GLOUCESTER CITY COMMUNITY SAFETY PARTNERSHIP SAFER GLOUCESTERSHIRE AND GLOUCESTERSHIRE SAFEGUARDING CHILDREN BOARD JOINT DOMESTIC HOMICIDE REVIEW AND SERIOUS CASE REVIEW

Overview Report into the death of Laura and Ella

May 2018

Independent Chair: Nicole Jacobs

Report Author: Gemma Snowball

Date of Final Draft Version 14: January 2021

"Laura was an extremely loving and caring mother, daughter, sister, granddaughter, aunty, niece and cousin. She lived life to the full and full of fun, with a great sense of humour. Laura was friendly to everyone and a happy person who loved to make others happy. She was adored by all of her family and by her many friends- by so many people. Laura was always the one who would be getting us together and organising family parties and meals out. She arranged a wonderful formal 90th birthday party for my mother, what such a lovely, thoughtful tribute to her grandmother. Laura cared about others. Several times she organised fund raising events for local charities. Laura, with her kind and giving nature, was always willing to go out of her way to help anyone. Laura was a really hard worker. She had done brilliantly well in setting up her own wedding planning business. She was expanding it all the time and had won several awards. In 2017, she won the South West Region, 'Guide for Brides Customer Service Award' and the 'Three Counties Wedding Award'. She always went the extra mile to help her couples and they had nothing but praise for her. This is a typical review: "Simply amazing- couldn't have asked for a better service- fab lady and fab company." She was held in such high regard in the wedding industry that they have created a special award in her memory… Most importantly, Laura was a wonderful, devoted mother, who absolutely adored her three children and showered them with love and affections. She loved having fun with them…Laura had so much to live for and so much promise." ***– Mother of Laura***

"Ella was my adored first grandchild and we were extremely close. She was such a beautiful, loving, happy girl. She was also very talented at ballroom dancing… She loved to dance and was a natural performer, so good that she achieved 93% marks on her dance exam- the highest in the dance school… She adored her mother and they were also great friends, who loved shopping together and doing girlie things like pamper days. She adored her father and his family and loved spending time with them also. She adored her siblings and was like a little mother to them, always looking out for them. She adored her cousins and was very close to them. She had many friends and had just made many more at her new school." ***– Ella's maternal grandmother***

"Ella was our only grandchild and she brought great joy and love to our lives. She was a lovely girl and was adored by everyone. Ella was a very talented dancer, she had studied Ballroom and Latin American dancing since the age of five years old. Her great-grandmothers and her other grandmother and I would accompany her to dance competitions in the Southwest and

Midlands. We all loved to watch her dance, she won many awards and we were all so very proud of her. It made a lovely family day out for Ella and all of her grandmothers. I cherished that time with Ella and I'm deeply saddened that I will never see her dance again." ***– Ella's paternal grandmother***

"Ella would usually spend every weekend with us, she would also come for tea midweek or I would take her out for a treat. We were so close, she was real Daddy's girl. I loved her with all of my heart and was so very proud of her. She was my world and I cannot see my future without her". Her uncle recalls, "I would try to give Ella guitar lessons on her pink (her favourite colour) guitar that I bought her for her eighth birthday. We would make singing and dancing videos and write stories and scripts together. Ella loved to play her keyboard and enjoyed anything that was creative. We all enjoyed some lovely holidays together and I miss her terribly. She was a gorgeous child." ***– Tributes from Ella's father and uncle***

1. Preface

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004. This review is also a Serious Case Review (SCR) which is overseen by the Gloucestershire Safeguarding Children's Board (GSCB).

1.1.2 This report of a Domestic Homicide Review examines agency responses and support given to Laura and Ella, a mother and daughter who were residents of Gloucester prior to the point of their murders at their home in May 2018.

1.1.3 The following is from the sentencing remarks by Hon. Mrs. Justice May DBE:

In retrospect there were danger signs: in 2010 you have been convicted of assaulting your then partner when she told you that the relationship was over. There was an episode on Boxing Day when Laura ran to neighbours, telling them you had assaulted her. When one of Laura's friends reported to her that they had seen you out, you called her telling her that she and her family should "watch their backs". The same friend saw you punch a hole through a wall in temper. By all accounts you were never kind to Ella, often referring to your 11-year-old stepdaughter as a "cunt".

Around the start of the year Laura discovered that you were having an affair. That was effectively the end of the marriage although due to convenience and financial necessity, you both remained living at the same address, with all three children.

Ten days before the murder, one of Laura's friends got a text from Laura saying that she had had to leave the house. Laura said that you had gone for her; she said she wanted a divorce, after which you had punched a hole in a wall telling her, "that was meant for your face". Your hand was in a plaster cast from that incident when you murdered Laura and Ella 10 days later.

On the evening of the murder, Laura went out to the pub with friends. She was in good spirits. She told her friends that she had asked to you to leave the house within 2 weeks and that you were not happy about it. She got home around 1 in the morning and went to bed from where she had a FaceTime call with her aunt.

You have not given the Police a complete account of what happened next that night…Perhaps the most coherent account is the separately sad one given by your 6-year-old child when they were interviewed by the Police 2 weeks later.

