marks on the neck of C3 are recorded by the Social Worker to have almost faded away when C3 was seen on 14-11-'88</p> <p>There is no apparent recorded deliberation or consideration of an enquiry being undertaken via discussion with managers. There is no other apparent reference to C2 being slapped and the assessment and /or treatment he received concerning the missing tooth.</p> <p>The social worker records Adult B to be suffering neurological issues including facial paralysis and blinding headaches of</p> |

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|             |                                  |                                              |                           |                                                                                                                                                                  |                                                                                                                                                                                                                                                                                       | <p>which a subsequent case recording informs of there being no identifiable cause found by neurologist.</p> <p>The SW and HV considered this to be responsible for the behaviour of Adult B and no further action was taken.</p>                                                                                    |
| 02 Dec 1988 | Cornwall PCT > Health Visitor KR |                                              |                           | A letter - Cause for Concern Report relating to four eldest children of (Adult B).... Letter addressed to Senior Nurse, ( <i>Redacted</i> ) Clinic, Luton, Beds. | <p>The incident was reported to social services by the health visitor and the local school. A joint visit was performed by the Health Visitor and 'HC'.</p> <p>'It was decided that no further action would be taken by social services but intensive support would be offered by</p> | <p>Relating to an incident on 10/11/1988. (Adult B)... informed the health visitor that she had attempted to strangle her son C3– aged 4 years) by 'putting her hands around his neck, she picked him up by his neck...' 'She had also smacked (C2– dob (<i>Redacted</i>) /9/81 age 7 years and knocked a loose</p> |

| Date        | Source of Information                                            | Contact with or by the Victim or Perpetrator | Contact with the Children                                           | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                                                                                                                                                                                                                                            | Comments                                                                                                                                                                                                                                                                                                                                 |
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|             |                                                                  |                                              |                                                                     |                                                                | <p>myself, and HC would visit as necessary'</p> <p>Offered temporary full time nursery placement for 4 year old; discussion re housing; drop-in sessions at (<i>Redacted</i>).</p>                                                                                                                                                      | <p>tooth out...'.<br/>(Adult B)... is under considerable stress from an unknown illness – she has an appointment at UCH on 1/12/88' (see previous entry).</p>                                                                                                                                                                            |
| 28 Feb 1989 | Luton Council > Beds C.C. Children's services. Luton Area office | Internal closure summary                     | Children referred to collectively as chatty and appear to cope well | Social work closure summary                                    | <p>Reason for closure is stated as "the withdrawal of step parent adoption application. Moving house". Location/new address not present /or recorded</p> <p>Reasons for Future contact are recorded as "possible if the strains in the marital relationship continue. There could be further injuries on the children if Adult B is</p> | <p>Clear concerns remain regarding the issues within the family and future injuries to children .No apparent consideration of preventative services family support etc.</p> <p>Summary also records a health visitor to have a press cutting of Adult B being taken into care and of attempting to strangle a relative. There was no</p> |

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|             |                                                                  |                                                                                                                                                                            |                                                                                                                                                                                                                  |                                                                                  | under stress again”                                        | apparent overt linking to the incident with C3.                                                                                                                                                                                                                                                                                                                                       |
| 12 May 1989 | Luton Council > Beds C.C. Children’s services. Luton Area office | Referral by <i>(Redacted)</i> advising Luton children’s services of an incident during which Adult B stabbed H2 who is in intensive care at the <i>(Redacted)</i> hospital | The schools of children were traced and schools reported children to be staying with the maternal grandmother. No recording of visits to the children apparent ( Grandmother resident in <i>(Redacted)</i> area) | Schools were unaware of the incident until advised by Luton Children’s Services. | Children traced by social services to maternal grandmother | The details of injuries to H2 cannot be located within case files one and two. Case file recording states H2 would not press charges against Adult B and the police did not charge Adult B or take any other action.<br><br>The case was closed at Luton children’s services 3 days later 15-05-’89 and signed off by a manger as “ this matter appears to have resolved itself. NFA” |
| 26 May 1989 | Cornwall PCT > Health Visitor<br><i>(Redacted)</i> Clinic,       |                                                                                                                                                                            |                                                                                                                                                                                                                  | Letter to Child and Family Psychiatric Department, <i>(Redacted)</i> , Luton.    |                                                            | Referral for family psychiatric support. Son C1 – ‘aggressive and disruptive’ and difficulties                                                                                                                                                                                                                                                                                        |

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|             | Luton                 |                                              |                           |                                                                |                                                                     | at home. 'I feel that many of the family's problems are caused by (Adult B's)... mental state and vulnerability to stress. She has a long psychiatric history and there have been two incidents of violence in the last six months...I am concerned about the risks her intermittent and unpredictable violent outbursts pose to the children...' |
| 22 Jun 1989 | Cornwall PCT > GP     | Adult B                                      |                           | Lloyd George record - handwritten                              | Prescribed prothiaden 25mg 1-2 at night ( <i>anti-depressant</i> ). | 'Feeling unwell for months – began with headaches...shaky...sleepy all the time.'                                                                                                                                                                                                                                                                 |
| 04 Jul 1989 | Cornwall PCT > GP     | Adult B                                      |                           | Lloyd George record - handwritten                              |                                                                     | Review appointment. '...a veritable outburst...forever being "palmed of with tablets by doctors who did not                                                                                                                                                                                                                                       |

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|             |                                                                     |                                                                                             |                                                                                                                 |                                                                                                                                                                                                            |                                                                                                                                                                                                                   | help her” ...she stormed out...’                                                                                                                                                                                                                       |
| 08 Jun 1990 | Luton Council > Bedfordshire Health authority                       | Health visitor cause for concern notification to Bedfordshire C.C children’s services.      | Health visitor reporting contact form routine transfer visit.                                                   | Health visitor to Bedfordshire C.C. children’s services.                                                                                                                                                   | No actions apparent to the referral of which stated for information only.                                                                                                                                         | Referral states health visitor had referred family to child and family guidance due to the level of violence in family. Family had failed to attend appointments. Health Visitor clear not a referral to children’s services just for information only |
| 18 Jun 1990 | Luton Council > Bedfordshire Education Service<br>(Redacted) School | Letter of concern from Lower school head teacher to person addressed as only as (Redacted). | Letter advises of Child concerns re- .C3, aged 6 attending school with a bruised lip of which the child alleged | Unclear which agency or professional the letter is addressed to.<br><br>4 hand written social work report sheet. There does not appear to be any other recording relating to the referral or action within | The Visiting social workers did not believe the explanation provided by Adult B of which they considered inconsistent with the injury. The closing recording on the report is “There is a worrying background and | Letter refers to children having four different home addresses and schools within past three years.<br><br>Letter also refers to Adult B being described as aggressive and dangerous                                                                   |

| Date | Source of Information | Contact with or by the Victim or Perpetrator                                                                                                                                                                                                                                                                     | Contact with the Children                                                                                                                                                                                                                           | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                  | Comments                                                                                                                                                                                    |
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|      |                       | <p><i>(Redacted) home address</i></p> <p>and recordings by social workers present.</p> <p>4 social worker report sheets are present relating to joint visit (two social workers) to the family home on 28 -06-'90.</p> <p>Back ground concerning the visit are recorded as refer to the attached referral of</p> | <p>Adult B had hit him for not putting on a shirt quickly enough.</p> <p>C2, aged 8 had also attended school with a bruised eye of which he claimed had been caused by an elder brother.</p> <p>C3 was seen to have a 1inch swelling on his lip</p> | Case files one and two                                         | the stories about this injury are inconsistent. Seems like a family to watch" | <p>by the previous school.</p> <p>Unclear form the Recordings why a strategy meeting was not held and why the case was closed when the explanations for the injuries were not believed.</p> |

| Date        | Source of Information                                                    | Contact with or by the Victim or Perpetrator                                               | Contact with the Children                                                                                                                                                                              | Communication (identify if within agency or to another agency)                          | Actions taken/Decisions made                                                                                                      | Comments                                                                                                                                                                       |
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|             |                                                                          | which the referral does not appear to be attached or located within case files one or two. |                                                                                                                                                                                                        |                                                                                         |                                                                                                                                   |                                                                                                                                                                                |
| 30 Oct 1990 | Luton Council > Beds C.C. Children's services.<br>(Redacted) Area office | Professionals meeting record- Children's services                                          | Professionals meeting to discuss general concerns.<br><br>C1 aged 10, recorded as excluded from some lessons due to his anger and walking out of school.<br><br>C4 ,aged 1+ is reported as not causing | One page meeting minutes .Social Worker, Health Visitor and year tutor attended meeting | No further meeting was considered necessary. Recorded actions School to monitor C1. Other concerns of family considered contained | The report is concise and without details of the historical concerns raised during the year and previous year. Family recorded as moving 4 times in a year causing disruption. |

