BRADFORD
Community Safety
Partnership

Domestic Homicide Review Overview Report into the death of Adult W

Died: 5th November 2013

Paul Johnston

(Johnston and Blockley Ltd)

Date: 30th June 2015

Index

1 Introduction

1.1 This Domestic Homicide Review Overview Report is about Adult W who died on 5th November 2013. She was murdered by her former partner, Adult G, in her home town of Bradford, West Yorkshire.

1.2 Adult G was arrested on 5th November and on 12th May 2014, he appeared at Bradford Crown Court where, after a trial, he was found guilty of Adult W's murder. He was sentenced to life imprisonment with a recommendation that he must serve 15-years before being eligible for parole.

1.3 He has not responded to an invitation to participate in this Domestic Homicide Review.

2 Sequence of events leading up to 5th November 2013

2.1 Adult W was born in Bradford where she lived for all of her short life. She was extremely popular and worked part-time in a fish and chip shop in Bradford city centre.

2.2 She had two children with her then partner, Adult 1. In 2012, they parted company; the two children stayed with Adult W, but their father continued to see them on a regular basis.

2.3 The children were both very young when their devoted and caring mother was cruelly taken from them.

2.4 Adult W first met Adult G in 2007. After a short period, he left for Afghanistan where he worked for a private contractor to the Navy, Army and Air Force Institute (NAAFI).

2.5 Adult G returned from Afghanistan in 2009 and Adult W started seeing him again after she had parted company with Adult 1. They did not set up home together, but he occasionally stayed over at Adult W's house. He lived at his mother's house in Bradford where he slept in a caravan in the back garden.

2.6 On 17th April 2013, Adult W noticed some marks on Child One's neck and behind the ears. She took the child to the doctor who made a referral straight to hospital for blood tests and a paediatric consultant's opinion. The diagnosis was that the child had developed an upper respiratory tract infection. There were no indications or suspicion that Child One had been assaulted in any way.

2.7 Three weeks later, on 9th May 2013, Adult W took Child One back to the accident and emergency department of the same hospital. She had

noticed bruising to the child's ear and cheek that morning and also had a rash on the neck. An immediate paediatric consultation was arranged.

2.8 Adult W was unable to explain how Child One's injuries had been caused. She said she put the child to bed at 7.30pm the previous evening and at that time he had been fine. She told hospital staff about the previous admittance to the hospital and that it was thought the child had been suffering from a viral infection.

2.9 During a telephone conversation, the doctor told the police that he suspected the child's injuries had not been caused by accident, but at that stage he could not rule out a blood disorder. He added that the results of the blood tests would not be known until the following morning. In the meantime, Child One would stay in hospital. Adult W said she was going to spend the night by her child's bedside.

2.10 In line with normal practice, the hospital telephoned the Bradford Council Emergency Duty Team (EDT) and told them that 13 bruises had been found Child One's face and right ear. They told the EDT of the doctor's suspicion that the injuries had not been caused by accident. The EDT and Police held a strategy discussion and it was decided that the Police would go to the hospital to speak to Adult W and the child's father, Adult 1.

2.11 The police went straight to the hospital and interviewed Adult W and Adult 1 under caution. Both said they had no idea how the injuries to Child One had been caused or who may have been responsible.

2.12 Adult W explained that she lived alone with her two children. Her boyfriend, Adult G, occasionally stayed the night but was never left alone with the children.

2.13 Adult W added that Child One slept alone in the bedroom. She said that Adult G had been in the house during the previous evening, as had her younger sister. It was when Adult W woke up around 6.45am that she noticed the marks on Child One's face. She telephoned 111 and was told to ring her GP when they opened. She did so and was given an appointment for 5pm. Rather than keep the appointment, she took Child One to hospital herself.

2.14 Adult 1 told the police that he had collected the children the day before and had then dropped them off with Adult W as normal. At that time they had both been fit and well.

2.15 When members of the medical team at the hospital asked what had happened, the child's *response was, "The wall"* , pointing to the wall in accident and emergency department.

2.16 The hospital agreed to allow Child One to stay on the ward overnight even though the youngster was well enough to be discharged. Arrangements were made to ensure that Child Two was safe and an examination revealed there had been no assaults. Plans were put in place to ensure that a joint investigation was conducted by the police and Children's Social Care (CSC) and that suitable arrangements were made for both children to be subject to local authority placement plans.

2.17 The following day, 10th May, Child One was discharged from hospital. Provisional arrangements had been made for the two children to stay with Adult W's sister, with Adult W having supervised contact with them.

2.18 On 14th May 2013, the police spoke to Child One in the presence of Adult W's sister. The child did not say who had caused the injuries but Adult W's sister told the officers that during the previous Sunday, Child Two had been hitting Child One in the face with some toys when Child One said *"Don't do that, coz* [Adult G] *does that."*

2.19 Adult W's sister also telephoned Social Services and told them what Child One had said about Adult G. She added that she had also heard the child say that he/she does not like Adult G and that he/she did not want anything to do with him.

2.20 On 15th May, the police took a witness statement from Adult W's sister about what she had heard the child say the previous Sunday. While they were there, the police took the opportunity to speak with Child One but there was no disclosure made about how the injuries had been caused.

2.21 On 16th May 2103, Adult W's sister told a social worker that the day before, while playing with toy trains, Child One told Adult W's mother that he/she had been on a train with Adult W. Adult W's mother asked the child if Adult G had gone as well and, pointing to his/her cheeks and ear, the child replied, *"No,* [Adult G] *did this to me.*"

2.22 The police interviewed Adult G under caution on 16th May. He said he occasionally stayed overnight at Adult W's house but it was not a regular occurrence. He also said he had been there between 7pm and 9.30pm on 8th May and that when he arrived, the children were in the bath. They then went to bed as normal.

2.23 He said he first found out what had happened the following day when Adult W told him about it. He also told the officers that he did not have anything to do with Adult W's children because it wasn't his place to do so. He denied emphatically that he had caused the injuries to Child One

2.24 The following day, social workers spoke to Adult W in an attempt to establish whether Adult G had had any opportunity to injure Child One. She said that as far as she could recollect, Adult G had not been alone with Child One during the evening of 8th May. The social workers told her what Child One had said about Adult G. She was visibly upset and shocked, but said she had no reason to believe that Child One would lie about such a thing.

2.25 Adult W said that because of what Child One had said, she would never again have anything to do with Adult G. She said she would stay at her mother's house over the weekend so that he wouldn't be able to find her.

2.26 On 21st May 2013, a social worker telephoned Adult W's sister. Adult W was there at the time. Adult W told the social worker that she had not seen Adult G since she had learned of what Child One had said. She also said he had been texting her all weekend, but she had ignored him. Adult W's sister said that over the weekend (it was Tuesday), Child One had again said that Adult G had caused the injuries and that he/she did not want to see him.

2.27 During a telephone conversation on 21st May, the police told CSC that they would not be taking any further action because Child One had not made any disclosures to them or to any other professional. They pointed out that both Adult W and Adult G had said that he (Adult G) had not been alone with Child One that evening.

2.28 The following day, CSC visited Adult G. He told them he had visited Adult W on 8th May, around 7pm. He said he played with the children for about 10 minutes before Adult W took them to get ready for bed. Once they were in bed he went upstairs to the toilet but he did not see Child One because the bedroom door had been closed. He insisted that he did not know how the injuries to Child One had been caused.

2.29 On 23rd May, a social worker conducted a play session with Child One. Her case note regarding this session states:

"Spent time with [redacted] *colouring in and drawing. I asked* [redacted] *to draw a picture of his mum which [Redacted] was happy to do. I then asked [Redacted] if [Redacted] wanted to draw and* (sic) *picture of* [redacted] *and [Redacted] said "no, don't want to draw* [redacted], *he did this to me" and pointed to his cheek.*

Later on in the session, [redacted] *stated that he didn't like B's juice (B is* [redacted] *4 year old cousin who is staying with). [The child] then went on to say 'B did it'. I asked B did what? And* [redacted] *said 'he did this to me and pointed to [redacted's] eye'."*

2.30 The following day, a child protection planning meeting recommended that the children be allowed to return home. The decision was made on the basis of the disclosures made by Child One that Adult G had caused the injuries, that Adult W had ended her relationship with Adult G, that Adult W had co-operated fully with Children's Social Care and other agencies, all checks and information gathered in relation to Adult W had been positive, Adult W's two children clearly had a good relationship with her and that the police were not taking any further action.

2.31 The return home was conditional; Adult W's mother was to stay at Adult W's house, Adult W was to have no contact with Adult G, the Child Protection Plan would be pursued and CSC would speak to the police about Child One's disclosure to them. Adult W reiterated she would never have anything to do with Adult G again because of the number of times Child One had said he had caused the injuries.

2.32 On 29th May, CSC told the Police about the disclosures, in particular the one the previous week when Child One had made a disclosure to a social worker. The police officer told the social worker that Child One had not wanted to talk to them as soon as they had arrived at the house and also emphasised that Adult W had always maintained that Adult G had not been left alone with Child One.

2.33 CSC records indicate that the police said they would speak to Child One again. The records also indicate that a social worker tried to speak with the officer over the telephone on 19th June to enquire whether it had been done. The officer was not available, so a message was left for the call to be returned. (There is no record of that actually happening).

2.34 Police records show that on 7th June 2013, they had conducted a review of the evidence and a formal decision had been made that the evidential threshold for a prosecution had not been met. (The police are adamant they did not enter into an undertaking to see Child One again; this issue will be discussed in more detail later in this report).

2.35 The Initial Child Protection Conference was held on 17th June 2013. It concluded that it was no longer necessary for Adult W's mother to stay at Adult W's home, but that she should visit daily. (This arrangement was later changed to having daily contact, either directly or indirectly).

2.36 In September 2013, Adult W met another young man, Adult 2. They soon began making plans to set up home together at Adult 2's house in Leeds. Adult W had made enquiries about finding alternative schools for the children and had enquired about changing their GPs practice. She and Adult 2 decorated a room especially for Adult W's children and shortly before her death, Adult W and her sister had been shopping

together to buy new bedding for the room.

2.37 It was during a meeting between Adult W and CSC on 17th October 2013, that Adult W disclosed the fact that she was in a relationship with Adult 2 and that she would like to move to Leeds to live with him.

2.38 On 28th October 2013, Adult W reported to the Police that someone had tried to break in to her house sometime between 24th and 26th October. She said she had been staying at her boyfriend's house in Leeds between those dates and that her children had been with other family members. (Adult 2 was with Adult W when she discovered the attempted break-in and believes it hadn't been a genuine attempt to get into the house. He has told this review that when the police arrived, Adult W told them about the assault on Child One and that she thought Adult G had caused the damage to her house in an attempt to intimidate her).