1.1.4 The sentencing remarks go on to describe how the children heard shouting and banging downstairs and the smallest children went to the top of the staircase where they were comforted by Ella and put back to bed. They heard screaming and something breaking. The perpetrator appeared with blood on his hands and carrying a knife. Child A reported that the perpetrator said he had killed their Mummy and sister and to wait in bed until their Nan arrived. He put on a DVD for them, changed his shoes and left the house.

1.1.5 The perpetrator pleaded guilty to murdering Laura and Ella and in November 2018 received a life sentence with a minimum term of 29 years.

1.1.6 The review considered agencies contact/involvement with Laura, Ella and the perpetrator from the birth of Ella in 2006 until the date of Laura and Ella's murders in May 2018. This was later reviewed following a further meeting with Laura and Ella's family and it was agreed that all involvement prior to the relationship between Laura and the perpetrator commencing in 2010 would be summarised and the review would only consider key events prior to 2010.

1.1.7 In addition to agency involvement, the review also examined the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.1.8 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. SCRs are also conducted in order to identify not just what happened but what can be learned from the case following the death of a child.

1.1.9 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.10 The Review Panel and Chair wish to acknowledge that reviews benefit enormously from the input of family members but that it takes courage to become actively involved in the review process. The panel and chair thank the family and the family's advocate and support, AAFDA for their active involvement in this review from the start to the end. The panel and chair express its sympathy to the family, and friends of Laura and Ella for their loss and thanks them for their contributions and support for this process.

1.2 Timescales

1.2.1 The Gloucester City Community Safety Partnership in conjunction with Safer Gloucestershire and in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review (hereafter 'review'). The Home Office was notified of the decision in writing on 12/06/2018. The GSCB decided after the first-panel meeting that it would be appropriate to establish this as a joint DHR/SCR, appropriate notification was made under Working Together (2015).

1.2.2 Standing Together Against Domestic Abuse (Standing Together) was commissioned to provide an independent chair for this DHR/SCR on 17/07/2018. The completed report was handed to the Gloucester City Community Safety Partnership, Safer Gloucestershire, and the GSCB on 12/01/2021, and submitted to the Home Office for Quaility Assurance 24th February 2021

1.2.3 Home Office guidance for DHRs states that the review should be completed within six months of the initial decision to establish one. Working Together (2015) similarly states that SCRs should be completed within 6 months. Delays occurred due to the need to pause the review process during the criminal trial and then to ensure that there was adequate time between meetings to meet with family members, and to arrange and undertake a meeting with the perpetrator. Additional time was given in order to allow the family opportunities to provide their feedback on multiple versions of the draft report. There were also separate meetings arranged throughout this process for the family to meet with particular panel members and with agencies in order to answer questions the family had, the latter of these being held virtually due to the COVID-19 pandemic. The report was then virtually circulated to the panel and approved November 2020.

1.3 Confidentiality

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel for DHRs. Information is publicly available only to participating officers/professionals and their line managers.

1.3.2 This review has been suitably anonymised in accordance with the 2016 guidance. The specific date of death and the gender of Laura's other children have been removed and only the independent chair and Review Panel members are named.

1.3.3 The review author discussed the use of pseudonym names with the victim's family in order to protect the identity of the victim, the perpetrator and family members, however, the family requested permission from the Home Office to use the real names as the case is widely known in the local area so the use of pseudonym names would not successfully protect the identities of the two victims. The names of the two younger children have been anonymised in order to maintain their anonymity. The victim's family did not wish for the perpetrator to be given a pseudonym and therefore he will be referred to as the perpetrator throughout the report. The following terms have been used throughout this review:

1.3.4 The adult victim: Laura – real name

1.3.5 The child victim: Ella – real name

1.3.6 The perpetrator

1.3.7 Older child of Laura and the perpetrator: Child A

1.3.8 Younger child of Laura and the perpetrator: Child B

1.4 Equality and Diversity

1.4.1 The Chair of the Review and the Review Panel considered all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.4.2 Laura was a 31-year-old heterosexual white British female. Laura was not registered as being a person living with a disability. Laura and the perpetrator had been married for 4-5 years and had two children together. The protected characteristics of gender reassignment, religion/belief and sexual orientation do not pertain to this case in that neither party was at any stage of transitioning from one gender to the other. They did not

hold particular religious or other beliefs as far as we can tell from the records and Laura was not pregnant.

1.4.3 Ella was Laura's daughter from a previous relationship and was aged 11 at the time of her death. The panel considered the biological factors relevant to this case given that the perpetrator was the biological father to two of Laura's children but not the biological father of Ella. This is analysed in more detail throughout the report.

1.4.4 The perpetrator is a white British male who was aged 28 and had been in a heterosexual relationship with Laura but was estranged at the time of Laura and Ella's murder. Whilst the perpetrator was not registered as having a disability throughout the scope of the review the panel considered the perpetrator's epilepsy diagnosis in relation to the Disability Discrimination Act (DDA). The perpetrator's inconsistent compliance with treatment made it challenging for the panel to fully understand his condition and to determine the impact it may have had on his situation and the violence that he perpetrated. It is noted that his epilepsy assessment was based on description, rather than medical professionals witnessing a fit. Whilst only a disability tribunal could say for certain whether the perpetrator's epilepsy could have been classed as disabled under the Disability Discrimination Act[1], the Act specifies that people are likely to be classed as disabled if someone has:

- epilepsy that has a substantial effect on the persons day-to-day activities; or;
- epilepsy that would have a substantial effect if someone were not taking their epilepsy medicine. A substantial effect might include being able to get around, hear, see, remember and concentrate; or;
- a type of epilepsy that is not currently causing any problems or needs epilepsy medicine, but could come back; or;
- epilepsy that has lasted, or is expected to last, for at least 12 months

The perpetrator's epilepsy and lack of engagement with services was identified throughout the chronologies and IMR's and will be reviewed at the relevant sections later in the report.