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|             |                                                                          |                                                                                                                                                                     | concerns                                                                                                                                                                    |                                                                                                                                                                          |                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                            |
| 31 Jan 1991 | Luton Council > Beds C.C. Children's services.<br>(Redacted) Area office | Self-referral by H2 advising of an incident at the family home during which he had pushed over Adult B resulting in Adult B being taken to hospital in an ambulance | There do not appear to be any records of contact with the children. The referral form is the only recording present in Case files one and two that relates to the incident. | Referral form states (self referral H2).                                                                                                                                 | Children's services established Adult B was taken to hospital and sustained severe bruising to left side of face, neck, arm and hand. One stitch was inserted in the cheek of Adult B who was also given a tetanus injection | The Duty Social work team appear to have established the children were to be cared for by a maternal aunt. Additionally advised mother to gain legal advice if concerned about a reoccurrence of violence. The children do not appear to have been seen. Case was NFA "as unnecessary for further involvement "and closed. |
| 18 Dec 1991 | Luton Council > Beds C.C.. Children's services. Luton Area office        | Anonymous referral alleging Adult B to be frequently hitting C1 aged 10 because he resembles his father. Injuries recorded as                                       | There is no apparent record of contact with the child or other children in the family.                                                                                      | The anonymous referrer was not identified in the referral record. The referrer stated mother Adult B "is a violent woman and that is why concerned people do not refer". | The referral was considered "not adequate enough to merit a responsive visit "The duty SW wrote a letter 20-12-'91 to the Head teacher of (Redacted) school advising of the referral                                         | The concerns were referred as historical and actions appear to have been taken at the point of closure and not at the point of referral.<br><br>Notably the referral records Files held                                                                                                                                    |

| Date        | Source of Information                                                                                        | Contact with or by the Victim or Perpetrator                                                          | Contact with the Children                                                                                                                                                         | Communication (identify if within agency or to another agency)                          | Actions taken/Decisions made                                                                                                                                                                                                                               | Comments                                                                                                                                                                |
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|             |                                                                                                              | bruised eye.                                                                                          | Referral relates specifically to C1                                                                                                                                               |                                                                                         | and requesting any future concerns to be referred.                                                                                                                                                                                                         | previously at ( <i>Redacted</i> ) team. ,Beds C.C. ( now Central Bedfordshire Council) could not be located                                                             |
| 19 Jun 1992 | Luton Council > Beds C.C. Children's services. ( <i>Redacted</i> ) Area office or Luton Children's services? | Referral /office visit by partner of H2 (now estranged from Adult B) referring concerns re C4, aged 4 | No contact with child or children apparent resulting from referral of which alleged C4 to have been be struck by the present partner of mother ,Adult B and general neglect of C4 | Case check recorded as completed. Referenced closed papers at ( <i>Redacted</i> ) 1990. | The partner of H2 was advised to seek legal advice concerning gaining custody of C4.<br><br>Partner was advised if marks were not visible on c4 no action can be taken<br>The referral was considered to be custody issue and NFA required<br>.Case closed | The Police are also recorded as visiting the family home of C4 concerning a fight of which no other details are apparent other than the Police did not become involved? |
| 18 Jun 1993 | Luton Council > Beds C.C.. Children's                                                                        | Referral from Teacher at ( <i>Redacted</i> )                                                          | Report of grazing around the                                                                                                                                                      | Aside the completed hand written referral there is one social worker report sheet       | The referral states C3 said his mother "did it" He later said he fell off a                                                                                                                                                                                | It is not possible to determine from Case files one and two why the                                                                                                     |

| Date                   | Source of Information                            | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                                                                                                                          | Actions taken/Decisions made                                                                                                                                                                                                                 | Comments                                                                                                                                                                                                                                      |
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|                        | services. Luton Area office                      | School                                       | right eye of C3, aged 9   | dated 20-06-? of which appears related to the referral details                                                                                                                                                                          | bike .The referral recorded C3 to have later given a further contradictory account stating another child had kicked him.<br><br>There do not appear to be any other recordings present within case files one or two related to this referral | child was not seen by a social worker, or a strategy meeting held.<br><br>The social worker records the school as stating “mother, Adult B is very violent and C3 becomes very worried if he thinks he will be in trouble when he goes home”. |
| (Redacted)<br>Oct 1993 | Cornwall PCT > DHR review – information provided | Adult B                                      |                           |                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                              | Birth of daughter                                                                                                                                                                                                                             |
| 20 Jun 1995            | Police > CATS 10151                              |                                              |                           | <b>Report of assault. Location of incident:</b> (Redacted) <b>School, Luton.</b> Call received from a teacher at (Redacted) Junior School, Luton that C3, aged 11 years was seen to be assaulted by his mother on the 19/06/95. She had | SSD checked and they have a list of previous referrals regarding Adult B. Police have no record of this family.                                                                                                                              |                                                                                                                                                                                                                                               |

| Date        | Source of Information                                             | Contact with or by the Victim or Perpetrator | Contact with the Children                                                                                                              | Communication (identify if within agency or to another agency)                                                                                                                                                                        | Actions taken/Decisions made                                                                                                                                   | Comments                                                                                                                                                                                                                                           |
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|             |                                                                   |                                              |                                                                                                                                        | started to hit him about his head and generally slapping him about. The teacher who witnessed the assault was not identified. When his teacher questioned C3 about a black eye, he stated that he got kicked in the face at playtime. |                                                                                                                                                                |                                                                                                                                                                                                                                                    |
| 20 Jun 1995 | Police > Family Protection Form ref 343/95                        |                                              |                                                                                                                                        | Police have strategy meeting with Social Services Department (SSD).                                                                                                                                                                   | SSD have a long list of referrals about this family but no Police involvement.                                                                                 | 15:00 hours.                                                                                                                                                                                                                                       |
| 20 Jun 1995 | Luton Council > Beds C.C.. Children's services. Luton Area office | Referral from <i>(Redacted)</i> School       | Telephone referral to advise of witnessing C3 aged 11 being beaten by his mother Adult B. Child was seen by a social worker and police | Telephone referral to a duty social worker outlining the referral details.<br><br>Strategy discussion minutes are non-dated and identifiable only by an action (4) no contact until 21\6\95<br><br>The minutes do not record          | The strategy discussion document<br><br>Has 6 actions recorded:<br><br>"1, gain more info from school<br><br>.2, contact Doctor.<br><br>3, Contact teacher for | The referral advised of School staff witnessing mother, Adult B "really laying into C3 Slapping him, shoving him with her knee. C3 returned to school the following day with an additional bruise near his left eye.<br><br>The Child, C3 was seen |

| Date | Source of Information | Contact with or by the Victim or Perpetrator | Contact with the Children      | Communication (identify if within agency or to another agency)                          | Actions taken/Decisions made                                                                                                                                                                                                                                                                                                                                                                                                                                 | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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|      |                       |                                              | officer at school on 21-06-'95 | those present although there appear to be 5 signatures on the colour coded record sheet | <p>statement.</p> <p>4, no contact until 21\6\95.</p> <p>5, contact mother.</p> <p>6,consider medicals+photographs”</p> <p>A non-dated child protection colour coded Summary of investigation sheet is present.</p> <p>Two decisions are present.</p> <p>“1, request school GP and health visitor to monitor situation.</p> <p>2, NFA and close “</p> <p>“The established facts are witnesses were too far away to be reliable. Mother had hit child but</p> | <p>and spoken with and the outcome appears inconsistent with the witnessed incident and injuries sustained.</p> <p>There does not appear to be a transcript /process recording of the interview within case files one or two.</p> <p>Children’s services had considered the school staff who had witnessed the incident whilst watching behind net curtains to have been unreliable.</p> <p>Whilst the distance of the window to the place of incident is not recorded</p> <p>It is apparent the staff</p> |

| Date | Source of Information | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
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|      |                       |                                              |                           |                                                                | <p>not excessively. Despite previous concerns of the parenting by Adult B the home environment is considered more stable. Adult B has remarried and would not welcome social work involvement conversely it would add more stress".</p> <p>Several Child protection colour coded, hand written social worker case records are also present. One typed record sheet records the Social worker and Police officer to be dissatisfied with the account of incident provided by Adult B and C3 .However, the professionals did not consider C3 to be at serious risk from Adult B.</p> | <p>saw sufficient inappropriate behaviour by mother, Adult B to be sufficient concern to merit service intervention by Children's services.</p> <p>It is not evident why a member of the school staff had not Intervened at the time of incident .It is reasonable for the reader to presume staff had been afraid of Mother, Adult B.</p> <p>A letter of 05-07--'95 from a care organiser in the Luton child protection team to Mother, Adult B, advises of a planned home visit to discuss "any need for future social services involvement".</p> <p>The summary of</p> |

| Date        | Source of Information                      | Contact with or by the Victim or Perpetrator | Contact with the Children                                                                                        | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                                                                                                         | Comments                                                                                                                                                                                                                                                                                                                      |
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|             |                                            |                                              |                                                                                                                  |                                                                | Letters were sent to the GP, Head Teacher and Health Visitor 21-09-'95 advising of the investigation outcomes and requesting professionals to monitor the family and refer any concerns.             | <p>investigations provides verification of why Luton Children's Services closed the case.</p> <p>A file and IMR reader might reasonably question the rational of the section 47 investigation processes and outcome.</p> <p>In consideration of the available information the decision to NFA appears equally mystifying.</p> |
| 21 Jun 1995 | Police > Family Protection Form ref 343/95 | Adult B<br>C3                                | Officers then went to <i>(Redacted)</i> Junior School where they spoke to C3 who gave a breakdown of his family. |                                                                | Officer spoke to Adult B. She was quite aggressive, but eventually allowed the officers inside the house. Adult B allowed the officers to see C3 but would not consent to a medical examination. She | 13:20 hours                                                                                                                                                                                                                                                                                                                   |

| Date        | Source of Information                        | Contact with or by the Victim or Perpetrator | Contact with the Children                                                                                                                                                                        | Communication (identify if within agency or to another agency)                                                                                                       | Actions taken/Decisions made | Comments    |
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|             |                                              |                                              | When asked about the incident outside the school, he stated that he deserved to get hit because he lost his hat. The injuries were not as a result of his mother hitting him. NFA. SSD informed. |                                                                                                                                                                      | said he had sunburn.         |             |
| 25 Nov 1995 | Police > Bedfordshire Police.<br><br>URN 224 | Adult B                                      |                                                                                                                                                                                                  | <b>Report of assault. Location of incident:</b> <i>(Redacted)</i> , <b>Luton.</b> 999 call received from Adult B stating that she had been beaten up by her husband. | Graded response – routine    | 10:05 hours |