2.39 The Police were of the view that the attempted break-in was one of a series committed by local drug addicts between 23rd and 28th October, and they arrested a suspect. He was later released without charge due to a lack of evidence. (The suspect was not connected to either Adult W or to Adult G).

2.40 On 29th October, social workers met with Adult W and Adult 2 in order to discuss the situation and to complete the paperwork that was necessary for them to commence suitability checks on Adult 2. At the same meeting, the social workers also told Adult W about a written referral they had received from the National Society for the Prevention of Cruelty to Children (NSPCC) on 27th October. It alleged that Adult W had been pulling Child One along by the wrist, that she had slapped Child One around the head after a fall, that a lot of people frequented her house at all times of the day and night, that on 21st October, Child One had appeared sheepish and pasty and finally that a few months previously, police cars and a scientific support van had been at her house. Adult W categorically denied all the allegations and was obviously distressed that such things had been said of her.

2.41 The social workers told Adult W they knew there was no truth to the allegations, and they later informed the NSPCC that they would not be taking any further action.

2.42 Adult W told CSC about the attempted break-in when they visited her at her mother's house on 31st October. Adult W said she was living there temporarily because she thought she and the children would be at great risk if they returned home. She said she planned to move in with Adult 2 as soon CSC gave her permission to do so.

2.43 **5th November 2013**

Shortly before 5pm on 5th November 2013, the ambulance service notified the police that they had received a telephone call to the effect that an assault had taken place and that a young woman had stopped breathing. That young woman was Adult W. Despite the best efforts of the ambulance crew, Adult W died where the ambulance crew had found her, in the caravan in the back garden of Adult G's mother's house.

2.44 When the police got there, they arrested Adult G on suspicion of murdering Adult W. He declined to answer any questions during subsequent interviews, but his solicitor read out the following statement on his behalf:

'I accept that my actions may have led to the death of [Adult W]. *I never had any intention to kill* [Adult W]. *This came about when I lost my self control and attacked her after she told me she was going to report me to the authorities for committing a serious offence against [redacted], which I deny.* [Adult W] *herself was suspected of committing the offence.'*

2.45 During the murder investigation, the police examined Adult W's mobile telephone and the one they had taken from Adult G. They found several recent text messages between the two. Adult G had been very demanding of Adult W. He often declared his love for her, a sentiment she did not reciprocate in her occasional responses. He said he wanted to spend time with her, but she made it clear that she did not want anything to do with him because she did not want to risk Social Services taking her children away from her again.

2.46 The last text message between Adult G and Adult W was on the day Adult W was murdered. He had asked where she was. She had replied that she had finished work and that she was on the bus.

2.47 The police investigation established that Adult W had agreed to meet Adult G that day. She left work at 3pm and caught the bus to Wrose. She had planned for them to take her dog for a walk, but because Adult G had insisted that he wanted time with her alone, he had picked her up in his car near to her home and had then driven to his mother's house where they both went into the caravan in the back garden.

2.48 Less than 2 hours after Adult W left work and caught the bus, the police received the call to say that a woman had been assaulted. Only Adult G can say exactly what happened in that caravan, but due largely to the support provided to this review by Adult W's family and by Adult 2, the family is sure that Adult W's sole reason for being there was to try to elicit evidence that Adult G had assaulted Child One.

2.49 Adult W was absolutely convinced of his guilt. Furthermore, she felt that the onus was on her to prove it. She believed that the authorities were not altogether convinced of her innocence. That, together with the fact that one of the conditions of the Child Protection Plan was that she should have no contact Adult G, made her petrified that Social Services would take her children from her if she was seen to be having anything to do with him. In Adult W's eyes, she had no choice but to meet with him – and she had to do it in secret.

2.50 The participation in this review of Adult W's family and Adult 2 has been immensely helpful. It has allowed the Panel to view events very much from Adult W's perspective. The DHR Panel would like not only to extend its sincere condolences to Adult Ws family, but also to express its gratitude to them for their support and for the courage and dignity they have displayed throughout the process.

3 Establishing a Domestic Homicide Review

Strategic Governance

3.1 Bradford forms part of West Yorkshire and makes up part of the Leeds Urban Zone. Bradford City includes a further seven towns: Keighley, Shipley, Bingley, Ilkley, Haworth, Silsden and Denholme.

3.2 According to the Office for National Statistics, in 2011, Bradford's population stood at 522,452 making it the sixth largest populated authority in England.

3.3 In 2009, Bradford was commended by the Equality and Human Rights Commission for being the best local authority in England for the level of service it provides to women and girls experiencing domestic and sexual violence.

3.4 In November 2013, strategic governance for domestic violence and abuse and issues linked to the national 'Violence Against Women and Girls Agenda' in Bradford was held by the Bradford Community Safety Partnership (CSP), which is the statutory community safety partnership for Bradford. The work of the Bradford CSP in relation to domestic violence and abuse is supported by the Bradford Domestic Abuse Partnership, which is chaired by the Strategic Director of Adult Services in the local authority. It provides strategic governance of domestic and sexual violence activity in the district.

3.5 Domestic Abuse is one of the four priorities of the Bradford Community Safety Partnership and this is set out in the Joint Strategic Needs Assessment. The work in relation to Domestic Abuse is undertaken on behalf of the CSP Bradford Domestic Abuse Partnership (DAP), which

ensures the work of the Bradford violence against women sector complies with the national agenda to End Violence Against Women and Girls.

3.6 The DAP provides strategic direction for the work of this sector and operational management of the Bradford Multi-Agency Risk Assessment Conference (MARAC). This strategic approach ensures a coordinated response to victims of Domestic Abuse in the support and protection of victims while holding perpetrators to account though delivery against the following themes:

Perspective
Policy/procedure
Prevention
Provision
Protection
Prosecution

3.7 These themes provide focus to the sector's work in encouraging victims to disclose the abuse and in the longer term reduce repeat victimisation.

3.8 Bradford is seeing an increase in referrals each year and is expecting this trend to continue. During 2013/14 there were 10,467 incidents of domestic violence reported to West Yorkshire Police in Bradford; an increase of 476 incidents in the previous 12 months.

3.9 The Community Safety Partnership delegated the Domestic Homicide Review process to the Domestic Abuse Partnership, in line with Home Office Guidance.

3.10 In line with agreed protocols, the police formally notified the Bradford Community Safety Partnership of Adult W's death.

3.11 The Partnership's Consideration Panel duly met and agreed that Adult W's death clearly fell within the definition of a domestic homicide.

3.12 The Consideration Panel decided that a Domestic Homicide Review should be carried out. (The Local Safeguarding Children Board agreed that as a Domestic Homicide Review was to take place, it would not be necessary to conduct a separate children's Serious Case Review - please see case specific considerations at paragraph 5.9).

3.13 The Partnership acknowledges that not all the timescales set out in the Home Office guidance for a DHR have been met. This has been due firstly to waiting for the conclusion of the criminal justice process and secondly in attempting to answer satisfactorily many of the issues raised by Adult W's family and Adult 2 during the review process.

4 The purpose of a Domestic Homicide Review

4.1 The purpose of a DHR is to:

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

4.2 A DHR is not an inquiry into how the victim died or what the motivation was behind his or her death. Those are matters for coroner and the judicial system to determine.

4.3 DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be undertaken and will be separate to the DHR process.

4.4 The rationale for the review process is to ensure that agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and violence. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

5 Terms of reference for the review

5.1 This review will:

- Consider each agency's involvement with Adult W, her children and Adult G between 1st May 2013 and 5th November 2013, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant

- Seek to establish whether the events of 5th November 2013 could have been predicted or prevented and to address whether the incident in which Adult W died was a 'one off', whether there were any warning signs and whether more can be done to raise awareness of services available to victims of domestic violence

- Invite responses from any other relevant agencies or individuals identified through the process and request Individual Management Reviews (IMRs) from each of the agencies that have identified involvement with Adult W, her children and Adult G

- Seek the involvement of Adult W's family, her employers, neighbours and friends and also Adult G to provide a robust analysis of what happened

- Take account of coroners or criminal proceedings in terms of timing and contact with Adult W's family

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and make recommendations regarding the safeguarding of victims of domestic abuse

- Undertake an assessment of the Partnership's existing procedures and protocols to ensure they are robust, reflect good practice and are understood and are adhered to by staff

- Undertake a review of recent and current awareness raising in relation to domestic abuse to ensure that all victims of domestic abuse and those who may be aware of it occurring know how to contact agencies to make them aware of the abuse, or for support and advice

5.2 The review identified the following general areas for consideration:

Family engagement

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?

- How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for it?

5.3 **Legal processes**

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

5.4 **Research**

- How should the review process take account of lessons learned from research and previous DHRs?

5.5 In order to reach a view on whether Adult W's death could have been predicted and/or prevented, each IMR author was asked to include information on and analysis of all the following issues specific to her case:

5.6 **Diversity**

- Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration?

5.7 **Multi agency responsibility**

- Was Adult W subject to a Multi Agency Risk Assessment Conference (MARAC)?

- Was Adult G subject to Multi Agency Public Protection Arrangements (MAPPA)?

- Was Adult G subject to a domestic violence perpetrator programme?

- Did Adult W have any contact with a domestic violence organisation or helpline?

- Was either Adult W or Adult G a 'vulnerable adult'

- Were there any issues in communication, information sharing or service delivery between services?

- Did Adult W, her family, friends or colleagues experience any

barriers in reporting any abuse in Bradford or elsewhere?

- Did they know how to report domestic abuse should they have wanted to?

- Did Adult W experience abuse in previous relationships in Bradford or elsewhere, and if so, did the experience impact on her likelihood of seeking support in the months before she died?

- Were there any opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Adult W that were missed?

- Did Adult G have a previous history of abusive behaviour to an intimate partner and if so did the agencies know?

- Were there opportunities for agency intervention in relation to domestic abuse regarding Adult W, Adult G or Adult W's dependent children that were missed?

5.8 **Individual agency responsibility**

- Was the work in Adult W's case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults and with wider professional standards?

- What were the key relevant points/opportunities for assessment and decision making in relation to Adult W and Adult G?

- What was the quality of any multi-agency assessments?

- Was the impact of domestic violence on Adult W recognised?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

- Was there sufficient management accountability for decision-making and were senior managers or other organisations and professionals involved at points where they should have been?