[1] https://www.epilepsy.org.uk/info/equality/disability-discrimination-act

1.4.5 *Sex*: Sex should always require special consideration. Analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[2] This characteristic is therefore relevant for this case, the victim of the homicide was female and perpetrator of the homicide was male.

1.4.6 The Review Panel provided special consideration to sex and disability throughout this review to determine if responses of agencies were motivated or aggravated by these characteristics.

1.5 Terms of Reference

1.5.1 The full Terms of Reference for this DHR/SCR are included at **Appendix 1**. This review aims to identify the learning from Laura's, Ella's and the perpetrator's case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel was comprised of agencies from Gloucestershire, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

1.5.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from July 2006 to the date of the homicide. Due to this report being a joint DHR and SCR, the panel felt that it would be of benefit to review agency involvement for the duration of Ella's lifespan. Agencies were asked to summarise any relevant contact they had had with Laura or the perpetrator outside of these dates.

1.5.4 Key Lines of Inquiry: The Review Panel considered both the 'generic issues' as set out in the 2016 statutory guidance and identified and considered equality and diversity as described in 1.4 above, as well as the following case specific issues:

[2] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole Standing Together DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

- The communication, procedures and discussions, which took place within and between agencies
- The co-operation between different agencies involved with Laura, Ella, the perpetrator and the wider family, specifically Child A and Child B
- The opportunity for agencies to identify and assess domestic abuse risk, including during any contact with Laura, Ella, the perpetrator and / or Child A and Child B in relation directly to domestic abuse and / or other needs and issues
- Agency responses to any identification of domestic abuse issues.
- Organisations' access to specialist domestic abuse agencies.
- The policies, procedures and training available to the agencies involved on domestic abuse issues.

1.5.5 While the Review Panel included agencies that could bring expertise in relation to these additional issues, due to this report being a joint DHR/SCR there was also representation on the panel from the GSCB Business Unit Manager in order to satisfy that all aspects of child protection and child death were included within the scope of the DHR review.

1.6 Methodology

1.6.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:

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

1.6.3 Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

1.6.4 Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

1.6.5 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.6.6 This review has followed the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicides, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Laura, Ella, the perpetrator, Child A and Child B. A total of seventeen agencies were contacted to check for involvement with the parties concerned with this review. Six agencies returned a nil -contact, and after Panel consideration, six agencies submitted IMRs and chronologies. The chronologies were combined and a narrative chronology written by the Overview Report Writer.

1.6.7 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. All IMRs received were comprehensive and enabled the panel to analyse the contact with Laura, Ella and/or the perpetrator, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Six IMRs made recommendations of their own, and evidenced that action had already been taken on these. The IMRs have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this review.

1.6.8 *Documents Reviewed:* In addition to the six IMRs, documents reviewed during the review process have included previous DHR and SCR reports in the area, Victim Impact Statements of the family for the criminal trial, and DHR Case Analysis from the Home Office.

1.6.9 *Interviews Undertaken:* The chair of the review has undertaken four interviews in the course of this review attended by two or three family members together. This has included three face to face interviews, one telephone interview, and one zoom meeting. The chair is very grateful for the time and assistance given by the family and friends who have contributed to this review and to their expert advocate at AAFDA for her support to ensure that the views of the family are integral to this review.

1.7 Contributors to the review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Gloucestershire County Council Adult Social Care Services
- Gloucester City Council Local Authority Housing services
- Gloucester City Homes
- Gloucestershire Domestic Abuse Support Service (GDASS/ Greensquare)
- Change, Grow, Live (CGL) (commissioned substance misuse service)
- Working Links Probation Community Rehabilitation Company (CRC)

1.7.2 The following agencies and their contributions to this review are:

Agency	Contribution
Clinical Commissioning Group (CCG) (GP's for Laura, Ella, the perpetrator, Child A and Child B)	IMR and Chronology
Gloucestershire Care Services NHS Trust Community Health Services (e.g. health visiting, school nursing and community physiotherapy)	IMR and Chronology
Gloucestershire Hospitals NHS Foundation Trust	IMR and Chronology
Gloucestershire Council Children's Services	IMR and Chronology
Gloucestershire Constabulary (Police)	IMR and Chronology
Safeguarding in Education Traded Services Team (Education)	IMR and Chronology