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| 25 Nov 1995 | Police > Bedfordshire Police.<br><br>URN 224 | Adult B<br><br>H3                            |                           | Adult B states she has locked her husband outside but he is trying to get in. He has hit her across her back with a lump of wood. It is not bleeding and she does not need an ambulance.                                                                                                                                                |                                                                                                    | 10:09 hours |
| 25 Nov 1995 | Police > Bedfordshire Police.<br><br>URN 224 | Adult B and H3                               |                           |                                                                                                                                                                                                                                                                                                                                         | Officers arrived at scene. Male has made off down alleyway, his name is H3. Area search commenced. | 10:11 hours |
| 25 Nov 1995 | Police > Bedfordshire Police.<br><br>URN 224 |                                              |                           | <b>Update:</b> Adult B had suffered injuries to her back, forearm and face, but does not wish hospital treatment. Long standing argument between husband and wife. Declined to make a formal complaint but will contact a solicitor. Comment added – Any further calls to location to be treated as urgent. Offender made off on Police | Crime ref 51061/1995<br>Filed NFA.                                                                 | 10:49 hours |

| Date        | Source of Information                                                        | Contact with or by the Victim or Perpetrator                                                                                                                                           | Contact with the Children                                                | Communication (identify if within agency or to another agency)                                                                                                                                                                                                                                                                          | Actions taken/Decisions made                                                                                                                                                                                                                                                                                   | Comments                                                                                                                                                                                                                                                                                  |
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|             |                                                                              |                                                                                                                                                                                        |                                                                          | arrival and has not yet been advised regarding his conduct.                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                           |
| 01 Mar 1996 | Cornwall PCT > Accident and Emergency Department, <i>(Redacted)</i> Hospital | Adult B                                                                                                                                                                                |                                                                          | Letter from A+E                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                | 'Hit head on kitchen cupboard...not (knocked out)...vision blurred...tender right side of neck..'                                                                                                                                                                                         |
| 17 May 1996 | Luton Council > Luton Borough Council Children's Services                    | Referral from non-stated school advising of C4 aged 8, having cut on the back of her head. The explanation by C4 is of being hit on the head by her mother Adult B with a shower head. | No contact date with C4, could be located within case files one and two. | The referral also included information of the child, C4 being bruised on 13-01-'96 and her appearance neglectful on 09-02-'96.<br><br>The school advised children's services of not previously referring the latter incidents and concerns.(explanation for the school not referring latter concerns is not evident in the case files.) | A colour coded hand written Child protection Summary of investigations sheet non dated but dated as closed 24/6/96 is present on case file one. No professionals are named/identified on the investigation sheet<br><br>The initial allegation clearly records C4 being cut on the head by mother whist in the | There is no apparent investigation or record of verification with Police concerning mother Adult B attacking another parent in the playground<br><br>There is additionally no record of verification \or contact with Police concerning the information of mother stabbing her husband in |

| Date        | Source of Information | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                                                                                                                                                                                                                    | Actions taken/Decisions made                                                                                                                                                                                                                                                                                                   | Comments                                                                                                                                                                                                                                                                                                                                                                                                      |
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|             |                       |                                              |                           | <p>Additionally the school advised of an incident of Adult B attacking another parent in the school playground. The Police had been called. The school believed the police had notified children's services of the incident.</p> <p>The school also reported Adult B to have stabbed her husband in a leg severing an artery.</p> | <p>shower at home.</p> <p>"Established facts are recorded as C4 jumping up and hitting her head on shower unit". Explanation by mother and child is recorded as plausible No medical concerns. "If Parent is lying it is too late to investigate."</p> <p>Decision to NFA and close due to no significant harm identified.</p> | <p>the leg.</p> <p>It is not possible to confirm if the school were recalling the earlier incident of H2 being stabbed or a new incident concerning the 3rd husband of Adult B</p> <p>Additional recording on social work record sheets state the school nurse refused to examine the cut on the head of child C4 17-05-'96 insisting "the examination should be completed by a clinical medical officer"</p> |
| 25 Jul 1996 | Cornwall PCT > GP     | Adult B                                      |                           | Lloyd George record - handwritten                                                                                                                                                                                                                                                                                                 | Mensol - 20                                                                                                                                                                                                                                                                                                                    | '...Mood swings v bad – temper – tearful – shouts at kids – 2 relationships ruined – 3rd partner                                                                                                                                                                                                                                                                                                              |

| Date        | Source of Information                     | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                      | Comments                                                                                                          |
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|             |                                           |                                              |                           |                                                                |                                                                                                   | already getting worried. Stabbed the 1st husband in the leg 5 years ago...'                                       |
| 23 Oct 1996 | Cornwall PCT > GP                         | Adult B                                      |                           | Lloyd George record - handwritten                              | Mensol 20                                                                                         | 'Mood swings same...not tearful... not tired...full-fledged fight with husband last week. (pre period)...'        |
| 25 Jun 1998 | Cornwall PCT > <i>(Redacted)</i> Hospital | Adult B                                      |                           | Letter from Consultant Gynaecologist                           | Listed for surgery. Trans-cervical resection of endometrium for heavy periods performed 17/08/98. | 'Her PMS has not been so bad recently since you commenced her on Lustral.' ( <i>Antidepressant</i> ).             |
| 07 Jul 1998 | Cornwall PCT > GP                         | Adult B                                      |                           | Lloyd George record - handwritten                              | Prescribed sertraline 50mg once daily ( <i>Lustral</i> )                                          | 'Depressive illness.'                                                                                             |
| 15 Mar 1999 | Cornwall PCT > GP                         | Adult B                                      |                           | Lloyd George record - handwritten                              |                                                                                                   | 'Depression ++ with mood swings – to go back onto sertraline (relationship problems, unhappy (with) work etc)...' |
| 21 Jun      | Cornwall PCT >                            | P                                            |                           | Lloyd George record -                                          |                                                                                                   | 'Adjustment reaction+                                                                                             |

| Date        | Source of Information                                 | Contact with or by the Victim or Perpetrator                                                                 | Contact with the Children                                | Communication (identify if within agency or to another agency)                                                                         | Actions taken/Decisions made                                                                                                                                                                                                            | Comments                                                                                                                                                                                                                                                                                                                                     |
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| 1999        | GP                                                    |                                                                                                              |                                                          | handwritten                                                                                                                            |                                                                                                                                                                                                                                         | tearful+ agitation + boyfriend split.'                                                                                                                                                                                                                                                                                                       |
| 10 Aug 1999 | Cornwall PCT > GP                                     | P                                                                                                            |                                                          | Lloyd George record - handwritten                                                                                                      |                                                                                                                                                                                                                                         | 'Better. Domestic situation – not good. Bruising ++ R orbit; bruising ++ L orbit finger-shaped bruises left mandible and left iliac fossa (hip/groin area)'                                                                                                                                                                                  |
| 14 Apr 2000 | Luton Council > Luton B.C.<br><br>Children's services | Referral from <i>(Redacted)</i> school. Notification of C4, aged12, being hit on left arm by mother ,Adult B | No contact apparent with C4 correlating to the referral. | Referral received from school of C4. In addition a completed form for designated teachers outlines the bruising on the left arm of C4. | A letter to mother 15-05-'00 requesting contact with the Initial assessment team concerning the referral 14-04-'00. A further letter on 14-08-'00 requesting contact as a matter of urgency due to non-response to the letter 15-05-'00 | Social worker case recordings 10-05 to 31-10-'00 record the non-responses by mother, Adult B to contact the Luton Children's Services Initial Assessment Team.<br><br>It is not possible to determine from case files one and two why contact was not attempted until approximately four weeks after the referral and by correspondence only |

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|      |                       |                                              |                           |                                                                |                              | <p>until 31-10-'00? (6 months)</p> <p>It appears Mother Adult B and the children were resident at a different address when telephone contact was established 31-10-'00 (the details of new address do not appear to have been recorded?)</p> <p>In addition to the referral of possible physical abuse 14-04-'00 Luton Children 's services Initial Assessment Team received a referral from an Education Welfare Officer informing of C4, causing concern due to persistent truanting and behavioural problems at school and outside of school. "C4 is often fearful</p> |

| Date        | Source of Information          | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)         | Actions taken/Decisions made                          | Comments                                                                                                                                                                                                                                                                              |
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|             |                                |                                              |                           |                                                                        |                                                       | of returning home”.                                                                                                                                                                                                                                                                   |
| 27 Jun 2000 | Cornwall PCT > GP              | Adult B                                      |                           | Lloyd George record - handwritten                                      | Referred to gynaecologist<br>Referred to psychiatrist | ‘Mood swings++ heavy periods ++<br>...depression++’                                                                                                                                                                                                                                   |
| 30 Jun 2000 | Cornwall PCT > GP              | Adult B                                      |                           | Referral letter to Psychiatrist, <i>(Redacted)</i> , Beds              |                                                       | ‘...severe mood swings...for at least 12 months. She describes it as “like severe PMT” which has progressively got worse with aggressive outbursts, sleep disturbance...increasingly severe mood swings...I think she has had problems in the past with domestic violence at home...’ |
| 16 Aug 2000 | Cornwall PCT > Psychiatry team |                                              |                           | Letter from Team Administrator, Bedfordshire and Luton Community Trust | No follow-up appointment was arranged.                | In response to appointment to see Consultant Psychiatrist on 15/08/00: ‘she neither cancelled nor attended                                                                                                                                                                            |

| Date        | Source of Information                        | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                                                                                                                                      | Actions taken/Decisions made                                    | Comments            |
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|             |                                              |                                              |                           |                                                                                                                                                                                                                                                     |                                                                 | the appointment...' |
| 07 Sep 2000 | Cornwall PCT > <i>(Redacted)</i> Hospital    |                                              |                           | Letter from Consultant Gynaecologist                                                                                                                                                                                                                | Scheduled for hysterectomy and removal of ovaries for 7/12/2000 | Menorrhagia and PMS |
| 26 Sep 2000 | Police > Bedfordshire Police.<br><br>URN 287 |                                              |                           | <b>Report of missing person. Location of incident:</b> <i>(Redacted)</i> , Luton. Adult B states her daughter; C4 aged 12 has not attended school and not returned home. Adult B has been to where she believes C4 is, to be told she is not there. | Graded response – routine.                                      | 18:02 hours         |
| 26 Sep 2000 | Police > Bedfordshire Police<br><br>URN 287  |                                              |                           | Further call from Adult B asking why nobody has attended. Description of C4 given. She has now been seen wandering around the estate. She has never done this before. She is hanging around with a girl called <i>(Redacted)</i> . Adult B          |                                                                 | 20:26 hours         |