5.9 **Case specific issues**

Child One was assaulted only a few months before Adult W's death. Although there is no conclusive evidence as to who was responsible, there is no doubt that the abuse Child One suffered played a significant

part in the events that led to Adult W's untimely death at the hands of Adult G. Following careful consideration, the Local Safeguarding Children Board agreed that as a Domestic Homicide Review is being carried out, it is not necessary to carry out a separate children's Serious Case Review. It was agreed that any issues pertaining specifically to safeguarding Adult W's child/ren should be integrated into the work of this Domestic Homicide Review. In particular, the following should be considered:

- To highlight any learning from Adult W's case that would improve safeguarding practice in relation to domestic violence experienced by the parents or guardians of children at risk
- Was there sufficient management accountability for decision-making and were senior managers or other organisations and professionals involved at points where they should have been?
- In delivering services to Adult W's family, did all agencies ensure that decisions and actions taken comply with the policy and procedures of Bradford Safeguarding Children Board?
- Did professionals from the agencies involved with the family ensure that appropriate consideration was given to potential risks specific to the children and to the children's needs, and did this consideration lead to the delivery of services that were focused specifically on the children?
- Is there any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in the case?
- Was appropriate consideration given to multi-agency actions to assess the needs of the children and to agree actions to provide necessary help, including early help and the provision of child protection services?

5.10 **Methodology**

This overview report has been compiled from analysis of the multi-agency chronology, the information supplied in the IMRs, supplementary reports from some agencies, interviews conducted by the DHR Chair with Adult W's family and Adult 2, consideration of previous reviews and findings of research into various aspects of domestic abuse.

In preparing the overview report the following documents were referred to:

- The home office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004.
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007.
- Agency IMR's and Chronologies.

5.11 **Participating Agencies**

The following agencies were asked to give chronological accounts of their contact with Adult W, her children and Adult G between 1st May 2013 and Adult W's death on 5th November 2013.

- West Yorkshire Police
- Bradford Teaching Hospital NHS Foundation Trust
- Bradford District Care Trust
- Bradford Metropolitan District Council, Children's Social Care,

  Children's Specialist Services
- Bradford District CCG (GP Services)

5.12 Each agency was required to report the following:

- A chronology of interaction with Adult W, her children and Adult G

- What action was taken and to provide an analysis of what was done
- Whether internal procedures were followed and if those procedures were appropriate in light of Adult W's death
- Conclusions and recommendations from the agencies' point of view.

5.13 DHR Panel Chair and Overview Report Writer

The Consideration Panel requested tenders from suitable applicants to act as Chair and Overview Report author for the review. Following a competitive process, a company specialising in Domestic Homicide Review, Johnston and Blockley, was commissioned.

5.14 One of its partners, Mr Paul Johnston, undertook the role of Chair and Overview Report writer. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in many aspects of public protection. He has been involved in numerous homicide reviews throughout the United Kingdom and abroad and has also been involved in several DHRs. He is currently a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Bradford Community Safety Partnership).

5.15 The DHR Panel

The consideration panel agreed the formation of a panel comprising of agencies that had had contact with Adult W, her children and Adult G during the period under review.

5.16 The DHR Review Panel consists of:

Paul Johnston	• Chair and Report Writer
Val Balding	• Domestic Violence Manager, City of Bradford Metropolitan District Council
Terry Long	• West Yorkshire Police
Simone Burden	• Probation Service
Di Watherston	• Bradford Metropolitan District Children's Social Care

- Amanda Lavery
- Sue Thompson
- Bradford District Care Trust
- Bradford District CCG and NHS England (Also Bradford Teaching Hospitals NHS Trust)

5.17 Adult W's family members were invited to participate in the review process. Through his solicitor, Adult G was asked to engage with the review, but at the time of writing this report, there has been no response.

5.18 The review panel met on the following dates:

19th March 2014
19th May 2014
7th July 2014
16th September 2014
16th October 2014
22nd May 2015

5.19 The agenda for each meeting was appropriate; there was a good level of debate and appropriate challenge, themes were identified and recorded as they emerged and the minutes and actions were promptly circulated and the latter closely monitored.

5.20 West Yorkshire Police provided regular updates about the progress of the criminal investigation and briefed the Overview Panel about the circumstances of Adult W's murder. Helpfully, they identified which witnesses were likely to give evidence during the subsequent trial so that informed professional judgments could be made as to who may be interviewed by the Panel and when.

5.21 On the basis of the information supplied by the Police, the panel considered it appropriate to defer the DHR until the ongoing criminal proceedings had been concluded, so as not to risk compromising the judicial process.

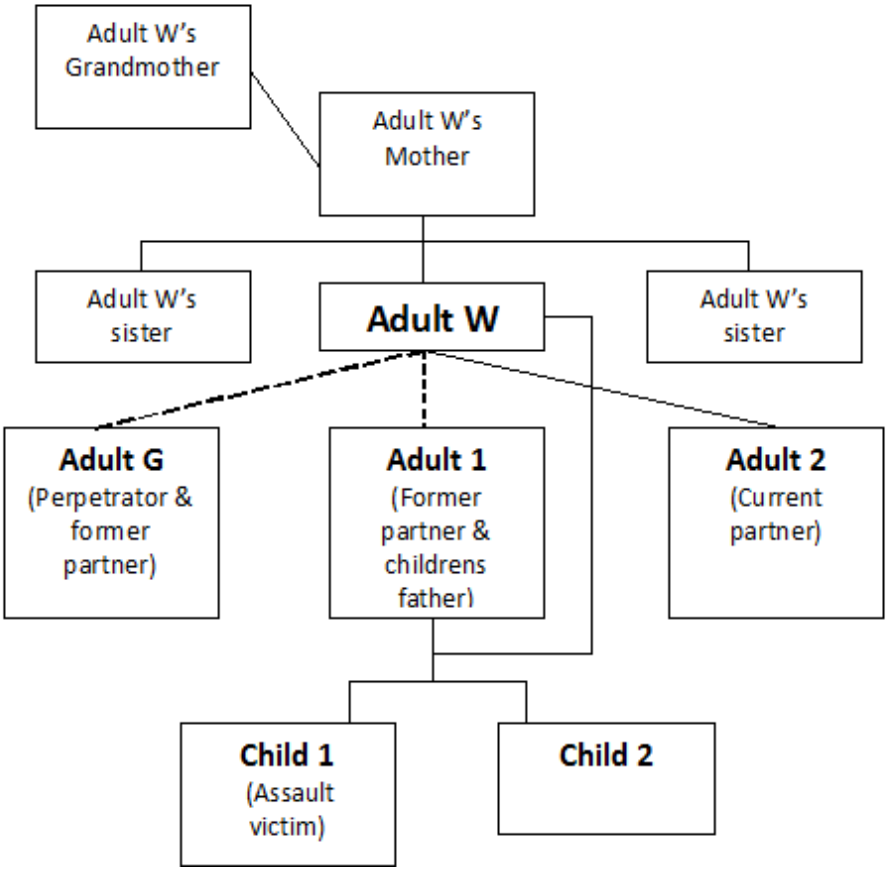
5.22 **Parallel processes**

There was a thorough police investigation into the circumstances of Adult W's death and a subsequent criminal trial which culminated on 12 May 2014 with the conviction of Adult G for her murder.

5.23 Although Adult W's death was referred to the Coroner, no inquest will take place because all the evidence and information about her death was aired during the criminal proceedings against Adult G.

5.24 **The Involvement of family members**

Family Composition



5.25 Adult W's family were contacted at the conclusion of the criminal trial to inform them of the DHR process and to ask if they would be prepared to participate in it. Whilst the panel acknowledges this was not strictly within the Home Office guidelines, it was felt appropriate, after consultation with the Police Senior Investigating Officer, to delay the notification and invitation because many of the family were likely to be called as witnesses during the criminal proceedings.

6 Engagement with Adult W's family

6.1 Adult W's mother, her grandmother and one of Adult W's sisters participated in this review and have been interviewed by the DHR Chair on several occasions.

6.2 Between them, the family members raised the following specific issues: (These issues will be discussed in more detail as this report progresses and analysis of the findings can be found at section 10 as indicated.)

6.3

- **Adult W's fear of her children being taken into care -** (Analysis at 10.1 to 10.11)

They all stated that they were present when a social worker told Adult W not to have any contact at all with Adult G because if she did, her children would be taken from her.

6.4 When the children were later returned to Adult W as part of the ongoing Child Protection Plan, she had agreed to a condition that she would have no contact with Adult G.

6.5 They said that another social worker told Adult W that she was not to move in with Adult 2 in Leeds because she had to demonstrate to Social Services, that after the attempted burglary at her home, she was strong enough and independent enough to cope on her own; if she didn't, she could lose her children.

6.6 Even though Adult W had made enquiries at a new school and at a doctors' surgery in Leeds in preparation for her and the children moving in with Adult 2, and they had decorated and furnished a room for the children, she was so frightened of upsetting Social Services, that she felt she had no alternative but to stay where she was.

6.7 Adult W's family said that all she could talk about was her fear that Social Services would take her children from her and that if they did, she would never get them back. (Adult W's mother still has several text messages sent to her by Adult W in which she talked about those fears.)

6.8

- **Adult W's attempts to elicit a confession from Adult G –** (Analysis at 10.12 to 10.16)

They added that even though the social worker had warned Adult W not to have anything to do with Adult G, the family (and Adult W) got the impression that she was really hinting that Adult W should do exactly the opposite. They thought the social worker wanted her to *'get close to him'* in the hope that he would say something incriminating about the assault upon Adult W's son.

6.9 Adult W's mother has told the review that Adult W discussed the situation with her. She said Adult W was convinced that, in effect, Social Services wanted her to *'play detective'* and elicit a confession from Adult G.

6.10

- **The joint Police/Children's Social Care investigation –** (Analysis at 10.17 to 10.40)

The family believe that had there been a more effective joint Police and

Social Services investigation into the assault on Child One, the truth would have emerged and Adult W would therefore not have been a suspect. In turn, she would not have felt driven to meet with Adult G, a person she had grown to dislike and distrust, to elicit evidence of his guilt.

6.11 In particular, the family consider that not enough was done by either organisation to secure a disclosure from Child One about how and by whom the injuries had been caused. They are of the opinion that the police closed their investigation far too soon and that Adult G should have been arrested.

6.12 None of the family knew whether Adult W had ever been a victim of domestic violence or abuse, either when she was with Adult G or with anyone else. They believe though, that even if she had, she would not have told Social Services or the Police because of her fear of the children being taken from her.