1.8 The Review Panel Members

1.8.1 The Review Panel members were:

Name & Job Role	Agency
Annette Blackstock, Designated Nurse Safeguarding Children	Clinical Commissioning Group (CCG)
Rebecca Williams, Associate Named Nurse for Safeguarding Children	Gloucestershire Care Services NHS Trust
Clare Hicks, Specialist Nurse Safeguarding Adults	Gloucestershire Care Services NHS Trust
Jon Burford, Divisional Chief Nurse Division of diagnostics & specialties	Gloucestershire Hospitals NHS Foundation Trust
Andy Dempsey, Director for Partnerships	Gloucestershire County Council Children's Services
Kanchan Jadeja, Quality Assurance and Improvement Consultant	Gloucestershire County Council Children's Services
Anne Brinkhoff, Corporate Director	Gloucester City Council
Georgina Summers, Safeguarding Children Manager (education)	Safeguarding in Education Traded Services Team
Dave Jones, GSCB Business Unit Manager	Gloucestershire Safeguarding Children Board Business Unit
Alison Feher, Safeguarding lead	2gether NHS foundation trust
Heather Downer, Deputy Manager	Gloucestershire Domestic Abuse Support Service (GDASS)
DCI Richard Ocone, DCI for CID and Police DA lead	Gloucestershire Constabulary
Sophie Jarrett, County DASV Strategic Coordinator Seconded to role of Outcome Manager for violence prevention during review but remained on DHR panel.	Gloucestershire Constabulary
Helen Pritchard, County DASV Strategic Coordinator Seconded into role during the review and joined panel.	Gloucestershire Constabulary

1.8.2 Independence and expertise: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.8.3 The Review Panel met a total of 4 times, with the first meeting of the Review Panel on the 23/10/2018. There were subsequent meetings on 31/01/2019, 11/07/2019 and 13/12/2019.

1.8.4 The last full panel meeting was attended by family members and the Chair would like to thank AADFA for their support in this important meeting, the family for their candour and bravery and the panel for their willingness to engage so openly in the discussion. This

mutual understanding is a key aim of the DHR process which is emotional and difficult at times but it is both critical and beneficial to the process.

1.8.5 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 The Gloucester City CSP, in conjunction with Safer Gloucestershire, notified the family of Laura and Ella in writing of their decision to undertake a review via the Gloucestershire Constabulary Family Liaison Officer (FLO) in August 2018. The Chair of the Review and the Review Panel acknowledged the important role Laura's, Ella's and the perpetrator's family could play in the review. From the outset, the Review Panel decided that it was important to take steps to involve the family, friends, work colleagues, neighbours and the wider community.

1.9.2 Consideration was initially given to approach Laura's family and Ella's biological father.

1.9.3 A letter was sent from the chair via the FLO, describing the DHR and SCR process, that participation in the review was voluntary, and that the family could contribute in a number of different ways. The letter was accompanied by the Home Office leaflet for families, as well as a leaflet describing the support available from Advocacy After Fatal Domestic Abuse (AAFDA). This letter was sent to the FLO in September 2018.

1.9.4 The family were supported throughout the duration of the review process by a specialist and expert advocate from AAFDA. The AAFDA advocate established contact with the Chair of the Review in December 2018.

1.9.5 The chair initially had email and telephone contact with Ella's paternal grandmother prior to the first-panel meeting.

1.9.6 The terms of reference were shared with the family of Laura and Ella to assist with the scope of the review.

1.9.7 The family were updated regularly and reviewed the draft report in private with agreed adequate time which was aided and negotiated via the AAFDA advocate. The family were given the opportunity to comment and make amendments to the report as required and their feedback was incorporated into the report.

1.9.8 The family met the Review Panel on the 13/12/2019.

1.10 Involvement of Perpetrator and/or his Family:

1.10.1 In March 2019 the perpetrator was sent a letter from the chair via both the prison governor and his probation officer with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back. He sent back the signed consent form and the chair met him in prison for an interview on 30/04/2019.

1.11 Parallel Reviews

1.11.1 Criminal trial: The perpetrator initially pleaded not guilty to two murder charges in a hearing at Bristol Crown Court on July 2018. The perpetrator accepted he was responsible but indicated he would cite diminished responsibility due to loss of control and abnormality of mind. A medical report on September 2018 found there were no grounds for the perpetrator to argue there was a diminished responsibility. He pleaded guilty to the murders in November 2018 at Bristol Crown Court. The criminal trial concluded on 5th November 2018 and was sentenced to life imprisonment with a minimum term of 29 years.

1.11.2 The Gloucestershire Constabulary Senior Investigating Officer (SIO) was invited to the first meeting of the Review Panel. It was agreed approaches would not be made to witnesses until after the criminal trial had been concluded, with the exception of an introductory letter to Laura and Ella's family as described above. However, as the trial was concluded shortly after this first meeting, this had a relatively limited impact on the timeframe of the review.

1.11.3 *No parallel reviews:* An Inquest was opened and suspended in June 2018 at Gloucester Coroners Court. Following the perpetrator's conviction, Her Majesty's Coroner decided no investigation was required and therefore closed the matter. Consequently, following the completion of the criminal investigation and trial, there were no parallel reviews that impacted upon this review.