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|             |                                             |                                              |                           | informed that as she said she knew where her daughter was she was not considered missing. No officers available at this time.   |                                                                                                                     |                                                   |
| 26 Sep 2000 | Police > Bedfordshire Police<br><br>URN 287 |                                              |                           | Adult B spoken to again who states that she has heard that her daughter and <i>(Redacted)</i> are planning to run away tonight. | To be allocated to night shift and suggest it is dealt with quickly due to the age of the missing person.           | 21:38 hours                                       |
| 26 Sep 2000 | Police > Bedfordshire Police<br><br>URN 287 |                                              |                           |                                                                                                                                 | Officer arrived. Child located at house elsewhere in the road and taken home. Not clear why she denied being there. | 23:24 hours                                       |
| 19 Mar 2001 | Cornwall PCT > <i>(Redacted)</i> Hospital   |                                              |                           | Letter from Consultant Gynaecologist                                                                                            | No follow-up appointment was arranged.                                                                              | 'You did not attend your planned hysterectomy...' |
| 01 Apr 2001 | Police > Bedfordshire                       | Adult B and C4                               |                           | <b>Report of missing person.</b><br><b>Location:</b> <i>(Redacted)</i> , Luton.                                                 | Graded response - routine                                                                                           | 20:56 hours                                       |

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|             | Police.<br><br>URN 449                       |                                              |                           | H2 reporting his daughter C4 aged 13 years missing. Last seen 18:00 hours. Last went missing three months ago. Informant has been to an address but the occupant's state she is not there. Believe they are lying. H2 states that he will start hitting people soon if he does not get a response. |                                                 |                                               |
| 01 Apr 2001 | Police > Bedfordshire Police.<br><br>URN 449 |                                              |                           | Missing person arrived home.                                                                                                                                                                                                                                                                       | Found at address visited by the father earlier. | 23:51 hours                                   |
| 06 May 2001 | Police > Bedfordshire Police.<br><br>URN 154 | Adult B and C4                               |                           | <b>Report of missing person.</b><br>Adult B reporting her daughter C4 aged 13 years. Left house at 08:30 hours on Friday and has not been back since.                                                                                                                                              | Graded response – routine.                      | 11:41 hours<br><br>Not reported for two days. |
| 06 May      | Police >                                     |                                              |                           |                                                                                                                                                                                                                                                                                                    | Officer arrived at                              | 20:40 hours                                   |

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| 2001        | Bedfordshire Police.<br><br>URN 154          |                                              |                           |                                                                | incident. Missing person is believed to be staying at a sleepover party at home address of a <i>(Redacted)</i> , but informant does not know the address. Voters reveal <i>(Redacted)</i> in Luton. Missing persons report completed. | Mother does not know where her 13 year old is staying. |
| 07 May 2001 | Police > Bedfordshire Police.<br><br>URN 154 |                                              |                           |                                                                | From mother, C4 is now at home; they are just going out, will be back at home at 19:00 hours. Mother collected C4 from the town at 02:00 hours this morning. Mother is put-out about us going to see C4.                              | 11:52 hours                                            |
| 07 May 2001 | Police > Bedfordshire Police.                |                                              | C4                        |                                                                | Seen alive and well. PNC missing persons report cancelled.                                                                                                                                                                            | 23:03 hours                                            |

| Date        | Source of Information                                 | Contact with or by the Victim or Perpetrator                                                                                                                           | Contact with the Children                                                               | Communication (identify if within agency or to another agency)                                                                                                                                                                                                                                                      | Actions taken/Decisions made                                                                                                                                                                                                                                                     | Comments                                                                                                                                                                                                                                                                              |
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|             | URN 154                                               |                                                                                                                                                                        |                                                                                         |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                       |
| 20 May 2001 | Police > Bedfordshire Police.<br><br>URN 457          | Adult B                                                                                                                                                                | C4                                                                                      | <b>Report of missing person.</b><br>Adult B reporting her daughter C4 missing. Last seen by mother on the 18/05/01, but seen by C4's friend earlier today.                                                                                                                                                          | Graded response – Routine. Comment on log indicating C4 goes missing regularly. Last time was two weeks ago.                                                                                                                                                                     | 21:50 hours                                                                                                                                                                                                                                                                           |
| 20 May 2001 | Police > Bedfordshire Police                          |                                                                                                                                                                        |                                                                                         |                                                                                                                                                                                                                                                                                                                     | C4 has just arrived home, safe and sound. Incident closed.                                                                                                                                                                                                                       | 22:22 hours<br><br>No checks made?                                                                                                                                                                                                                                                    |
| 22 May 2001 | Luton Council > Luton B.C.<br><br>Children's Services | Referral from Education Social Worker – <i>(Redacted)</i> School.<br><br>Luton Children's Services informed of issues relating to C4, aged 13, poor school attendance, | Contact with child not apparent within case files one and two relating to the referral. | A letter was sent to mother ,Adult B on 23-05-'01 .A copy of the letter has "responded 06-6-'01" recorded on it .<br><br>Further correspondence appears to have been sent to the referrer on 15-10-'01 advising of no contact with Mother, Adult B "and the case file will be closed on 15-10-'01 as it is presumed | Correspondence sent by Children's Services to Mother Adult B, is apparent (2 letters in 5 months) and non - responses to the contact also apparent.<br><br>Decision was taken of non-intervention during October 2001 with letter to Mother, Adult B 09-10-'01 and the referring | 22.05.01 – 15.10.01.It is inexplicable why only two letters were sent by children's services attempting to engage mother during the five month period following the referral when the strategy discussion document clearly recorded the accumulative concerns regarding the safety of |

| Date | Source of Information | Contact with or by the Victim or Perpetrator                           | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Comments                                                                                                                                                                                                                         |
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|      |                       | behavioural problems and "mother Adult B does not appear to be coping" |                           | no social work input is required".                             | <p>Education Welfare Officer 15-10-'01.</p> <p>There is a hand written Chid protection colour coded strategy discussion document dated 06-06-'01 of which appears to be related to accumulative referrals of concern /safety of Child,C4 26-09-'00. There are three signatures present but no other identification of the professional involved in the discussion. Actions agreed:</p> <p>"1,Speak to Mum (Adult B)</p> <p>2, contact Dad (H2?)</p> <p>3, School check on C5,</p> | <p>the child C4.</p> <p>This is the last document located on Case file two. There do not appear to be any other contacts concerning Adult B and her children after 17-01-0202.within Bedfordshire or other local authorities</p> |

| Date        | Source of Information                                                             | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                                                                           | Comments          |
|-------------|-----------------------------------------------------------------------------------|----------------------------------------------|---------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
|             |                                                                                   |                                              |                           |                                                                | aged 7"<br><br>There are school logs of the issues concerning C4 08-09-'00 to 09-05-'01 of which document the truanting and behavioural problems of C4 |                   |
| 01 Jun 2001 | Police > Bedfordshire Police<br><br>Child Protection form 271/01<br><br>CATS 7220 |                                              |                           |                                                                | Referral to SSD re C4 a regular missing person. Concerns raised.                                                                                       | CATS 7220 refers. |
| 06 Jun 2001 | Police > Bedfordshire Police<br><br>Child Protection form 271/01                  |                                              |                           | Strategy meeting with SSD.                                     | Single agency enquiry at this time by SSD. No further Police action.                                                                                   |                   |

| Date        | Source of Information                                | Contact with or by the Victim or Perpetrator                                                 | Contact with the Children                   | Communication (identify if within agency or to another agency)                                                                                 | Actions taken/Decisions made                                                                                                                                         | Comments                                                                                                                                                                                                                                |
|-------------|------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 17 Jan 2002 | Luton Council > Luton B.C<br><br>Children's Services | Part referral from ( <i>Redacted</i> ) School concerning C4 aged 13, re: continuing concerns | No contact with the child could be located. | Page one of the school referral is absent from the case file                                                                                   | No other recording appears present relating to the referral                                                                                                          | C4 had informed school of being picked on by her mother Adult B. School report Issues at school for C4 continue.<br><br>This is the last recorded contact at Luton Children's Services concerning Adult B and any member of her family. |
| 03 Feb 2002 | Police > Bedfordshire Police<br><br>URN 119          | Adult B                                                                                      | C4                                          | <b>Report of Missing Person.</b><br><b>Location:</b> ( <i>Redacted</i> ) Adult B reporting her daughter C4 missing. Last seen Friday at 08:30. | Graded response: routine. No units available.                                                                                                                        | 09:21 hours                                                                                                                                                                                                                             |
| 03 Feb 2002 | Police > Bedfordshire Police<br><br>URN 119          |                                                                                              |                                             |                                                                                                                                                | From Oscar 1. This is a 14 year old who appears to have been missing since Friday. Obtain more details. Inf. States she has gone missing before but always returned. | 11:36 hours                                                                                                                                                                                                                             |