7 Other avenues explored

On behalf of the Panel, Adult W's mother asked some of Adult W's friends and work colleagues to contact the Chair of the Review if they had any information that may have been relevant to the process. None did so. The Chair wrote to Adult W's employers and her former partner, Adult 1, but did not receive any responses.

7.1 Adult 2

Adult W's partner, Adult 2, kindly agreed to participate in the review.

7.2 He said that initially, Adult W did not want Social Services to know about their relationship because she thought they would tell her not to get involved with anyone else. Adult 2 said that Adult W was absolutely paranoid about upsetting Social Services. She believed they had the power to take her children from her if she didn't do completely as she was told and that they would not hesitate to do it.

7.3 About two weeks after meeting Adult W, she told him about the assault on Child One and that she was sure that Adult G had been responsible. Adult W told him that she had ended her relationship with Adult G the moment she learned of the disclosures made by her child.

7.4 Adult W told him that she had always been very wary of Adult G. He often lost his temper and was verbally abusive towards her, but she never suggested he had been physically violent.

7.5 He said that Adult W had asked Social Services if she could come to

Leeds to live with him. Adult W had said that the social worker had told her that she couldn't do that because she had to stay in her own house and that she shouldn't show she was scared because her home had been broken in to.

7.6 Adult W thought the social worker was being ridiculous. In the hope of reaching a compromise, she and Adult 2 suggested that they delay her move to Leeds until Christmas so that it could take place during the holiday rather than in term time. The social worker said, *"We'll see how it goes – we'll do a police check on* (Adult 2)*"*.

7.7 Adult W told him that the social worker had told her that in the meantime, she should not trust him (Adult 2) and that she was not to stay over at his house nor allow him to stay at her house until he (the social worker) gave his permission.

7.8 Adult 2 said he had been with Adult W when she had discovered the attempted burglary at her home. He said it was obvious that it hadn't been a genuine attempt to break in. He said that when the police arrived, Adult W told them about the assault on Child One and that she thought Adult G had caused the damage to her house to intimidate her. She told the officers where Adult G lived but they appeared to be sure that the burglary was one of a series committed by local drug addicts.

7.9 About a week before she died, neighbours told Adult W that they had seen Adult G walking up and down the road and also driving his mother's car in the area. Adult W said there had been no legitimate reason for Adult G to be anywhere near there. She decided not to tell her mother about it in case she told Social Services. Adult W said she wouldn't want Social Services to know because they might take the children from her.

7.10 Adult W told Adult 2 that she had not seen Adult G since the day Child One had been assaulted, but she had been in contact with him via text messages and on *'Facebook'.* She said she was trying to get him to admit that he had caused Child One's injuries. She added that the police had closed the case and she was trying to do their job for them because she needed to prove to Social Services that she hadn't assaulted her child ~~One~~.

7.11 Adult 2 said he told Adult W to *"leave it"* because he didn't think it would work. The following day, (26th October 2013), she sent him a text message saying that Adult G had admitted causing Child One's injuries. He said she was excited, but he told her to calm down and not get her hopes up. He later saw the text messages from Adult G and said they were on the lines of, *'I'm sorry about what I've done in the past*' and *'I just want to sort things out'*. Other messages said that she should be

with him and not with Adult 2. Adult 2 told Adult W that, in his opinion, she had been reading too much into the text messages.

7.12 He said he was absolutely sure that the only reason Adult W had agreed to meet Adult G on the day she died was to get the truth out of him. He added that he told the police as much when they interviewed him on 7th November 2013, two days after Adult W had been murdered.

7.13 The DHR Chair specifically asked Adult 2 whether he thought Social Services had in any way encouraged Adult W to keep in contact with Adult G to get him to admit his involvement in the assault on Child One. He said he never been under that impression and Adult W certainly didn't tell him that had been the case. In his opinion, Adult W had just taken it upon herself to do it.

7.14 Adult 2 mentioned the allegation the NSPCC had received about Adult W. He said that even though Social Services had told Adult W they didn't believe a word of what had been alleged, she came out of the meeting crying. She said it was obvious that Adult G had been behind it and that he was doing all he could to *'get to her'* and the best way to do that was through her children, because he knew how much they meant to her.

7.15 Finally, Adult 2 said that the last text message he received from Adult W was to say that she had telephoned the local primary school in Leeds about moving the children there. She had accepted their invitation to attend their open-day on November 12th.

8 Summary of what was known by agencies and professionals

8.1 Bradford City and Bradford Districts CCG's and NHS England (GP)

The GP records show that Adult W made appropriate visits to her doctor when there were routine health issues with her children. There is nothing in the records to indicate there were any concerns whatsoever about Adult W's ability to care for them.

8.2 The relevant entries in the GPs records are as follows:

- 7th September 2009 - Adult G visited his doctor to say he had returned from Afghanistan on compassionate leave from a company working with the army. While there, he had been upset and low in mood; he said he still was, but was reluctant to talk about it. He wanted the doctor to write a private letter to his employer.

- 31st October 2012 - A GP recorded that Adult W was a waitress, that she had two children and that she was in a new relationship.

He wrote that she was less anxious/stressed than before and that her previous relationship had been problematic. (The entry did not specify with whom she was in a relationship).

- 17th April 2013 - Adult W took Child One to the doctor because of a rash she had discovered around the child's eyes, neck and behind the ears. Child One was referred to hospital for blood tests and a paediatric opinion. The notes indicate that the diagnosis was an upper respiratory tract infection.

- 9th May 2013 - Adult W telephoned the surgery to request an appointment for Child One. The notes record that Adult W and Child One did not keep the appointment but instead went direct to the Bradford Royal Infirmary. The notes also state that Child One had what was suspected to be non-accidental injuries, that he had been admitted to the hospital and that a referral had been made to Social Services and Health Visitors. (There is a note that a social worker was keen for a GP to attend the children's safeguarding conference but that was not possible because the GP's surgeries were already booked. Instead, a plan was made to provide a copy of the medical records to the meeting).

- 18th October 2013 - Adult G went to the GP's surgery again complaining that he was feeling depressed. He said that something had happened to him five-months previously but he didn't want to discuss it. He was irritable and said he had thoughts of suicide but hadn't attempted it. He was prescribed anti-depressants and arrangements were made to see him again in two weeks.

- 1st November 2013 - An entry was made on Adult G's record that he had received no benefit from the anti-depressants and that he had physical symptoms of depression. He did not wish to receive counselling. He was to continue with the anti-depressants and the situation was to be reviewed in a week.

8.3 **Bradford Teaching Hospital NHS Foundation Trust (Bradford Royal Infirmary)**

The only relevant contact the Bradford Teaching Hospitals Trust had with anyone involved in this review was when Child One was admitted to the Bradford Royal Infirmary on 17th April and 9th May 2013 respectively.

8.4 When Adult W had taken Child One to hospital on the first occasion, blood samples were tested and the conclusion was that he had a viral infection. There were no indications or suspicions that Child One had been assaulted.

8.5 On the second occasion, Adult W had explained that when Child One had woken up that morning, she had noticed bruising to the right ear and cheek and a rash to the neck. An immediate referral for a paediatric consultant review was made, in line with the Trust's Safeguarding Children's policy.

8.6 A child protection medical examination was carried out which included the taking of blood samples to rule out any haematological cause for the bruising. Discussions also took place with social workers about Child One's previous admission under similar circumstances.

8.7 Adult W stayed with Child One in hospital overnight and most of the following day. The blood tests had proved normal, giving even greater rise to suspect the Child One's injuries had been non-accidental. Discussions took place with Children's Social Care with a view to a placement being arranged.

8.8 As a matter of urgency, a child protection medical examination was carried out on Adult W's other child. Nothing of concern was found.

8.9 **Bradford District Care Trust**

The Health Visiting Service became involved with Adult W after the birth of both of her children. Adult W engaged well with the service and demonstrated a caring attitude, seeking support and reassurance when appropriate. She was reportedly well supported by the children's father who was fully involved with them.

8.10 On 10th May 2013, the Health Visiting Service was told by CSC of the admission to hospital of Child One with the suspected non-accidental injuries and that an investigation was underway.

8.11 On the 17th May, discussions took place with a social worker about the placement of Child One under a voluntary agreement with the children's maternal aunt.

8.12 A health visitor saw Adult W and her two children at home on 10th June 2013 in the presence of their grandmother. Both children were described as being active, alert and sociable and were well presented. Nothing of concern was noted. Adult W was specifically asked whether she had encountered domestic violence or had any issues she required support with. She said *"No"* to both questions.

8.13 On 16th August, a home visit was made to share the child protection report prior to a review on 27th August. It was noted that the children were well presented and that there was spontaneous affection between

both children and Adult W.

8.14 **Bradford Metropolitan District Council, Children's Social Care, Children's Specialist Services**

Adult W and her children were not known to Children's Social Care prior to 9th May 2013, when the Emergency Duty Team received the telephone call from a doctor at the hospital about the unexplained bruising to Child One.

8.15 Neither Adult W nor the children's father (Adult 1), had been involved with CSC as children and there is no record of mental health, drugs or alcohol issues in respect of either of them.

8.16 CSC commenced an immediate investigation and began to develop an action plan which included liaison with the police, obtaining further information from the hospital and determining what was going to happen over the weekend.

8.17 On 10th May they were told by the hospital that it was highly unlikely that Child One had been injured accidentally. As a precaution, arrangements were immediately put in place for Adult W's child to be medically examined. The examination took place that day and raised no cause for concern.

8.18 Later that afternoon, Child One was discharged from hospital. Following satisfactory police checks and with the agreement of the police and the paediatrician, arrangements had been made for the children to stay with Adult W's sister, with Adult W having supervised contact with them.

8.19 A strategy discussion took place with the police, the outcome of which was the initiation of a joint investigation and the start of a 'Core Assessment'.

8.20 Social workers visited the children's father on 13th May. Other members of his family were there and none of them said they had ever seen Adult W use physical force on either of her children. The children's father said that on 8th May, Adult G had been sending him threatening text messages; the last one was *'game over*'. He wondered whether it had anything to do with Child One receiving the injuries that evening.

8.21 On 17th May, CSC visited Adult W to ask whether Adult G would have had any opportunity to injure Child One on 8th May. Adult W said that she never left her children with Adult G but she could see no reason why Child One would lie about such a thing. She said she would not want any further contact with Adult G if he had hurt Child One.

8.22 On 21st May, a social worker spoke with Adult W by telephone. Adult W said she had not seen Adult G, but he had been texting her all weekend; she had ignored him. Adult W explained that her phone had now been cut off and that it was in Adult G's name. Adult W's sister said that over the weekend, Child One had mentioned that Adult G had caused the injuries and that Child One did not want to see Adult G again.