1.11.4 *Combined SCR/DHR: Prior to the DHR starting, consideration was given to whether a separate SCR should be carried out following the death of Ella. A SCR is a locally conducted multi-agency review into the circumstances where a child has been abused or neglected, resulting in serious harm or death and there is cause for concern as to the way in which the relevant authority or persons have worked together to safeguard the child. The GSCB felt that the circumstances around Ella's death and subsequent learning would be best placed to be combined with the DHR in order to combine the learning. In order to ensure that the DHR considered all of the relevant learning points from a SCR the Terms*

of Reference were reviewed at the first-panel meeting to ensure that this was in line with the SCR requirements. The panel also had representation from the GSCB Business Unit Manager in order to ensure that all SCR considerations were considered and explored throughout the duration of the review.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The Chair of the Review is Nicole Jacobs, who during the course of the review was CEO of Standing Together. Nicole has received training from her predecessor at Standing Together, Anthony Wills and attended the Home Office training on DHRs in 2013 and she attended an initial Home Office training on DHRs. She has over 20 years of experience working in the domestic violence and abuse sector and has chaired five DHR reviews and has led in the work related to dissemination of findings of all the Standing Together chaired DHRs with the Child and Women Abuse Studies Unit at London Metropolitan University, published in 2016. In late September 2019, Nicole was appointed to the role of Designate Domestic Abuse Commissioner. Nicole negotiated finishing this DHR with the Home Office and has not charged the CSP for any further work on this DHR since her appointment.

1.12.2 The Author of the review is Gemma Snowball, during the course of the review she was Domestic Homicide Review and team development manager at Standing Together. Gemma has completed the Home Office Domestic Homicide Review Chair's training delivered by AAFDA. Gemma has previous managerial experience in the domestic violence and abuse sector including management of Multi-Agency Risk Assessment Conferences (MARACs) and Independent Domestic Violence Advisor (IDVA) service provision within London. Gemma left Standing Together prior to the report being finalised so the final stages of the report were completed by Nicole Jacobs and the Standing Together DHR Team. The chair wishes to apologise to the family for any disruption or unnecessary stress caused by these changes at the final stage of the DHR Process.

1.12.3 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK to adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.12.4 Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 70 reviews.

1.12.5 *Independence:* Both Nicole Jacobs or Gemma Snowball have no connection with Gloucester City Community Safety Partnership (CSP), Safer Gloucestershire, or any of the agencies involved in this case.

1.13 Dissemination

1.13.1 The following recipients have received/will receive copies of this report:

- Panel members listed below
- Family members
- Standing Together DHR Team
- Gloucestershire Safeguarding Children Executive and Delivery Board
- Safer Gloucestershire
- Police and Crime Commissioner

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to V**	**Age at time of V death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Laura	Adult victim and mother of Ella	31	White British	No religious affiliation	British Citizen	N
Ella	Child victim and daughter of Laura	11	White British	No religious affiliation	British Citizen	N
The perpetrator	Husband (pending divorce) of Laura and step-father of Ella	28	White British	No religious affiliation	British Citizen	Epilepsy
Child A	Child of Laura and the perpetrator	Redacted	White British	No religious affiliation	British Citizen	N
Child B	Child of Laura and the perpetrator	Redacted	White British	No religious affiliation	British Citizen	N

2.1 The Homicide

2.1.1 *Homicide:* Laura and Ella were murdered by Laura's husband, whom she was in the process of separating from, and Ella's step-father. Laura had been out for a meal with a friend and took a taxi and arrived home at 1:10 am. Laura was on Facetime with her Aunt at 01:18 am. In between then and 4:30 am the perpetrator killed Laura and Ella at their home. Both Laura and Ella were attacked in the kitchen, it is believed that Ella came

downstairs to intervene and had also been killed. Both Laura and Ella had received multiple stab wounds consistent with defence wounds to their faces, necks, hands, and body. After both were attacked, the perpetrator went into the bedroom of Child A and Child B who were awake. The perpetrator is reported to have gone upstairs after the murder, put a DVD on, and then left the children in the property to leave and call his mother. As retold to family member later the children recalled that when doing so, the perpetrator was covered in blood and carrying the murder weapon in his hand.

2.1.2 Laura and the perpetrator had been married 4 years and lived together in their Gloucester home with their two children Child A and Child B and Ella, Laura's child from a previous relationship. Laura had become aware that the perpetrator had had an affair earlier in 2018, Laura asked him to leave and informed him she wished to end the relationship and would be seeking a divorce.

2.1.3 The Police and ambulance were called at 4:50 am by the perpetrator's mother's partner. In between this time and the time of the perpetrator's arrest the Police officer exchanged multiple phone calls with the perpetrator to encourage him to turn himself in. When the perpetrator was subsequently arrested he had one of his hands in a cast which is believed to have been sustained by punching a wall during a previous incident that was not reported to Police.

2.1.4 *Post Mortem*: The Coroner conducted a Post Mortem examination of Laura and Ella at Gloucester Mortuary the day after their deaths. The cause of death in both cases was given as multiple stab wounds. Laura was stabbed 18 times and Ella stabbed 24 times.

2.1.5 *The family commented that the attack on both Laura and Ella was so ferocious to both including injuries to the face that meant that the family were unable to fully say their goodbyes and mourn the loss of both Ella and Laura due to the severity of the injuries sustained.*

2.1.6 *Criminal trial outcome*: The criminal trial concluded in November 2018, with the perpetrator pleading guilty to both Laura and Ella's murders. In November 2018 the perpetrator was sentenced to life imprisonment with a minimum term of 29 years.