| Date        | Source of Information                       | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                        | Actions taken/Decisions made                                                                                | Comments    |
|-------------|---------------------------------------------|----------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------|
|             |                                             |                                              |                           |                                                                                                                                       | Mother does not sound overly concerned.                                                                     |             |
| 03 Feb 2002 | Police > Bedfordshire Police<br><br>URN 119 |                                              |                           |                                                                                                                                       | Officer arrives at scene. Missing person form completed. Request circulation, may be in <i>(Redacted)</i> . | 12:37 hours |
| 03 Feb 2002 | Police > Bedfordshire Police<br><br>URN 119 |                                              | C4                        | Call from Adult B. Missing person has returned home.                                                                                  |                                                                                                             | 20:29 hours |
| 03 Feb 2002 | Police > Bedfordshire Police<br><br>URN 119 |                                              | C4                        |                                                                                                                                       | C4 seen and advised. PNC cancelled.                                                                         | 21:18 hours |
| 24 May 2002 | Police > Bedfordshire Police                |                                              |                           | <b>Report of missing person.</b><br><b>Location:</b> <i>(Redacted)</i> . Adult B reporting her daughter C4 missing since 20:00 hours. |                                                                                                             | 00:53 hours |

| Date        | Source of Information                      | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                             | Actions taken/Decisions made                                          | Comments    |
|-------------|--------------------------------------------|----------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------|
|             | URN 11                                     |                                              |                           | Suffers from asthma. Not known if she has medication with her. Mobile phone turned off.                                                    |                                                                       |             |
| 24 May 2002 | Police > Bedfordshire Police<br><br>URN 11 |                                              |                           |                                                                                                                                            | Officer arrives at scene. Missing person form completed. PNC updated. | 01:08 hours |
| 24 May 2002 | Police > Bedfordshire Police<br><br>URN 11 |                                              |                           | C4 returned home.                                                                                                                          |                                                                       | 07:55 hours |
| 24 May 2002 | Police > Bedfordshire Police<br><br>URN 11 |                                              |                           |                                                                                                                                            | C4 seen alive and well. PNC updated.                                  | 08:39 hours |
| 17 Oct 2002 | Police > Bedfordshire Police               |                                              |                           | <b>Report of Missing Person.</b><br><b>Location:</b> <i>(Redacted)</i> <b>Adult B</b> reporting her daughter C4 missing since 16:30 hours. | Graded response – High.                                               | 01:24 hours |

| Date        | Source of Information                                | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                             | Actions taken/Decisions made                                                                                                                              | Comments    |
|-------------|------------------------------------------------------|----------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
|             | URN 20                                               |                                              |                           | Informant also states C4 is suspended from school. C4 stated she was going to her father's address, but informant states she is not there. |                                                                                                                                                           |             |
| 17 Oct 2002 | Police > Misper form<br>40CH/MFH674/02<br><br>URN 20 |                                              | C4                        |                                                                                                                                            | Officer arrived at scene. Officer states C4 may be at ( <i>Redacted</i> ), Luton. Checking now. Placed on PNC as missing. Missing Person Forms completed. | 01:36 hours |
| 17 Oct 2002 | Police > Bedfordshire Police<br><br>URN 20           |                                              | C4                        | Comment from Insp.1182. Missing person had been seen at fathers h/a at 21:00 hours.                                                        |                                                                                                                                                           | 08:54 hours |
| 18 Oct 2002 | Police > Bedfordshire Police                         |                                              |                           | Information from mother that C4 has just returned home.                                                                                    |                                                                                                                                                           | 15:50 hours |

| Date        | Source of Information                                  | Contact with or by the Victim or Perpetrator | Contact with the Children                                                          | Communication (identify if within agency or to another agency)                                                                                                                                                                                                                                 | Actions taken/Decisions made                                            | Comments                            |
|-------------|--------------------------------------------------------|----------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------|
|             | URN 20                                                 |                                              |                                                                                    |                                                                                                                                                                                                                                                                                                |                                                                         |                                     |
| 18 Oct 2002 | Police > Bedfordshire Police<br><br>URN 20             |                                              | C4 seen by officer. Alive and well. She was with a friend <i>(Redacted)</i> Luton. |                                                                                                                                                                                                                                                                                                | PNC and Missing person forms cancelled.                                 | 16:10 hours                         |
| 14 Jan 2003 | Police > Bedfordshire Police<br><br>Crime ref. 4549/03 |                                              | C4                                                                                 | <b>Allegation of Common Assault. Location of incident: <i>(Redacted)</i>, Luton.</b><br>PM born (19), boyfriend of C4 (14), alleging that at between 00:10 hours and 00:20 hours on the 13/01/2003 Adult B drove her car at him striking his foot after finding him with C4. No injury caused. | Witness statement obtained from aggrieved, PM.                          | 20:00 hours<br><br>No referral made |
| 10 Feb 2003 | Police > Bedfordshire Police                           | Adult B                                      |                                                                                    |                                                                                                                                                                                                                                                                                                | Adult B interviewed and admitted the offence. She was given a 'Caution' |                                     |

| Date        | Source of Information                        | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                                                               | Actions taken/Decisions made                                                                                      | Comments                                                |
|-------------|----------------------------------------------|----------------------------------------------|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
|             | Crime ref. 4549/03                           |                                              |                           |                                                                                                                                                                              | for Common Assault.                                                                                               |                                                         |
| 02 May 2003 | Police > Bedfordshire Police.<br><br>URN 375 |                                              | F                         | <b>Report of assault. Location of incident: (Redacted). C4</b> reporting that she had been beaten up by her mother. Informant is very scared and upset. She is 15 years old. | Graded response - Immediate                                                                                       | 21:23 hours<br><br>Crime file 23248/2003 not available. |
| 02 May 2003 | Police > Bedfordshire Police.<br><br>URN 375 |                                              |                           |                                                                                                                                                                              | Officers arrived. C4 has sustained bruising to eye and marks to hand. C4 taken to aunties. Mother to be arrested. | 21:32 hours                                             |
| 02 May 2003 | Police > Custody record<br>DH/1657/03        | Adult B                                      |                           |                                                                                                                                                                              | Adult B arrested                                                                                                  | 21:43 hours                                             |
| 02 May 2003 | Police > Custody record<br>DH/1657/03        | Adult B                                      |                           |                                                                                                                                                                              | Released on Police bail pending further enquiries to return on the 06/07/2003.                                    | 23:44 hours                                             |
| 08 May      | Bedford Council >                            | Reported C4                                  |                           |                                                                                                                                                                              | Police took C4 to her                                                                                             |                                                         |

| Date        | Source of Information                        | Contact with or by the Victim or Perpetrator                                  | Contact with the Children                                                                                                                                        | Communication (identify if within agency or to another agency) | Actions taken/Decisions made                                                                               | Comments               |
|-------------|----------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------|
| 2003        | Referral received from Police (Police)       | had run out of home because her mother had punched her and scratched her hand |                                                                                                                                                                  |                                                                | dads in <i>(Redacted)</i><br><br>Strategy meeting proposed for 4pm 8.05.03                                 |                        |
| 26 May 2003 | Bedford Council > Telephone call from Police |                                                                               | C4 informed Police she is now living with her dad and no longer wishes to make a complaint against her mother but agreed they need to explore all possibilities. |                                                                | Police to contact <i>(Redacted)</i> police as C4's Dad (H2) who refused to bring C4 to <i>(Redacted)</i> . |                        |
| 26 May 2003 | Bedford Council > Telephone call from Police | C4 has returned to the area, staying with a                                   | C4 no longer wants to pursue the                                                                                                                                 |                                                                |                                                                                                            | There was no date here |

| Date        | Source of Information                 | Contact with or by the Victim or Perpetrator    | Contact with the Children | Communication (identify if within agency or to another agency)              | Actions taken/Decisions made                                                                                | Comments                                                                                                                                                                                                |
|-------------|---------------------------------------|-------------------------------------------------|---------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|             |                                       | friend but then moving back in with her mother. | incident.                 |                                                                             |                                                                                                             |                                                                                                                                                                                                         |
| 02 Jun 2003 | Police > Custody record<br>DH/1657/03 | Adult B                                         |                           |                                                                             | Released from her obligation to answer bail. No further action. Total time in custody – 1 hour, 29 minutes. | 14:24 hours                                                                                                                                                                                             |
| 16 Dec 2003 | Cornwall PCT > GP                     |                                                 |                           | Referral letter to Consultant Gynaecologist for severe premenstrual tension |                                                                                                             | 'During the discussion about her PMT (Adult B)... became aggressive...she told me that she had stabbed a previous partner as a result of PMT...and that he subsequently died on the operating table...' |
| 29 Jun 2004 | Cornwall PCT > GP                     |                                                 |                           | Registered at ( <i>Redacted</i> ) Surgery Liskeard                          |                                                                                                             |                                                                                                                                                                                                         |
| 21 Mar 2005 | Cornwall PCT > Plymouth               | Adult B                                         |                           | Letter from Consultant Gynaecologist                                        |                                                                                                             | '...the main problem seems to be PMT...'                                                                                                                                                                |

| Date        | Source of Information                         | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                                                                                      | Actions taken/Decisions made                                                                           | Comments                                                                                                                                 |
|-------------|-----------------------------------------------|----------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
|             | Hospitals NHS Trust                           |                                              |                           |                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                          |
| 21 Aug 2005 | Education > <i>(Redacted)</i> School          |                                              | C5                        | Report by another pupil alleging bullying by C5. 'The bullying has started again. In German today (13/10/06) , she kept poking me, called me a skank threw a rubber at me and put glue on my chair' | C5 accused of bullying 'poking another pupil, name calling, throwing object and putting glue on chair' |                                                                                                                                          |
| 19 Apr 2006 | Cornwall PCT > <i>(Redacted)</i> Cornwall PCT |                                              |                           | Letter from Associate Specialist in Gynaecology                                                                                                                                                     | Scheduled for hysterectomy and removal of ovaries which was performed on 4/08/2006.                    | 'Her partner calls her a "tamed lion" as the GnRH <i>(analogue – i.e. hormone suppressant therapy)</i> has now taken away her symptoms.' |
| 14 Jun 2006 | Education > <i>(Redacted)</i> School          | Student referral form                        |                           | The student referral form reports that C5 hit another pupil around the face causing a nose bleed.                                                                                                   | Dealt with by the teacher.                                                                             |                                                                                                                                          |
| 26 Sep 2006 | Education > <i>(Redacted)</i>                 | Student referral form                        |                           | Deliberately disruptive.                                                                                                                                                                            | Head of Dept, Head of Year and tutor informed.                                                         |                                                                                                                                          |