8.23 A social worker spoke with Adult G on 22nd May 2013. He said he had visited Adult W on 8th May, about 7pm, and had played with the children for about ten-minutes before Adult W took them to get ready for bed. Once they were in bed, he went upstairs to the toilet; he said Child One's bedroom door was closed so he could not see into the room. He added that he did not know how Child One's injuries had been caused.

8.24 On 23rd May, a social worker conducted the play session with Child One after which she completed the case note that described how Child One had disclosed to her that Adult G had caused the injuries.

8.25 On 29th May, CSC told the Police about the various disclosures Child One had made, but in particular the one made to the social worker. According to CSC records, the police said they would speak to Child One again. The records also indicate they tried to contact the police officer again on 19th June, to enquire whether Child One had been re-interviewed.

8.26 On 17th June, the initial child protection conference was held. The children were made the subject of Child Protection Plans under the category 'Physical abuse'. It was noted that there had been no prior notifications of domestic abuse relating to Adult W or to Adult G.

8.27 On 27th August 2013, a child protection review was held. It was decided that the children should remain subject of Child Protection Plans. During the review, Adult W said that on 24th August, she had been out with friends when she saw Adult G in a bar. She said she refused to engage in conversation with him and left.

8.28 The CSC received a written referral from the NSPCC on 27th October 2013. (The NSPCC had received the information anonymously). It alleged that Adult W had been pulling and slapping Child One. It also mentioned that people were frequenting her house at all times of the day and night and that a few months previously, police cars and a scientific support van had been at her house.

8.29 On 29th October, Adult W was spoken to about the allegations. She denied them all and became very distressed. (The social worker later told the NSPCC that no further action would be taken in relation to the

referral).

8.30 The following day, Adult W rang a social worker and told him that someone had tried to break into her home on 26th October. She later said her patio door had been smashed and the police had not been able to get any scientific evidence. Adult W added that she thought they would be at great risk if they returned home and she was considering moving out of the area to live with her new partner.

8.31 On 4th November 2013, the day before she died, Adult W told CSC that she thought Adult G had committed the burglary and damage at her home, but that she could not prove it. She added that a local resident had told the police that Adult G had been seen driving up and down the street. Adult W said the police were continuing with their investigations.

8.32 **West Yorkshire Police**

West Yorkshire Police had no contact with either Adult W or Adult G prior to 9th May 2013 when Adult W took Child One to the hospital on the second occasion.

8.33 The police spoke to a doctor over the phone, who said he suspected that the injuries sustained by Child One were non-accidental, but he could not rule out a blood disorder; the result of blood test would not be known until the morning.

8.34 Two police officers went straight to the hospital and spoke to Adult W under caution. She said she lived alone with her two children. Her boyfriend at that time, Adult G, occasionally stayed overnight but was never left alone with the children. Adult W told the officers that at 6.45am that day she had noticed the marks on Child One's face. Adult W said she had not caused the injuries and had no idea how they had happened or who may have been responsible.

8.35 They also spoke to the children's father (Adult 1) under caution. He told them that he had collected the children from Adult W as normal at 11am that day and had taken them to his brother's house and to the supermarket. He noticed the marks Child One's face but didn't take the child to the doctor or to hospital because he knew Adult W would prefer to do it herself. He denied he had caused the injuries to the child.

8.36 The police then went to Adult W's home address and took photographs of every room in the house. They then commenced a joint child protection/criminal investigation with Children's Social Care.

8.37 On 13th May, the police tried to contact Adult G by telephone to arrange

to interview him. He did not answer so they left a message for him to contact them.

8.38 On 14th May, 2013, the police spoke to Child One in the presence of Adult W's sister. He did not say how he had been injured or who had been responsible. Adult W's sister told the officers that during the previous Sunday, when Child Two had struck Child One in the face with a toy, Child One had said *"Don't do that coz* [Adult G] *does that".*

8.39 The following day, the police took a witness statement from Adult W's sister about what Child One had said on Sunday. Again, the officers spoke to Child One, who did not disclose what had happened.

8.40 On 16th May 2013, the police interviewed Adult G under caution. He said he had been at Adult W's house on the evening of 8th May, between 7pm and 9.30pm. He told them that when he arrived, the children were having a bath and they then went to bed as normal. He said he did not see any marks or bruising to Child One's face. He said the first he knew of what had happened was the following day when Adult W told him about it.

8.41 On 21st May, the police told CSC that they would not be taking any further action because everyone involved had given a consistent account and Child One had not disclosed what had happened. They added that even though Adult G had been in the house during the evening of 8th May, Adult W did not recall him being alone with Child One. She had recalled that the bedroom door had been shut and the baby-gate was closed as she had left it. She also said that her own sister had been there all the time.

8.42 The police made a formal decision to close the investigation on 7th June 2013, pending any further information coming to light. They considered the evidential threshold to pursue a prosecution had not been met because there were no independent witnesses, no disclosures had been made by Child One as to who had been responsible and everyone interviewed had denied causing the injuries. (Child One had actually made disclosures by this time; this will be discussed in the analysis section of this report).

8.43 Police records indicate that on 17th June, they provided a report to the initial Child Protection Conference and on 28th June, Adult W's children were made subject to a child protection plan under the category of physical abuse. The next review was on 27th August 2013. (The police did not attend any of the conferences; this will also be commented upon in the analysis section of this report).

8.44 On 28th October 2013, Adult W reported an attempted burglary at her

home address. The police record indicates that they believed it to have been one of a series of seven burglaries in the area committed by drug dealers. They arrested a suspect (who was not linked to either Adult W or Adult G), but there was insufficient evidence to charge him with any offences.

8.45 At 4.58pm on 5th November, the ambulance service told the police they had received a request to assist a female who had been assaulted and was not breathing. They went straight to the scene where they arrested Adult G.

9 Analysis

9.1 Analysis of involvement of GPs

Record keeping at the GP practices was comprehensive and appropriate and (other than their inability to attend the Child Protection Conference – see below), they were fully engaged in safeguarding processes.

9.2 Adult W and Adult G were registered at different GP practices.

9.3 There was an appropriate range of services, interventions and referrals made by the GP practices in respect of Adult W and her two children. GPs have the ability to make direct referrals to the Children's Assessment Unit at hospital so that children can be seen directly by a paediatric doctor, by-passing the Accident and Emergency Department. That is precisely what happened when Adult W took Child One to the GP on 17th April 2013.

9.4 No GP was able to attend a safeguarding meeting because all of their surgeries were already booked up. This issue has been identified during other reviews in the Bradford area and other parts of the country where GPs have been invited to initial case conferences but they haven't been able to attend because of other pressing and pre-arranged clinical commitments. As a result, a case conference report template has been developed in Bradford and its use is included in local GP training. The use of the template ensures that safeguarding information is properly shared.

9.5 Although Adult G visited his GP with what he described as depression, there was nothing to indicate to the doctor that he was likely to go on to commit such a terrible crime. He declined to discuss in any detail why he felt as he did and he was offered counselling which he declined. It appears that Adult G had visited the GP to obtain a private letter for his employer rather than for any treatment. He did not want to talk about his underlying problems and from the record appears not to have presented with symptoms of anything other than mild depression. The private letter,

(which has been made available to this review), consisted of a request to Adult G's employer that he be deployed within this country if possible, because he was suffering from anxiety and had symptoms of depression due to his experiences in Afghanistan.

9.6 There would have been no reason for the GP to suspect anything untoward when Child One was admitted to hospital on the first occasion. The circumstances did not amount to a missed opportunity to intervene in a child protection issue.

9.7 **Analysis of involvement of Bradford Teaching Hospital NHS Foundation Trust**

The child protection medical process at the hospital was supplemented by an in-depth social history screening during which Adult W was asked whether she had a history of mental health, drugs, alcohol or domestic abuse issues. Adult W said she did not. The fact that she was specifically asked these questions was good practice.

9.8 There were other examples of good practice. On the morning of 10th May 2013, Adult W's request to take Child One off the ward was refused by a nurse. The nurse did so to prevent any chance of Child One being removed from the hospital while the child protection investigation was ongoing. (There was no suggestion that Adult W intended to leave the hospital, but the reason she wanted to take the child off the ward is not known).

9.9 Once the blood tests had shown nothing untoward, there was no medical reason for Child One to stay in hospital, but the doctor and Children's Social Care negotiated for the child to remain on the ward to allow time for a placement plan to be developed and for the child protection investigation to be progressed.

9.10 An issue identified during this review is that although domestic abuse awareness training is available to all clinical staff at BTHFT, it is not mandatory. Although a lack of training did not have any bearing whatsoever on Adult W's case, a recommendation will made in this review to rectify the situation.

9.11 The need to review routine child protection documentation within BTHFT was also identified. Terms such as *'Dad'* had been used throughout and it was not always clear whether the term referred to Child One's natural father or not. A recommendation about this will also be made.

9.12 **Analysis of involvement of Bradford District Care Trust**

There were no warning signs that would have led the Health Visiting

Service to consider that domestic abuse and/or violence was a feature of Adult W's life. The question about domestic abuse had quite correctly been raised with her as a matter of routine.

9.13 The records do not make it clear whether the subject was raised by the Health Visiting Service while Adult W was alone or if she had been with her grandmother at the time. Adult W's grandmother does not recollect being present when the question was asked, and believes it must have taken place when the health visitor and Adult W were upstairs together.

9.14 During meetings the DHR Chair has had with Adult W's family, it was clearly apparent that they hold the Health Visiting Service in extremely high regard and are grateful for the support they have received from them throughout what has been a very difficult time.

9.15 **Analysis of involvement of Children's Social Care**

There is clear evidence that from the moment Child One was admitted to hospital on 9th May, CSC put in place entirely appropriate provision for the wellbeing of both of Adult W's children. They acted quickly and decisively to ensure Child Two was safe and well and negotiated for Child One to remain in hospital until appropriate interim care arrangements could be organised.

9.16 The arrangements for the children to stay with Adult W's sister from the time Child One was discharged from hospital until 24th May, (with Adult W having supervised contact), to allow for enquiries to be made was entirely appropriate as was the subsequent decision to allow them to return to Adult W. The rationale behind the decision was well considered and documented. The conditions that were imposed, that Adult W's mother stayed at Adult W's house, that Adult W had no contact with Adult G and that the Child Protection Plan was pursued were all entirely appropriate in the circumstances.