2.1.7 The perpetrator initially claimed diminished responsibility due to loss of control and abnormality of mind. The perpetrator's solicitor had argued that he had a history of depression and epilepsy. These were some of the reasons they gave as to why they were considering the 'loss of control' as a defence. Following a medical report completed in

September 2018, it was determined that the perpetrator had no grounds for claiming diminished responsibility.

2.1.8 *Judge's sentencing summary:* On sentencing the perpetrator in November 2018, the judge described the murders as "unspeakable savagery" and paid tribute to "brave" Ella for going to her mother's aid. "She would have witnessed some part of your murderous attack on her mother and tried to stop you before you turned on her". "What a brave girl. She and her mother were found lying together, side by side."

2.2 Background Information about Laura and Ella

2.2.1 Laura was a much-loved mother, daughter, sister, cousin and friend. She was a loving mother who raised her children among a close-knit community of family and friends. She was hard-working and entrepreneurial and put the needs of her family and friends first. At the time of her death, Laura was 31 years old. She was White British and had no known disability or religious affiliation. Laura was a successful businesswoman who started her work life at age 14 when she started working part-time in a local hairdresser. At the time of her murder, she ran a business offering bespoke bridal gowns and wedding planning services.

2.2.2 Ella was a talented and energetic daughter, sister, granddaughter, niece, cousin and friend. She was loved and adored by her father, siblings, grandparents, aunts, uncles, cousins and friends. She attended her grandmother's nursery and every nuance of her spirited personality was known to her family. Much like her mother, she was close and open with her friends and family and was able to share her hopes, thoughts, feeling and concerns. Although her parents had separated, both sides of her family always got along well and shared in their commitment to her care and wellbeing. She had a passion for dance and had competed and won awards for her dancing skills. At the time of her murder, Ella was in secondary school.

2.2.3 Laura had three children. The perpetrator was the biological father of the youngest two children (Child A and Child B). The birth father of Ella was contacted as part of the review. His participation in the review was done via his mother, Ella's grandmother, due to the severe mental trauma and anguish he has experienced since the death of his daughter.

2.3 Background Information about the perpetrator

2.3.1 The perpetrator was aged 28 when he murdered Laura and Ella. He is White British and has no religious affiliation. The perpetrator does not have a diagnosed disability but does

have a diagnosis of epilepsy. This was later used by the perpetrator to claim diminished responsibility due to loss of control and abnormality of mind which was not upheld by a medical report completed in September 2018 which concluded that the perpetrator had no grounds for claiming diminished responsibility.

3. Chronology

3.1 Summary of key events and information by year from 2007 onwards

3.1.1 Although the panel reviewed all agency involvement from the date of Ella's birth in 2006 through to the beginning of the relationship between Laura and the perpetrator in 2010 only key agency involvement has been included in the overview report. From 2007 to 2010, Laura and Ella were seen by medical services for routine appointments and minor health issues. The following are details that relate to the perpetrator's interaction with services from 2007-2010 prior to him forming a relationship with Laura in 2010.

2007

3.1.2 In mid-March, the perpetrator attended hospital with injuries to his left hand but did not wait to be seen. He would not have known Laura at this time.

3.1.3 In late summer, the perpetrator attended the emergency department for an injury to his left ankle and was treated and discharged.

2008

3.1.4 In late March the perpetrator attended the emergency department with an injury to his right index finger. The perpetrator was treated and discharged.

3.1.5 In early July the perpetrator attended the emergency department following a road traffic collision. The perpetrator was diagnosed with bruising and discharged.

2009

3.1.6 In mid-March, the perpetrator attended the Emergency Department after his first epileptic fit. The seizure was witnessed by the perpetrator's partner at the time who described the seizure to the ambulance staff and the Emergency Department. The perpetrator reported that he had been working 24 hours on a factory site and an aluminium ladder fell onto his forearm and head. He later had a seizure at home. The perpetrator's presentation at the hospital was consistent with someone experiencing their first epileptic fit and therefore there were no grounds for questioning this diagnosis following the referral to neurology outpatients. The epilepsy nurse made contact however the perpetrator did not get back to her to make an appointment. The perpetrator was advised not to drive and to inform the Driver and Vehicle Licensing Agency (DVLA) of the fit. DVLA guidance[3] states that

[3] https://www.gov.uk/epilepsy-and-driving

someone must notify the DVLA if they have had any epileptic attacks, seizures, fits or blackouts and must stop driving straight away and should remain fit free for a period of 12 months before permitted to drive again. Attempts to contact the DVLA to confirm that the perpetrator had notified them of this seizure were unsuccessful as to date the DVLA has not responded to requests for information. Should someone not notify the DVLA about a medical condition that affects their driving they can be fined up to £1,000 for failure to notify and may be prosecuted if they are involved in an accident as a result. The Neurologist noted that the perpetrator had a car accident in 2008 when he rolled his car and there were no other vehicles involved.

3.1.7 In late June the perpetrator attended the Emergency Department with a cut to his right wrist. He was treated and discharged. A few days later the perpetrator was seen at the GP surgery for dressing of cuts, having broken three knuckles after punching a mirror in anger. The perpetrator was advised to see the doctor for anger management in relation to a "stress reaction" relating to issues regarding recent job loss, relationship & finances. The perpetrator was referred to a mental health worker appointment the same day and was started on Propranolol to lower anxiety. There is no record of him keeping this appointment. A few days later he was started on an antidepressant, Citalopram.