| Date        | Source of Information         | Contact with or by the Victim or Perpetrator  | Contact with the Children                                                                                                                                     | Communication (identify if within agency or to another agency)                                                       | Actions taken/Decisions made                      | Comments                                 |
|-------------|-------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------|
|             | School                        |                                               |                                                                                                                                                               |                                                                                                                      |                                                   |                                          |
| 13 Oct 2006 | Education > (Redacted) School | Student referral form                         |                                                                                                                                                               | Student referral form reports that C5 hit another pupil (male) in the face so hard that he was seriously distressed. | Reported to Head of Year, Head of Dept and tutor. |                                          |
| 08 Nov 2006 | Education > (Redacted) School | Letter to Adult B about C5's recent behaviour | Letter alleges that C5 has been verbally attacking another girl in Year 8. The letter asked the parent to contact the school if they wish to discuss further. | Letter to parent.                                                                                                    |                                                   |                                          |
| 10 Nov 2006 | Cornwall PCT > GP             | Adult B                                       |                                                                                                                                                               | GP computerised medical record                                                                                       | Increased HRT dose                                | 'Emotionally and HRT wise feeling awful' |

| Date        | Source of Information                | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                                                                                                                          | Actions taken/Decisions made                   | Comments                        |
|-------------|--------------------------------------|----------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------|
| 28 Nov 2006 | Education > <i>(Redacted)</i> School | Student referral form                        | Parent informed           | The student referral form reports that C5 had been disruptive, singing, refusing to do any work for the first half of the lesson and also continually on mobile phone.                                                                  | Head of Dept, Head of Year and Tutor informed. |                                 |
| 14 Dec 2006 | Cornwall PCT>GP                      | Adult A                                      |                           | Depression screening questionnaire                                                                                                                                                                                                      |                                                | Not symptomatic with depression |
| 10 Jan 2007 | Cornwall PCT > GP                    | Adult B                                      |                           | GP computerised medical record                                                                                                                                                                                                          | Changed HRT                                    | 'Mood problems. '               |
| 15 Jan 2007 | Education > <i>(Redacted)</i> School | Student Referral Form                        |                           | Report that C5 shouted at another pupil                                                                                                                                                                                                 | Matter resolved by the teacher.                |                                 |
| 15 May 2007 | Education > <i>(Redacted)</i> School | Letter to Adult B (C5's mother)              | Letter to Parent          | Letter re non-attendance at school. C5 had been absent from school since the 11 <sup>th</sup> May 2007. Letter requesting the mother to contact the attendance officer at <i>(Redacted)</i> School to provide reasons for the absences. |                                                |                                 |

| Date        | Source of Information         | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                                                                                                                                                               | Actions taken/Decisions made                                | Comments                  |
|-------------|-------------------------------|----------------------------------------------|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------|
| 19 Jun 2007 | Education > (Redacted) School | Letter to Adult B (C5s mother)               | Outstanding absences.     | With mother who reported back that she couldn't remember exactly why C5 was off that afternoon, she remembers picking C5 up a few months ago because she was ill and was sure that C5 had not left school without permission | Reported to Head of Year 8 and letter placed on pupil file. |                           |
| 23 Sep 2007 | A&E (Redacted)                | Adult A                                      |                           | Letter from (Redacted) Eye Infirmary (Redacted)                                                                                                                                                                              |                                                             | Corneal abrasion to eye   |
| 24 Sep 2007 | Education > (Redacted) School | Student Referral form                        | C5                        | Argued with the teacher when she was challenged over her eye make up                                                                                                                                                         | Pastoral leader, Head of Year, head of Dept and Tutor       |                           |
| 05 Nov 2007 | Education > (Redacted) School | Student referral form                        | C5 Parents informed       | Behaviour referral form                                                                                                                                                                                                      | Head of Dept and Head of Year informed                      |                           |
| 18 Dec 2007 | Education > (Redacted) School | Student Referral Form                        | C5 Parents informed       | Behaviour referral form                                                                                                                                                                                                      | Parents informed of poor behaviour                          |                           |
| 30 Apr      | A&E (Redacted)                | Adult A                                      |                           | Letter from (Redacted) Eye                                                                                                                                                                                                   |                                                             | Corneal abrasion to right |

| Date        | Source of Information                  | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                    | Actions taken/Decisions made                                    | Comments                  |
|-------------|----------------------------------------|----------------------------------------------|---------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------|
| 2008        |                                        |                                              |                           | Infirmery ( <i>Redacted</i> )                                                     |                                                                 | eye                       |
| 03 Jun 2008 | Education > ( <i>Redacted</i> ) school | Student referral form                        | C5                        | C5 was rude and ignored instructions throughout a PE lesson and left school site. | Pastoral leader, Head of Year, Head of Dept and Tutor           |                           |
| 06 Jun 2008 | Cornwall PCT > GP                      | Adult B                                      |                           | GP computerised medical record                                                    | Changed to tibolone ( <i>HRT</i> ) PMS reduced ++ by 12/08/2008 | 'severe PMT...tearful...' |
| 12 Jun 2008 | Education > ( <i>Redacted</i> ) school | Student referral form                        | C5                        | Failure to attend Lessons                                                         | Pastoral Leader, Head of Year, Head of Dept and Tutor.          |                           |
| 08 Jul 2008 | Education > ( <i>Redacted</i> ) School | Student Referral form                        | C5                        | Used inappropriate language                                                       | Head of Year, Head of Dept, Pastoral Leader and Tutor           |                           |
| 16 Jul 2008 | Education > ( <i>Redacted</i> ) School | Student Referral Form                        | C5                        | Continuing to ignore rules and using mobile phone                                 | Head of Year, Head of Dept, Pastoral Leader and Tutor           |                           |
| 29 Sep 2008 | Education > ( <i>Redacted</i> ) School | Student Referral Form                        | Phoned home               | Very uncooperative.                                                               | Head of year informed.                                          |                           |

| Date        | Source of Information                | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)  | Actions taken/Decisions made                                          | Comments                                                               |
|-------------|--------------------------------------|----------------------------------------------|---------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------|
| 23 Oct 2008 | Education > <i>(Redacted)</i> School | Student Referral Form                        | C5                        | Verbally abused Maths teacher – used foul language.             | Head of Year informed.                                                |                                                                        |
| 25 Nov 2008 | Cornwall PCT > GP                    | Adult B                                      |                           | GP computerised medical record                                  | Prescribed fluoxetine ( <i>antidepressant</i> ) and change to new HRT | ‘Mood terrible... break up relationship...low mood...anger...volatile’ |
| 02 Dec 2008 | Cornwall PCT > GP                    | Adult B                                      |                           | GP computerised medical record                                  |                                                                       | ‘Mood calmer...less aggressive’                                        |
| 12 Jan 2009 | Education > <i>(Redacted)</i> School | Student Referral form                        | C5                        | Refused to move in lesson. Very Rude to other people.           | In DTO for 2 weeks.                                                   |                                                                        |
| 13 Jan 2009 | Education > <i>(Redacted)</i> School | Student Referral Form                        | C5                        | Rude and truanting.                                             | Head of Year informed.                                                |                                                                        |
| 24 Feb 2009 | Education > <i>(Redacted)</i> School | Student referral form                        | C5                        | Rude and truanting.                                             |                                                                       |                                                                        |
| 18 May 2009 | Education > <i>(Redacted)</i> School | Student Referral Form                        | C5                        | C5 She used rude and abusive language as she left the classroom |                                                                       |                                                                        |
| 04 Jun 2009 | GP                                   | Adult A                                      |                           | Referral letter to Consultant Urologist                         |                                                                       | <i>(Redacted)</i> ‘impacting on his relationship.’                     |

| Date        | Source of Information                | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)            | Actions taken/Decisions made              | Comments                                           |
|-------------|--------------------------------------|----------------------------------------------|---------------------------|---------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------|
| 12 Jun 2009 | Education > <i>(Redacted)</i> School | Letter                                       | C5                        | Letter expressing concern over bad behaviour by C5                        | Warned                                    |                                                    |
| 22 Sep 2009 | Education > <i>(Redacted)</i> School | Student Referral form                        | C5                        | Rude and truanting.                                                       |                                           |                                                    |
| 14 Oct 2009 | Education > <i>(Redacted)</i> School | Student Referral Form                        | C5                        | Truanting.                                                                | Detention – Pastoral Leader informed.     |                                                    |
| 21 Oct 2009 | Education > <i>(Redacted)</i> School | Student Referral form                        | C5                        | Rudeness                                                                  | Dealt with by teacher                     |                                                    |
| 12/11/2009  | Consultant endocrinologist           | Adult A                                      |                           | Letter from Endocrinology outpatient clinic.                              | Prescribed hydrocortisone injections      | Symptoms of 'tiredness, weight loss, dizziness...' |
| 19 Nov 2009 | Education > <i>(Redacted)</i> School | Letter re: Outstanding absences C5           | Letter to Adult B         | Letter asking for reasons of absence on the 22 <sup>nd</sup> October 2009 | Letter filled out and returned by Adult B |                                                    |
| 02 Dec 2009 | Practice Nurse                       | Adult A                                      |                           | Depression screening questionnaire                                        |                                           | Not symptomatic for depression                     |
| 04 Jan 2010 | Education > <i>(Redacted)</i> School | Letter: re Non-attendance at                 | Letter to Adult B         | Letter asking for update on C5 absences                                   |                                           |                                                    |

| Date        | Source of Information                | Contact with or by the Victim or Perpetrator | Contact with the Children | Communication (identify if within agency or to another agency)                   | Actions taken/Decisions made                    | Comments                       |
|-------------|--------------------------------------|----------------------------------------------|---------------------------|----------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------|
|             |                                      | school C5                                    |                           |                                                                                  |                                                 |                                |
| 18 Jan 2010 | Education > <i>(Redacted)</i> School | Letter re: January absences C5               | Letter to Adult B         | Letter asking for reasons of absence on Wednesday 13 <sup>th</sup> January 2010. | Letter returned to school with absence reasons. |                                |
| 16 Mar 2010 | Education > <i>(Redacted)</i> School | Student Referral Form                        |                           | Rude and truanting.                                                              | Break detention                                 |                                |
| 16 Feb 2011 | Practice Nurse                       | Adult A                                      |                           | Routine depression screening questionnaire                                       |                                                 | Not symptomatic for depression |