9.17 During a meeting with Children's Social Care on 21st May 2013, Adult W said that Adult G had been texting her but she had ignored him. She added that her mobile phone, which was in Adult G's name, had since been cut off. During this review, CSC has been critical of itself for not asking Adult W why the phone was not in her own name or what the financial arrangements were between her and Adult G. They say that with hindsight, more clarity about the 'power' balance between the two may have shed more-light on their relationship.

9.18 Although it is always good practice to probe such issues, in Adult W's case, even if it had been done, it would not have produced more clarity about the relationship between the pair. Adult W's mother has told the review that she was present during the meeting on 21st May and that no

matter how detailed the questioning may have been, Adult W would not have gone into any detail about her relationship with Adult G because she was a very private person by nature. Adult W's mother also said that as far as she was aware, the explanation for the phone being in Adult G's name was simply that he had upgraded his own phone and had given the old one to Adult W. She added that Adult W would have paid him for it though.

9.19 On a similar note, CSC has been critical of itself for not asking Adult W whether Adult G had been violent towards her or whether she had witnessed him being violent towards anyone else. In addition, the nature of the relationship between the two, for example, how often Adult G stayed overnight at Adult W's house and how long had they known one another were not explored. These questions undoubtedly should have been asked, particularly those in respect of domestic violence, but again, evidence from Adult W's mother is that Adult W would not have divulged any information; it was simply not in her nature to discuss such matters.

9.20 According to Adult W's family, backed up they say by text message evidence produced during the trial, Adult W met Adult G on only two or three occasions after she had learned of the disclosures made by Child One. The family say that no matter how rigorous CSC may have been in their questioning of Adult W, she would never have disclosed that she was meeting him because of her fear of losing her children; a condition of the children being returned to her was that she must have no contact with him. (None of Adult W's family had any idea that she had been meeting Adult G).

9.21 The social workers who the family say hinted that Adult W should 'play detective' by trying to elicit a confession from Adult G cannot understand what would have made them come to that conclusion. They say that as far as they are concerned, nothing was said or done that could possibly have been misconstrued in that way. (Adult 2 has told this review that Adult W did not give him the impression that she had been influenced by Social Services in that regard.)

9.22 Adult W's family and Adult 2 are adamant that a social worker told Adult W that she could not move to Leeds to live with Adult 2 because she had to demonstrate that she was strong enough and independent enough (after the attempted burglary at her home), to cope on her own and that if she did not, she could lose her children. They believe that had Adult W gone to Leeds, she would probably have abandoned her quest to elicit a confession from Adult G.

9.23 The social worker says he did not say anything of the sort. His account is that when Adult W asked him whether it would be possible to move to Leeds while the children were subject to child protection plans, he told

her that it was up to her to decide whether she wanted the plans to end before she made the move.

9.24 He he ~~a~~lso told her that if she did move, the child protection plan would follow the children to Leeds and that access arrangements to the children by Adult 1 had to be resolved before the plans could end.

9.25 **Analysis of police involvement**

The police responded quickly and professionally when they received the referral from CSC after the admission to hospital of Child One on 9th May 2013. They went straight to the hospital where they interviewed Adult W and Adult 1. It is clear from the level of communication between the police and CSC that the priority for the two organisations was to ensure the immediate safety of both children.

9.26 Both parents denied any knowledge of how Child One had been injured and Adult W went on to say that the only other people who had been in the house at the time had been Adult G and her sister. At that time, Adult W genuinely had no reason to believe that either Adult G or her sister could have been responsible and she told the police as much.

9.27 They examined Adult W's home for evidence and also took photographs of all the rooms in the house.

9.28 They interviewed Adult G under caution after he voluntarily attended at a police station on 16th May. He was not arrested because Adult W had already told the officers that he had not been alone with her children that evening. The only evidence at that time that he may have been responsible was the comment Child One had made the previous Sunday to Child Two, namely, *"Don't do that, coz* [Adult G] *does that."*

9.29 The police insist they sought a disclosure on three or four occasions from Child One about what had happened, although they did not maintain a record of all of them. At no time did Child One indicate to them who had caused the injuries or how ~~he~~ they had come about.

9.30 The Review Panel recognises the many difficulties associated with repeated attempts to elicit an explanation from such a young child and is mindful of the 2011 Achieving Best Evidence guidelines on the subject issued by the Ministry of Justice.

9.31 Those difficulties can be exacerbated when two organisations are involved in the same investigation; the need for effective communication between them and accurate record keeping is absolutely crucial.

9.32 When Child One was admitted to hospital, a strategy discussion took place between Police and Children's Social Care and it was agreed that a joint S47 investigation would take place. The police were to lead the criminal investigation and CSC would focus on the safety and well-being of the children. They agreed to share any information in line with established 'Working Together' protocols.

9.33 Of concern to this review is the fact that there appears to have been a breakdown in communication between the two agencies during the joint investigation. Identifying precisely what went wrong and why has been made all the more difficult because the police accept they did not always record the full extent of discussions between them and Children's Social Care.

9.34 Mentioned previously was the fact that on 23rd May, a social worker conducted a play session with Child One during which the disclosure was made about Adult G causing the injuries.

9.35 CSC records indicate that on 29th May, they told the Police about various disclosures Child One had made, in particular the one to the social worker the previous week. Their records are also endorsed to the effect that the police said they would speak to Child One again. The records also indicate that the social worker tried to speak with the police officer again by telephone on 19th June to enquire whether another interview had taken place. The officer was not available and a message was left asking for the call to be returned. There is no record of that happening.

9.36 The police categorically deny that any such undertaking was entered into and say that any further attempt to elicit a disclosure from such a young child would not have been in keeping with the principles of 'Achieving Best Evidence'.

9.37 Police records do include the fact that on 14th May 2013, they interviewed Child One when no disclosures were made. Further entries on 21st May and 4th June confirm that discussions had taken place with CSC and that no further police action would be taken.

9.38 When the Police made the formal decision to close the investigation on 7th June 2013, one of the considerations they recorded was that Child One had not made any disclosures about who had been responsible. In fact, by 7th June 2013, Child One had actually made disclosures in the presence of family members on two occasions plus the one to the social worker during the play session on 23rd May.

9.39 The police can always re-open a previously closed criminal investigation and the fact that Child One made a disclosure to a professional should have at least prompted a further review of the evidence. Either they did

not receive that information, in which case the CSC records are inaccurate, or they did receive it and they subsequently failed to act appropriately. In either case, there was a missed opportunity to progress the investigation.

9.40 Both organisations independently interviewed Adult G. He told CSC that when he arrived at Adult W's house on 8th May, he played with the children for about 10 minutes before Adult W took them to get ready for bed. He apparently told the police that when he arrived, the children were in the bath and they then went to bed as normal.

9.41 Slight variations in accounts provided in such circumstances are not unusual or necessarily sinister, but it is clear that the two organisations did not know that there were discrepancies in the two accounts Adult G had provided.

9.42 The Police did not attend the initial child protection conference or subsequent reviews. They say the reason was that by the time the invitation to attend had been issued, they had already closed the criminal investigation and also that the police officer seconded to Bradford CSC was unable to attend due to 'capacity issues'. The police did, however, provide a report to be considered during the conference.

9.43 Guidance issued by the Association of Chief Police Officers (ACPO) states that where a criminal investigation has been undertaken or is on-going, Child Abuse Investigation Unit staff should attend all initial conferences. Although the guidance goes on to say that in exceptional circumstances, a report can be submitted to the Chair of the conference instead, West Yorkshire Police accept that a representative of their safeguarding unit, who had been involved in the investigation into how Child One had received the injuries, should have attended the initial child protection conference.

9.44 They now monitor, on a monthly basis, their attendance at such conferences to improve their compliance with the ACPO Guidance.

9.45 Adult 2 has told this review that he had been with Adult W when she had discovered the attempted burglary at her house. He also said that when the police arrived, Adult W told them about the assault on Child One and that she thought Adult G had caused the damage to her house in an attempt to intimidate her.

9.46 The officers though, appeared to be sure that the burglary was one of a series committed by local drug addicts in the area between 23rd and 28th October 2013. (They later arrested a local drug addict on suspicion of committing them all but he denied any involvement and was released without charge).

9.47 There is nothing on police systems to indicate that Adult G was ever considered a suspect for the attempted burglary.

10 Analysis of issues raised by Adult W's family

10.1 Adult W's fear of her children being taken in to care

Adult W's family understand fully that the authorities' primary concern at all times was the safety of Adult W's children. They also appreciate that in the absence of conclusive evidence as to who was responsible for causing Child One's injuries, everyone who had been in the house during the evening of 8th May 2013 must have been regarded as a potential suspect.

10.2 Although a painful experience for them all, the family consider that the child protection measures that were put in place, from the medical examination of Child Two to the interim placement arrangements, were conducted in a professional, timely and sensitive manner. They appreciate also, that as the investigations progressed, particularly after the disclosures had been made by Child One, the restrictions as to where and with whom the children lived were relaxed proportionately.

10.3 Adult W absolutely doted on her children. The thought that they could be taken away from her a second time absolutely terrified her. Adult W's family say that from the moment she entered into the undertaking that she would have no contact with Adult G, any chance that she would divulge anything about him to anyone in authority disappeared. Not only that, she would not have said anything to friends or family for fear of any of them passing the information on to Social Services.

10.4 Given the circumstances, there can be no doubt that the imposition of the condition that Adult W should have no contact with Adult G was not only correct but was inevitable. The police, CSC, Adult W's family and Adult W herself all believed Adult G had caused the injuries to Child One. As far as Adult W was concerned, she not only had to been seen to distance herself completely from Adult G, she also had to do what she could to prove her own innocence. (This will be discussed in more detail in the next section of this report).

10.5 Evidence provided to this review by Adult W's family as well as Adult 2, is that Adult W became paranoid about doing anything that may have upset Social Services. They believe that was the only reason she did not go to Leeds to live with Adult 2 and speculate that had she done so, she would have abandoned her quest to prove to Social Services that she had not assaulted Child One.

10.6 Adult W and Adult 2 met in early September 2103. They soon began to make plans to live together at Adult 2's home in Leeds. Adult W had made enquiries about finding alternative schools for the children and had enquired about changing their GPs practice. She and Adult 2 began decorating a room especially for Adult W's children and shortly before her death, Adult W and her sister had been shopping together to buy new bedding for the room. Adult W was nervous about telling Social Services about Adult 2, but on 17th October 2013, she disclosed the relationship to them and said she wanted to move to Leeds.

10.7 Adult W's family and Adult 2 say the social worker told Adult W that she could not move away because she needed to demonstrate to Social Services that she was strong enough and independent enough to cope on her own; if she did not, she could lose her children. The social worker also apparently used words to the effect that she wasn't to show that the burglary at her home had scared her.