2010

3.1.8 In early April, Gloucestershire Constabulary responded to a domestic assault where the perpetrator was recorded as the perpetrator and the victims were the perpetrator's partner at the time (not Laura) and her mother, the attack took place in front of the partner's two young children. The perpetrator had pushed her into a set of shelves, then kicked and punched her repeatedly. There was also damage to three doors and her mobile phone. The perpetrator was arrested and charged with two counts of Assault and Criminal Damage. The perpetrator later pleaded guilty and was sentenced to a suspended imprisonment for Actual Bodily Harm (ABH), battery and Criminal Damage and was assessed as a high-risk perpetrator of domestic abuse.

3.1.9 Three days later, the perpetrator was seen by his GP presenting with memory loss symptoms. The perpetrator reported drinking "mildly" and was still taking Citalopram. The perpetrator reported his violent behaviour towards his partner and her mother but said he had, "no recollection". The GP was concerned about seizure activity so referred the perpetrator back to neurology and this was expedited after a further seizure in late April.

The perpetrator was started on medication (Epilim) in July and followed up by neurology until the perpetrator defaulted appointments and was discharged in October 2011.

3.1.10 On two occasions in April, the neurology service received a letter from the perpetrator's GP requesting an appointment. The GP had concerns that the epilepsy nurse had not made contact with the perpetrator and flagged the perpetrator reporting of multiple episodes of memory loss.

3.1.11 In mid-May, the perpetrator attended a neurology outpatient appointment. The perpetrator's epilepsy dosage was increased, alongside a conversation around driving issues and lifestyle related to epilepsy and a detailed letter was sent to the perpetrator's GP. This appointment was requested by the GP following the seizure in 2009. The consultation recorded the perpetrator's trouble with the Police 4-5 months previous and states that the perpetrator had been arrested when trying to visit his partner in hospital. The partner is not named in the records.

3.1.12 In mid-June, a letter was sent to the perpetrator from the neurologist who informed the perpetrator that the recent MRI results came back normal.

3.1.13 In later June, the perpetrator failed to attend an appointment with the Epilepsy Specialist Nurse. A letter was sent to the perpetrator's GP.

3.1.14 In late July the perpetrator attended his appointment with the Epilepsy Specialist Nurse. The perpetrator disclosed that he had run out of his medication and had not been taking it for a few weeks. Medication was prescribed. A letter was sent to the perpetrator's GP confirming the diagnosis of epilepsy which had been confirmed with the consultant neurologist and a record of their discussion and advice given.

3.1.15 The perpetrator attended the clinic without an appointment to see the Epilepsy Specialist Nurse as he was concerned that his rising stress levels were going to cause seizures. The perpetrator's medication was adjusted and a summary letter sent to the perpetrator's GP. The letter detailed that the perpetrator had focal epilepsy with complex partial seizures and tonic/clonic[4] seizures. The letter states that the Neurologist was trying to stabilise the

[4] Tonic seizures involve sudden stiffening and contraction of the muscles. Clonic seizures involve rhythmic twitching or jerking of one or several muscles. Tonic-clonic seizures are a combination of these two types in a specific pattern and are a type of generalized seizure.

perpetrator's medication and the stress of an upcoming court case was causing difficulties in stabilising the perpetrator's epilepsy.

3.1.16 In early December, the perpetrator attended his scheduled appointment with the Epilepsy Specialist Nurse who recorded the perpetrator's compliance with medication had improved. A letter was sent to the perpetrator's GP.

3.1.17 Late in this year, Laura and the perpetrator began a relationship. The perpetrator remembered that they connected through Facebook. The family have clarified that the perpetrator pursued Laura and approached her for friendship on Facebook. They had not ever met until mid-December. Laura's family report that he came to the door during a family gathering at Christmas which was the first time they were alerted to this new relationship.

2011

3.1.18 The perpetrator moved in with Laura and Ella at the start of this year, just weeks after meeting and starting to date. This was a sudden decision from the perspective of Laura and Ella's family and one they were unsure about. They had heard information about the perpetrator from neighbours and previous girlfriends which caused them to be concerned about his previous treatment of women but none of it was easy to substantiate.

3.1.19 At the start of February, Laura brought Ella to the GP due to concerns over hyperactive behaviour. It was recorded that Ella was experiencing problems with sleep as well as hitting and biting other children. Laura's family, who spent time with Ella regularly, were not aware of this behaviour and question its validity. Advice was provided at the first GP consultation. Health Visitor and School support were advised to keep a symptom diary. A further consultation occurred in June 2011 but the symptom diary was not seen. Other behaviours were described, including Laura being concerned regarding Ella's "obsessive" behaviour. The referral to Child and Adolescent Mental Health Services (CAMHS) was declined in mid-June 2011. The records noted that Laura's fiancé had moved in 7 months prior although no name was recorded. There are also notes that the GP discussed the case with the Youth Emotional Support team (YES team) at the Kaleidoscope Children's Centre. The notes also make reference to further follow up letters to suggest involvement with the School Nurse and a note that the YES team verbally said that they were able to accept the referral but that the referral was not accepted. Laura was also referred to a parenting course and to a parental support advisor.