## APPENDIX C: The Duluth Model, Freedom Programme & Professor Johnson's Typologies

609. **The Duluth Model** is an internationally recognised tool to help communities eliminate violence in the lives of women and children by taking the blame off the victim and placing the accountability for abuse on the offender. In 1984 staff at the Duluth Domestic Violence Intervention Project in Minnesota created the 'Power and Control Wheel' - a tool that makes the pattern, intent and impact of domestic abuse visible to victims, abusers and professionals by documenting the most common abusive behaviours or tactics used by perpetrators of domestic abuse.
610. **The Freedom Programme** was first established in 1996 and devised to address women's awareness of the impact of abusive and dangerous relationships. It aims to educate women on how best to address and recognise abusive behaviours and tactics; understand what domestic abuse signifies and the impact it has on their dependent children. Inspired by the Duluth Power and Control Wheel, the Freedom Programme took the most common abusive behaviours and tactics to achieve power and control and created a pictorial image of a 'Dominator'. The Dominator is described as one man but changing into other characters to use different kinds of controlling behaviour. The Dominator is a person who can change from one character to another with lightning speed. The Dominator is comparable to Professor M. Johnson's typology of an 'Intimate Terrorist'
611. **Professor Michael Johnson** is the Author of '**A Typology of Domestic Violence**'. Johnson argues that domestic violence is not a unitary phenomenon. Instead, he delineates four major, dramatically different, forms of partner violence: intimate terrorism, violent resistance, mutual violent control and situational couple violence. He roots the conceptual distinctions among the forms of violence in an analysis of the role of power and control in relationship violence and shows that the failure to make these basic distinctions among types of partner abuse has produced a research literature that is plagued by both overgeneralizations and ostensibly contradictory findings.

## **APPENDIX D: Bedfordshire Police Changes to working practices since 2002**

### **Missing Persons;**

612. Since the missing person reports involving C4, numerous reviews have been conducted in relation to the policy and procedures for dealing with missing persons. These incidents would now be dealt with differently, with a view to understanding the underlying reasons for C4's behaviour in an attempt to prevent these incidents re-occurring.
613. Persons going missing from home are now viewed by Police as a strong indicator of domestic abuse within the family. Current protocol involves all 'Missing Persons Reports' being seen by officers from the Public Protection Unit with Social Services notified of individuals who had been the subject of previous referrals.
614. In 2005 Bedfordshire Police utilised the 'Compact' computer database for missing persons together with the 'Policy and Standard Operating Procedures' document relating to missing persons. This document gives clear and unambiguous guidance to all members of Bedfordshire Police when dealing with reports of missing persons. These reports are retained for two years after the missing person has been found safe and well.
615. There is also a dedicated Missing Persons Unit which oversees all reports of missing persons throughout the County. Force policy is that an Officer from the 'Missing Persons Unit' will endeavour to conduct or facilitate all return to safety interviews where the person is under 18 years of age, a vulnerable adult or subject to domestic violence or abuse.

616. The most recent policy document for missing persons is dated December 2010. This policy places responsibility on various departments and individuals to ensure the response to incidents of this nature are appropriate although it still remains the responsibility of the Patrol Officers to complete welfare checks on persons found or returning home.

617. This Review identified a loophole in current practice whereby Information relating to individuals who have been the subject of a strategy meeting with partnership agencies may not be available to Officers responding in the first instance. In this case, the responding Officers would have had no way of knowing whether the strategy meeting regarding C4 recorded any specific multi-agency actions or decisions pertaining to her future welfare. This has been identified as a recommendation for Bedfordshire Police and Devon and Cornwall Police.

### **Child Protection;**

618. In terms of agency concerns for the wellbeing of Adult B's children, the Police Service of England and Wales would now be required to follow ACPO/Centrex (2005) Guidance on Child Abuse and Safeguarding Children and the NPIA Guidance 2008 on Investigating Domestic Violence, which states "*where there is a need to carry out a joint enquiry under section S47 of the Children's Act 1989 involving social services and the police this should be undertaken in accordance with the guidance set out in working together to safeguard children (2013)*".

619. Bedfordshire Police Policy and Standard Operating Procedures for Child Abuse now require all Police Officers and staff who have concerns for the welfare of children to submit a report (Form 745) to the Child Abuse Investigation Unit.

620. It became apparent during this review that a vast amount of information was available to professionals to suggest that Adult B was a cause for concern, yet important information held particularly within education and medical records does not appear to have been shared with Police or Social Services and vice versa.

621. Information sharing over the last 10 years has improved greatly. Public Inquiries such as the Lord Laming Inquiry into the death of Victoria Climbié led to many child protection reforms across all statutory organisations and triggered subsequent improvements to information sharing between Public Protection Units and Children's Social Services.

622. Bedfordshire Police now has in place new protocols to share information and automatically notify Social Services of all incidents of domestic abuse when children are part of the family. There is also a formal policy and standard operating procedures for safeguarding and promoting the welfare of victims of domestic abuse. The policy document is based on the NPIA (National Police Improvement Agency) Guidance on Investigating Domestic Abuse (2008) and provides operational, tactical and strategic advice on reporting, responding to and investigating domestic abuse. It also provided an outline of multiagency roles and responsibilities in reducing domestic abuse.

### **Domestic Abuse Incidents;**

623. In addition to NPIA (2008) Guidance, the Domestic Violence, Crime and Victims Act (DVCVA) was introduced in 2004. It was the biggest overhaul of the law on domestic abuse since the 1980's. The following changes were implemented in England, Wales and Northern Ireland throughout 2006 and 2007;

- The Introduction of a statutory Victims Code of Practice and a Commissioner for Victims and Witnesses.

- A new offence of causing or allowing the death of a child or vulnerable adult (when a child or vulnerable adult suffers an unlawful death and it can be proved that one or more of a small group of people living in the same household as the victim caused the death, but not which of them).
- Extended availability of injunctions to same sex couples, and to those who have never cohabited.
- A new criminal offence of breaching a 'non molestation order' under Family Law Act 1996 (FLA) was introduced, with a maximum penalty of 5 years.
- Extended power of arrest to all offences and not just common assault (Section 10 of the DVCVA 2004 has now been superseded, following the implementation of the Serious Organised Crime and Police Act 2005, which – with a very few exceptions - makes all offences arrestable where a police officer has reasonable grounds to suspect that an offence has been committed).
- Developments to the provision for trials without a jury.

624. Domestic Violence and the drive to protect victims and prosecute offenders is a priority for Bedfordshire Police. Within the Public Protection Unit there is now a dedicated Domestic Abuse Unit with systems and policies in place to ensure procedures are carried out by individual officers in line with NPJA guidance and that the decision making process regarding referrals is re-evaluated by dedicated departments.

## Offender Management

625. Bedfordshire has introduced a Domestic Abuse Champion and a Domestic Abuse Repeat Offenders Target List. This list is published on the 'homepage' of the Force intranet and all officers are urged to make themselves familiar with the list of repeat

offenders in their area. The Domestic Abuse Repeat Offenders Team create in-depth profiles of the individuals, run operations, make arrests and assist in dealing with offenders in custody. The aim is to successfully prosecute target offenders and thereby reduce the number of repeat offences.

626. The issue of repeat offenders and the risk they pose to unwitting victims when they move from one relationship to another has been debated by Parliament on many occasions. In 2009 Clare Wood, was murdered by her former partner George Appleton. He had told Ms Wood that he had been to prison for driving offences, but she was unaware of previous convictions for harassment. Clare's family campaigned for a new law which would enable men and women to find out if new partners had a history of abuse and posed a threat to safety. Clare's Law was first introduced to four Police force areas to trial the scheme in July 2012. Following the successful 14-month pilot the Home Secretary Theresa May has announced that Clare's Law will be extended to police forces across England and Wales from the 8<sup>th</sup> March 2014.

627. Under Clare's Law, men, women, family or friends can apply to police to delve into the prison, social service and criminal records if they have concerns about a new partner. The scheme works in two ways:

- **A 'right to ask':** This is where information is disclosed following a request from a member of the public.
- **A 'right to know':** This is where police make a proactive decision to disclose details when they receive information to suggest a person could be at risk.

628. Even if this opportunity had existed for Adult A, it would have remained his decision to stay or leave the relationship on receipt of the disclosed information. For victims who decide to stay in 'high risk' relationships, a decision will be taken whether to refer the case to a Multi-Agency Risk Assessment Conferences (MARAC) (See 641) or monitor the offender through Multi

Agency Public Protection Arrangements (MAPPA) (See 632).