10.8 These discussions apparently took place on 1st November at Adult W's mother's home in Bradford. The family feel that the decision not to let her move away from her problems in Bradford was both selfish and illogical on the part of the social worker. Adult W chose not to move only because of her desire not to upset Social Services.

10.9 The social worker has been interviewed during this review and has a completely different recollection of events. He stated that Adult W had asked him whether it would be possible to move to Leeds while the children were subject to child protection plans; he did not tell her that she could not move there but did say it was up to her to decide whether she wanted the plans to end before she made any move.

10.10 He said he also told her that if she did move, the child protection plan would follow the children to Leeds. He said they also discussed issues around access arrangements to the children by their father and that the plans couldn't end until the dispute over the contact arrangements had been resolved. The social worker said he told Adult W that it was completely up to her whether she went to Leeds.

10.11 Adult W's family absolutely dispute what the social worker has told the review about Adult W's proposed move to Leeds.

10.12 **Adult W's attempts to elicit a confession from Adult G**

As far as Adult W was concerned, she had to do all she could to prove to the authorities that she had not caused the injuries to Child One.

10.13 When a social worker told Adult W not to have anything to do with Adult G, both she and the rest of her family took it that she was actually hinting

that Adult W do exactly the opposite. They all got the impression that the social worker wanted her to *'get close to him'* in the hope that he would say something incriminating about the assault upon Child One.

10.14 During this review, Adult 2 was specifically asked whether he thought Social Services had encouraged Adult W to get close to Adult G with a view to eliciting a confession from him. He said he did not gain that impression and that Adult W certainly didn't tell him that that had been the case.

10.15 Adult W did tell Adult 2 that she had not seen Adult G since the day Child One had been assaulted but that she had been in touch with him via text messages and on social media. She told him she was trying to get him to admit he had caused Child One's injuries and that because the police had closed the case, she was having to do their job for them.

10.16 On 26th October 2013, she showed him some text messages she had received from Adult G, which she had construed to amount to an admission of his guilt. He told her that in his opinion, she was reading too much into the messages.

10.17 **The joint Police/Children's Social Care investigation**

As mentioned previously, Adult W's family believe that had there been a more effective joint Police and CSC investigation into the assault on Child One, the truth would have emerged and Adult W would therefore not have thought she was a suspect. They speculate that had that happened, Adult W would not have felt compelled to meet with Adult G to elicit evidence of his guilt.

10,18 In particular, the family consider that not enough was done by either organisation to secure a disclosure from Child One about how and by whom the injuries had been inflicted. They are of the opinion that that police closed their investigation far too soon and that Adult G should have been arrested.

10.19 Once information is received that a child has suffered or is likely to suffer significant harm**,** a strategy discussion must take place between the responsible agencies. The main purpose is to share information, to consider the needs of the children and to establish if a joint enquiry should be undertaken (including who will do what and when).

10.20 The main role of CSC is to determine what action is required immediately and in the short term to safeguard the child(ren) and to provide support. The police take on any criminal investigation, but the agencies should agree who should be interviewed, by whom, for what purpose and when. All interviews should be carried out in accordance

with ‘Achieving Best Evidence’ guidance.

10.21 The Police and CSC have established arrangements for sharing information to enable them to put in place effective child protection services and there have been no indications during this review of a conscious unwillingness by either organisation to share what they knew.

10.22 The Bradford Safeguarding Children’s Board policy of holding a strategy discussion whenever there is an indication that a child has suffered or is likely to suffer significant harm was followed, and the decision was rightly made to establish a ‘Section 47 Enquiry’.

10.23 Appropriate plans were put in place to ensure the safety of the children including the safe discharge from hospital of Child One after medical assessments and treatment had been carried out.

10.24 The strategy discussions should include an agreement about the conduct and timing of any criminal investigation, including who should be interviewed, by whom, for what purpose and when (as well as carrying out interviews in accordance with ‘Achieving Best Evidence’ guidance – see below).

10.25 Bradford Council procedures state that (during the child protection aspect of the enquiry), the child must always be seen and communicated with alone by the Lead Social Worker, unless it is contrary to his or her interests to do so.

10.26 The procedures also state that the police should decide whether or not their investigations reveal grounds for instigating criminal proceedings and should make available to other professionals any evidence gathered to inform discussions about the child's welfare. Further, they should follow the principles set out in ‘Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses’.

10.27 CSC went to the hospital to speak with Adult W and Child One on 10th May. The child made no disclosures about what had happened and was clearly tired and fed up of being asked about it by medical staff and by his parents.

10.28 Two days later, Child One made the first disclosure that Adult G had been responsible, saying to Child Two, *“Don’t do that, coz* [Adult G] *does that.”*

10.29 The second disclosure was reported to CSC by telephone by Adult W’s sister two-days after the first one. Child One had said *“*[Adult G] *did this to me’”*. Adult W’s sister told CSC that the police had been the day before, but Child One had not said much to them.

10.30 A week later, on 21st May 2013, the social worker received a voicemail message from the police saying that they were not taking any further action, partly because Child One had not made a disclosure to them or to any other professional.

10.31 On 23rd May, social workers went to see Child One again, because of the disclosures made to family members. Their hope was that Child One would also tell them what had happened and if that happened, it would enable the police to resurrect the criminal investigation.

10.32 It was during a play session on that visit that Child One said to the social worker, *"No, don't want to draw* [Adult G], *he did this to me"*.

10.33 CSC say that on 29th May they told the Police about the disclosures, in particular the one made to them the week before and that as a result, the police agreed to speak to Child One again. As mentioned previously, their records also indicate that on 19th June they attempted to find out whether it had been done.

10.34 The police say they did not agree to speak to Child One again because they had already done so on at least three, possibly four occasions, although they concede they do not have a written record of them all (Adult W's family say they spoke to Child One twice). The police add that because Child One had not disclosed anything, any further attempt, in their view, would not have been in keeping with the principles of 'Achieving Best Evidence'.

10.35 The Review Panel acknowledge there is always a delicate balance to be achieved when interviewing young children about abuse they have suffered, and that serving the best interests of the child must always be the key objective. The police have quite rightly pointed out that limiting the number of occasions a child is asked to describe what happened to them and keeping to a minimum the frequency of visits by agencies to the child's home is very important to the child's welfare.

10.36 The police also point out that they have to take into account other considerations, for example, the potential for vulnerable children to say what they perceive adults want to hear, especially after repeated questioning, and the probity of such evidence in future criminal proceedings.

10.37 A joint investigation should be kept under review, especially when one agency, in this case CSC, is still actively pursuing their element of it. If the police did know of the disclosure made by Child One to the social worker, they should have at the very least secured the evidence of that professional and then re-apprised the decision to close the criminal

investigation. It did not necessarily require a further visit to Child One by the police to seek another disclosure to another professional.

10.38 CSC says the Police undertook to see Child One again; the Police say they did not. It is unacceptable and certainly not in keeping with the spirit of 'Working Together' for one agency to be saying the other agreed to a specific course of action and the other to deny it happened.

10.39 It is also evident that CSC and the Police did not know in advance when each was making their respective visits to speak to Child One or how often such visits were taking place. Of even more concern, the respective organisations did not always know what had been said by Child One and/or the family during the visits, until some considerable time later, if at all.

10.40 Comment has already been made in this report about the slight anomaly in what Adult G told CSC and what he told the Police. The anomaly was not identified and that should not happen. Details of every engagement with victim, perpetrator, family and friends/colleagues must be shared between agencies in a joint investigation, otherwise, key information will be missed and opportunities lost. Without that sustained level of communication, the inevitability will be that disparate investigations, running parallel with one-another, will develop.

11 Comment in relation to Terms of Reference

11.1 Family engagement

Adult W's immediate family and Adult 2 have fully engaged with this review.

Adult W's former partner and father of her two children (Adult 1), did not respond to an invitation to participate in the process.

Friends and work colleagues were canvassed by Adult W's family to determine whether they knew anything that may help progress the review. None were able to do so.

Through his lawyers, Adult G has been invited to participate in the DHR process, but to date he has not responded.

11.2 The panel decided that the Bradford Community Safety Partnership would handle all media and communication matters. It was agreed that the overriding aim was to protect Adult W's family from unwanted media attention so a reactive press statement was developed to cater for any enquiries that may have been made. Its purpose was to explain what a review was, why and who commissioned it and to stress that the review

works closely with the family throughout the process.

11.3 An executive summary of the review will be published on the Bradford Council website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed via the partnership website, the partnership's operational and strategic domestic abuse groups and applied to learning programmes involving partnership agencies responding to domestic abuse.

11.4 **Legal processes**

Many of the potential contributors to this review were likely to be witnesses in the murder trial. An early decision was made that the review would be suspended until the judicial process came to an end. When Adult G was sentenced to life imprisonment for murdering Adult W, the review re-commenced.

The Coroner opened an inquest into Adult W's death and then adjourned it because criminal proceedings were under way.

11.5 **Research**

Previous DHR's have been scrutinised during this review to take account of lessons learned.

No conflicts or issues have been identified that would suggest that independent legal advice will be required about any aspect of this review.

11.6 **Diversity**

There were no issues around equality or diversity.

11.7 **Multi-agency responsibility**

Multi Agency Risk Assessment Conferences (MARAC)

Adult W was not subject to MARAC.

(The MARAC process is well established within the region and there is a clear and unambiguous process surrounding it. Training and awareness has been provided and the process has twice been independently evaluated and approved by CAADA (Co-ordinated Action Against Domestic Abuse).

11.8 **Multi Agency Public Protection Arrangements (MAPPA)**

Adult G was not subject to MAPPA.

11.9 **Domestic Violence Perpetrator Programmes**

Adult G was not involved in a Domestic Violence Perpetrator Programme.

11.10 **Contact with DV organisations/help-lines**

Adult W did not have any contact with a domestic violence organisation or helpline.

11.11 **Vulnerable adults**

Adult W was not a 'vulnerable adult' within the definition of the Law Commission Report of 1997.

11.12 **Communication, information sharing and service delivery between agencies**

Communication, information sharing and service delivery between agencies as far as the short and medium-term welfare of Adult W's children was concerned was good. There are ample examples of agency liaison and co-operation and there was no hint of any reluctance or fear of sharing information.

The breakdown in communication between the Police and CSC as far as their respective investigations was concerned has already been discussed at length in this report.

11.13 **Did Adult W, her family, friends or colleagues experience any barriers in reporting any abuse in Bradford or elsewhere?**

Adult W's family has said that she was a very private person and would not readily have spoken to anyone, even them, about any concerns she may have had around abuse.

A certain barrier to Adult W reporting any contact with Adult G (to the Police, CSC and her family), was her fear that Social Services would take her children from her if they found out about it.

11.14 **Did they know how to report domestic abuse should they have wanted to?**

Adult W and her family would have had no difficulty in reporting abuse

had they wanted to. After the assault on Child One, they were all in regular contact with the Police. CSC and Health Visitors.

According to Adult W's family, prior to the assault on Child One, Adult W would have known how to make a report of abuse, although they consider it unlikely she would have done so.

11.15 **Did Adult W experience abuse in previous relationships in Bradford or elsewhere, and if so, did the experience impact on her likelihood of seeking support in the months before she died?**

There were no indications that Adult W was the victim of domestic abuse in any of her previous relationships.

11.16 **Were there any opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Adult W that were missed?**

Health visitors routinely enquired of Adult W whether she had experienced domestic abuse. Their records indicate though, that Adult W's grandmother may have been there at the time. Adult W's grandmother is aware that the question was asked of Adult W, but she does not recollect being present when it was discussed. Her belief is that the discussion took place in private when the Health Visitor and Adult W were upstairs in the house together. If that was the case, it was a demonstration of good practice on the part of the Health Visitor.

During the child protection medical process at the hospital, a doctor took the opportunity to ask Adult W whether she had any history of mental health, drug or alcohol issues and whether she had experienced domestic abuse.

Both CSC and the Police had ample opportunity to routinely enquire of Adult W whether she had experienced domestic abuse. Neither organisation reported they had done so.

11.17 **Did Adult G have a previous history of abusive behaviour to an intimate partner and if so did the agencies know?**

There is no record of Adult G having any previous history of abusive behaviour.

11.18 **Were there opportunities for agency intervention in relation to domestic abuse regarding Adult W, Adult G or Adult W's dependent children that were missed?**

No missed opportunities to intervene in relation to domestic abuse have

been identified during this review.

11.19 **Individual agency responsibility**

Was the work in Adult W's case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults and with wider professional standards?

Other than a failure by the Police to record some aspects of the Joint Strategy Decisions with CSC, and their non-attendance at the initial Child Protection Conference, all of the organisations complied with their policies and procedures for safeguarding and promoting the welfare of adults.

11.20 **What were the key relevant points/opportunities for assessment and decision making in relation to Adult W and Adult G?**

There was no known history of domestic violence involving Adult W and Adult G, therefore there were no identifiable assessment opportunities in respect of their relationship.

11.21 **What was the quality of any multi-agency assessments?**

Multi-agency assessments in relation to the threat posed to Adult W's children were of the highest standard. Assessments regarding the joint investigation involving Police and CSC were hampered at times by a breakdown in communication.

11.22 **Was the impact of domestic violence on Adult W recognised?**

Because there were no indications that Adult W was the victim of domestic violence, there was no factors that could have been recognised.

11.23 **Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?**

There were no assessments and subsequent decisions made in respect of domestic violence for the reasons already articulated.

11.24 **Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved at points where they should have been?**

Nothing has come to light during the review that would indicate a lack of

management accountability for decision making in respect of any of the organisations involved.

12 Comment in relation to case-specific issues

12.1 Learning to improve safeguarding practice

Safeguarding practice in respect of Adult W's children was of an extremely high standard – it was efficient, timely and effective and was understood by all of the professionals involved with the family.

12.2 Management accountability

Compliance with policy and procedures

There was an appropriate range of services, interventions and referrals made by both GP practices in respect of Adult W and both of her children. The only issue identified as far as the GPs were concerned was their inability, due to clinical commitments, to attend the child protection conference. This issue has been identified in other reviews, and as a consequence, work has been undertaken to ensure that GPs are able to contribute to child protection case conferences by way of a case conference report template. The template was developed through consultation with GP safeguarding children leads and Named GPs for safeguarding children and its use is included in local GP training.

12.3 The BDCT Health Visiting Service fully complied with policies and procedures and Adult W's family have nothing but praise for the support they and Adult W received throughout a very difficult time.

12.4 Children's Social Care followed Bradford Safeguarding Children Board policies and procedures in relation to the immediate and short-term care of the children who both successfully became subject to Child Protection Plans on 17th June 2013. The plans were still in place when Adult W died on 5th November 2013.

They complied fully with the principles of the 'Working Together to Safeguard Children' policy, effectively sharing information with other professionals to ensure excellent service provision.

12.5 The Police did not attend the initial child protection conference or child protection review but instead provided a report for the conference Chair. They acknowledge that they should have attended in line with the guidance issues by ACPO and have since put in place procedures to monitor future attendance. They correctly interpreted the provisions of the Police and Criminal Evidence Act Codes of Practice surrounding the question of whether to arrest Adult G on suspicion of assaulting Child

One and instead interviewed him under caution when he went to the police station on a voluntary basis.

12.6 The Police responded promptly and professionally to the referral to them by the CSC Emergency Duty Team and immediately went to the hospital to interview Adult W and Adult 1.

12.7 **Appropriate consideration to potential risks to the children**

There is no doubt that all of the agencies involved had at the forefront of their minds the potential risks to the children and that from the moment Child One was admitted to hospital, there was no possibility that either of them could come to further harm.

12.8 **Communication, information sharing and risk assessment**

Although there was undoubtedly a breakdown in communication between the police and CSC in respect of the re-interviewing of Child One, there is ample evidence that communication and cooperation between them was otherwise of a high standard.

There is evidence throughout of effective information sharing and communication between the Health Visiting Service and Children's Social Care.

12.9 **Appropriate consideration to multi-agency action to assess the needs of the children**

There has been clear evidence throughout the review of excellent multi-agency co-operation to assess the needs of the children from the time Adult W's son was admitted to hospital on 9th May 2013. Prior to that event, none of the agencies had cause to consider either child could have been at risk.

13 Comment on the IMRs

IMRs are intended to review the respective organisations processes and their involvement and also to provide an analysis of the service they provided.

The IMRs were quality assured by the respective agency, by the original author and Panel Chair. Where challenges were made they were responded to promptly and in a spirit of openness and co-operation.

14 Conclusions

- Prior to the admission to hospital of Child One on 9th May 2013,

none of the agencies that make up the Bradford Community Safety Partnership were aware of any issues involving domestic violence, child protection, drugs or alcohol involving Adult W, her extended family or Adult G.

- Although suspicious now, there was no reason for any of the professionals at the hospital to suspect Child One may have been the victim of an assault on the first occasion. It cannot be regarded as an opportunity missed to intervene in a child abuse scenario.

- Adult G had seen his GP, complaining of symptoms of mild depression. He did not wish to elaborate nor did he accept counselling. There was nothing to indicate to the doctor that he had the potential to go on and commit such a horrific crime.

- Although the Police, Children's Social Care, Health Visitors and GPs had dealings with Adult W and her family and/or Adult G during the six months between that event and Adult W's death, none could have foreseen the dreadful events of 5th November 2013. Adult W's death was therefore neither predictable nor preventable.

- The initial action of all the agencies involved in protecting Adult W's two children from the potential for further harm was commendable. Communication and co-operation between agencies was of a high standard as was dialogue and information sharing with Adult W's family.

- The decision of the police to close the child abuse investigation appears not to have taken into consideration the various disclosures made by Child One to family members and to CSC.

- There were clear breakdowns in communication between those involved in the respective Police and CSC investigations with inadequate record keeping by the police adding to the problem. CSC records indicate a degree of frustration on their part that the police had decided to close the criminal investigation and that they had apparently failed to honour a commitment they made to re-interview the boy.

- The S47 investigation was not 'joint' in the sense that the police did not know what Adult G had told CSC nor did CSC know what he had told the Police. Interviews with Child One were carried out by both organisations but there was no co-ordination between them beforehand or a 'comparing of notes' afterwards. In effect, two parallel and separate investigations took place.

- There was also a breakdown in communication between CSC and Adult W (and with members of her family) about her proposed move to Leeds to live with Adult 2. Adult 2 and the family remain adamant that CSC refused permission for that to happen; the social worker says otherwise.

- Adult W felt compelled to meet with Adult G to elicit a confession from him. In her mind, she had to do so in secret because of her fear of losing her children if it became known she was seeing him, having agreed, as part of the Child Protection Plan that she would not.

- The imposition of that condition was both necessary and proportionate. Inevitably though, a consequence was that it produced an even bigger barrier to Adult W telling anyone she was meeting Adult G. She did not tell the authorities, her family or even her new partner.

15 Recommendations

The following recommendations are made:

GP's

- That the template that has already been developed to enable GPs in Bradford to share information at Child Protection Conferences if they cannot attend in person be shared more widely throughout West Yorkshire and beyond.

- The existence of the template should continue to be shared at all local safeguarding training.

- Bradford CCGs should, through the Health Safeguarding Children Group and the Safeguarding in SystmOne Group, review the possibility of linking adults who are registered at different practices when there are safeguarding concerns about children in the household.

Bradford Teaching Hospitals Trust

- All clinical staff should receive mandatory domestic abuse awareness training and domestic abuse awareness should be included as part of the induction process for new staff.

- The current child protection documentation for clinical areas should be reviewed to ensure it includes provision for

comprehensive family assessments with special attention being paid to the accurate recording of the names of parents and guardians.

Bradford District Care Trust – Health Visiting Service

- Health Visiting standards should be updated to reflect current NICE guidance on Domestic Violence and Abuse.

- The use of 'routine enquiry' should be included in Health Visiting standards in line with the February 2014 NICE guidance.

Children's Social Care and West Yorkshire Police

- All CSC Team Managers should undergo mandatory training in critical enquiry and reflective supervision.

- Children's Social Care and the Police should review and agree their respective roles when Joint S47 enquiries are undertaken, particularly in respect of interviewing children, parents and suspects.

- The two organisations should also attempt to bring some clarity to the issue of when a child's disclosure reaches the threshold to warrant further action being taken. (Child One disclosed abuse several times, both to family members and a CSC professional).

- Both agencies should agree a policy around the recording of communications between them, decisions made and the outcome of any action taken and in particular, the Police should ensure that in Child Protection Investigations, a clearly defined investigative plan is documented within their Niche OEL.

- The Police should strive to ensure that an officer who has been involved in the child protection investigation attends the initial Child Protection Conference and subsequent reviews, irrespective of whether the criminal investigation has closed. Providing written reports for the Conference Chair instead of attending in person should only happen in genuinely exceptional circumstances.