629. Whilst the Multi Agency Risk Assessment Conferences were originally established to provide intervention and safety planning for victims and children, it is common practice to share information on the perpetrators of domestic abuse and identify serial, dangerous offenders who pose an on-going risk to children, families and the general public.
630. If this case had been referred to MARAC, the MARAC Chair may have decided to share necessary and proportionate information about Adult B with other relevant authorities to ensure that professionals were aware of her risk to children and/or new/current/ex partners.
631. As Adult B was convicted of the manslaughter of Adult A, it should be noted that she will be managed through Multi Agency Public Protection Arrangements (MAPPA) as a MAPPA Offender when she is released from prison in 2016/17.
632. Multi-Agency Public Protection Arrangements (MAPPA) are a set of statutory arrangements to assess and manage the risk posed by certain sexual and violent offenders. They are established by virtue of Sections 325 to 327 of the Criminal Justice Act 2003<sup>66</sup>.
633. MAPPA brings together the Police, Probation and Prison Service into what is known as the 'MAPPA Responsible Authority' for each MAPPA Area. The MAPPA area for Cornwall is aligned with the Devon and Cornwall Police force area, as set out in

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<sup>66</sup> [http://www.north-wales.police.uk/about\\_us/mappa/what\\_is\\_mappa.aspx](http://www.north-wales.police.uk/about_us/mappa/what_is_mappa.aspx)

the Police Act 1996.

634. Offenders eligible for MAPPA are identified, and information is gathered and shared about them across relevant agencies. The nature and level of the risk of harm they pose is assessed and a co-ordinated risk management plan is implemented to minimise any risk to the public.

635. Multi Agency Public Protection Arrangements will be applied to categorise the level of risk Adult B poses to her family, new partners and the general public on release from prison. This will determine the level of multi-agency co-operation required to implement effectively Adult B's risk management plan.

### **Domestic Abuse Risk Assessment**

636. The first risk assessment tool for Domestic Abuse, Stalking and Harassment and Honour Based Violence was introduced in the UK in 2009, bringing consistency to the domestic abuse risk assessment process for front-line officers and many non-police agencies. The DASH (2009) Model was developed by Laura Richards BSc, MSc, FRSA on behalf of the Association of Chief Police Officers (ACPO) and in partnership with Coordinated Action Against Domestic Abuse (CAADA).

637. The DASH (2009) risk checklist is now the most widely adopted multi agency risk assessment tool throughout the UK and the only evidenced based risk model resulting from 9 years of academic research, analysis, piloting and consultation. It gathers information on past physical abuse, escalation of abuse, use of weapons, unemployment or financial problems, substance abuse, pregnancy, jealous or controlling behaviour, impending or on-going relationship separation, threats, sexual abuse and

suicidal thoughts.

638. DASH (2009) provides a common assessment framework for professionals to identify, assess, manage and communicate high risk domestic abuse and is endorsed by;

- Children and Family Court Advisory and Support Service (CAFCASS)
- RESPECT (A National Organisation for Perpetrators of Domestic Abuse)
- The Greater London Domestic Violence Project (GLDVP)
- National Centre for Domestic Violence (NCDV)

639. Since 2009 the DASH Risk Assessment has been rolled out to other non-criminal justice professionals to help identify high risk victims of domestic abuse that do not report to the police. A combination of a scoring framework together with professional judgement is used to decide which cases would benefit from a multi-agency safety plan.

640. Today, 100% of families identified by the DASH Risk Checklist as high risk are routinely referred to a Multi-Agency Risk Assessment Conference (MARAC).

### **Domestic Abuse Risk Management (MARACs)**

641. The MARAC model of intervention was first pioneered in Cardiff in April 2003 (one year after the final intervention with Adult B) and combines the DASH Risk Assessment and a multi-agency approach to reduce future harm to very high-risk victims of

domestic abuse and their children by sharing information, taking action and facilitating joint safety plans.

642. Over 260 MARACs now operate throughout England, Wales and Northern Ireland.<sup>67</sup> On average MARAC meetings take place monthly (or more frequently) in each area and last between two and four hours depending on the volume and complexity of referrals/cases<sup>68</sup>.

643. Membership at MARACs includes non-criminal justice agencies as well as the Police. Victim-oriented professionals, such as Independent Domestic Violence Advocates (IDVAs) provide information from the victim's perspective; social services provide information about dependents and take action on their behalf; police and probation offer information about the perpetrator's history, and presence of other aggravating factors, such as drugs or weapons.

644. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by a specialist Independent Domestic Violence Advocate (IDVA) who speaks on their behalf.

### **Independent Domestic Violence Advocates (IDVAs)**

645. Independent Domestic Violence Advocates (IDVAs) are a relatively new development and are pivotal to the success of MARACs. The role was introduced in Cornwall in 2006 to offer intervention assistance to victims of domestic abuse, identified

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<sup>67</sup> <http://www.caada.org.uk/aboutus/Key%20CAADA%20FAQs%20-%20MARACs%20FINAL.pdf>

<sup>68</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/116538/horr55-technical-annex.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116538/horr55-technical-annex.pdf)

as high risk, whose cases have been referred to a MARAC and may be progressing through the criminal justice system.

646. An IDVA is a named professional case worker for domestic abuse victims whose primary purpose is to address the safety of 'high risk' victims and their children. Serving as a victim's main point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop coordinated safety plans.<sup>69</sup>

647. IDVAs are pro-active in implementing safety plans, which include practical steps to protect victims and their children, as well as longer-term solutions. These plans will include actions from the Multi-Agency Risk Assessment Conference (MARAC) as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations.

648. IDVAs operate independently of criminal justice agencies and work over the short to medium-term to put victims on the path to long-term safety. Each IDVA manages a caseload of approximately 80-100 high risk cases per annum.

649. Had Adult A reached out for support or been identified by an agency as a potential victim of domestic abuse whilst living in Cornwall (from 2004 onwards) the Review Panel would like to think that his safety would have been risk assessed by a Police Officer or an Independent Domestic Violence Advisor as per local and national practice. Depending on his level of risk, a decision to refer to MARAC would have been taken and a safety plan would have been created.

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<sup>69</sup> <http://caada.org.uk/aboutus/Key%20FAQs%20-%20IDVAs%20FINAL.pdf>

650. Although the Review Panel would like to believe that this would be the routine response for *any* victim of domestic abuse in 2013, one cannot overlook the gender dynamic within this case and ask whether gender specific support services exist (now or then) with equity of access for male and female victims.

## Male Victims

651. Unfortunately the Review has been unable to report a considerable development in the acknowledgement of male abuse by female partners during the scope of this Review (1963 – 2012).

652. Research conducted into male victims of domestic violence in 2003 concluded that male victims do not amount to a sizeable population and therefore, do not necessitate services available to them in the same way that female victims do<sup>70</sup>.

653. As society does not actively recognise domestic abuse towards men by their female partners as a widespread problem this adds to the reluctance of males, like Adult A, to come forward and seek help; creating an unrepresentative understanding of prevalence and a misleading demand for comparable services.

654. This is substantiated by the disparity identified at the start of this review (2012) between allocated resources for female victims compared to male victims (*e.g. one part time IDVA for male victims compared to 11.5 full-time equivalents for females*)

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<sup>70</sup> Gadd et al (2003)

655. It is not known if Adult A ever attempted to seek help confidentially between 2004 and 2012, or if he was able to locate or source the specific help he needed whilst residing in Cornwall. It is acknowledged that Adult A was the victim of domestic abuse during a time when commissioned services were not required to provide equitable services for men.

656. A new domestic abuse contract was commissioned and awarded in Cornwall in November 2012. The new provider is now contracted to increase the IDVA provision available to male victims across Cornwall and the Isles of Scilly.

657. There are still further developments to be made in raising awareness of male abuse by female partners and this has been acknowledged within the recommendations of this review (see Section Seven).

## **APPENDIX E: Summary of the proposed NHS Child Protection - Information System'**

658. CP-IS will be introduced to NHS Hospitals in 2015 and is sponsored by the Department of Health and supported by the Department for Education, the Association of Directors of Children's Services, a wide range of health professional bodies and charities including the National Society for the Prevention of Cruelty to Children.
659. Healthcare Professionals from a variety of unscheduled health care settings such as emergency departments, walk-in centres, minor injury units, GP out of hours services, ambulance services and maternity will be able to use CP-IS to see if the children they treat:
- are subject to a child protection plan or being looked after by the local authority.
  - have frequently attended emergency departments or urgent care centres over a period of time.
660. CP-IS will be an England wide solution. Healthcare staff in unscheduled care settings will be able to see whether any child with whom they deal has a child protection plan or is looked after, regardless of where in the country that child normally resides.
661. A record of who has viewed the indicator flag on CP-IS will be available to social care and healthcare staff, allowing them to see if that child has been visiting a range of different unscheduled healthcare settings.
662. Medical staff will be able to use this information as part of their overall clinical assessment, along with information about where and when children have previously been receiving urgent treatment. This will help them build up a better picture of what

is happening in the child's life so they can alert social services if they think something might be wrong. CP-IS will tackle a long standing problem for NHS staff and the lack of ready access to timely information which would help inform a clear assessment of a child's risk of abuse or neglect. The information will support the clinician in the decision making process and encourage communication with social care and other responsible authorities.

In practice, local authorities will feed information on children who are subject to a child protection plan or are looked after from their social care systems into a secure central data store area in the NHS national Spine. Then health professionals, during the process of registering a child at their care setting, will be informed of the child's child protection status. As soon as basic demographic information is inputted, if the child is looked after or subject to a child protection plan, an indicator flag will appear on screen, with the contact details for the relevant local authority.