3.1.20 In mid-February Ella was brought to the Walk-In centre with reports from 'Dad' that Ella was 'vomiting pure blood'. The IMR author highlighted that the notes make reference to 'Dad' but it is unclear whether this was the perpetrator or Ella's biological father. The family have confirmed that this was referencing the perpetrator. The report sheet stated 'nil [concerns] of note' and advice was given.

3.1.21 In early March the School Nurse recorded a meeting between Ella's 'parents' (referring to Laura and the perpetrator) and the School Nurse. It was recorded that Ella lived with her mum (Laura) and mum's partner (the perpetrator). It was noted that they have recently moved house. Laura and the perpetrator were described as engaging with the school and it was noted that Laura was supported by the perpetrator. The records indicated that Laura tended to not be consistent with discipline, it is unclear how this conclusion was established. The perpetrator told the School Nurse that Ella responded well to him and the school acknowledged this. Ella was considered to have good attendance and presented as well cared for and was in general good health. It was reported in this meeting that Ella had a tendency to wake during the night and early hours of the morning and had been refusing to go to sleep again. Ella's bedroom was on the second floor which was located away from Laura. It was noted that the school had identified some behavioural issues in class and discussed the need for firm boundaries. It was also noted that Ella was not mixing well with children her own age, and usually engaged better with older children. It was recorded that Ella tended to be obsessive at home e.g. lines up toys, pens, and was described as liking everything in place and liked to be in control and have a routine. This conclusion has been strongly refuted by Ella's family who did not see any indication of this in their frequent contact with her. Ella was also described as having tantrums and screams at home until the point of nearly being sick. They recalled once having to go to A&E due to Ella coughing up blood after extensive screaming. The family believe that had this been discussed with Ella, it would be clear that these behaviours were not true or were exaggerated and the root of the issue was more to do with the negative impact on the perpetrator in the home with Ella.

3.1.22 It is noteworthy the perspective of Laura and Ella's family during this time; they felt that Ella was unhappy with the recent change as the perpetrator had moved in with them. They had open discussions with Ella at the time about her unhappiness with her new living arrangements and they felt that many of the disruptions for Ella at school were due to her feeling unhappy and unsettled at home and the growing tension and emotional abuse and control of Ella by the perpetrator.

3.1.23 The action plan stemming from the meeting with the School Nurse included; parenting advice given regarding strategies and boundaries; a reward chart; the introduction of a night time routine and discussion of a second routine to settle, such as a storybook tape to comfort Ella due to her being on a different floor to Laura; encouraged play and out of school activities; and Parentline Plus information provided to Ella. Strategies were also put in place at school including monitoring and liaison, the use of home- school book for communication, and the SEAL programme (Social and Emotional Aspects of Learning for secondary schools). The School Nurse met with Laura and the perpetrator for this Health Needs Assessment as part of a routine Primary School drop-in which was normal practice at the time.

3.1.24 In early April Laura called the GP surgery complaining of waking up with right arm pain. Laura was advised on the phone and then advised to come for an appointment later that day but did not attend.

3.1.25 In early July, Laura called the GP out of hours reporting a fall onto her abdomen. Laura was reported as being 10 weeks pregnant at the time.

3.1.26 Laura's family recalled how motivated the perpetrator was to begin a family. He had moved in with Laura within the first months of their relationship and openly spoke of wanting to start a family from their earliest interactions.

3.1.27 Throughout July to September Laura attended several ante-natal scans and blood tests. It was not recorded if the perpetrator attended with her.

3.1.28 In late August the perpetrator attended the Emergency Department with an injury to his right ankle recorded as a sports injury. The perpetrator was treated and discharged. It is noted that from Laura's family's understanding, he was not playing sports at this time.

3.1.29 In early September, Laura spoke to the GP complaining of low abdominal pain and was recorded as being pregnant. Laura attended the Emergency Department with possible appendicitis. Laura was referred to maternity triage. The obstetrician diagnosed gastroenteritis and discharged. It was not recorded if perpetrator attended with her.

3.1.30 In early November Laura reported the first of three separate acute episodes of low back pain between November 2011 and April 2012. The cause of the back pain was not known, the family believe that this could have been as a result of abuse within the relationship, however, this is unclear. It was not recorded if the perpetrator attended with her.

3.1.31 In October the perpetrator's GP was sent a letter from the Neurologist advising that the perpetrator had failed to attend his appointment. No subsequent appointment was provided with the proviso that the GP re-refer the perpetrator if needed.

3.1.32 Laura's family can recall an incident in 2011 which was an example of a general pattern of the perpetrator excluding Ella from family activities which led to Ella feeling excluded from feeling part of the family. The family describe Ella being left alone in the car outside the perpetrator's mother's house as Ella was not allowed inside the home. A neighbour had seen Ella alone in the car so went outside to speak to Ella. There are further examples of this intentional exclusionary behaviour referenced later in the report.

2012

3.1.33 Ella received her MMR vaccine and immunisations and had some medical involvement for a minor injury to her eye when playing with a friend at school.

3.1.34 In late January the perpetrator attended the Emergency Department with swelling to his right arm four days after having a tattoo. The perpetrator was referred to his GP for a same day appointment. Laura's family recall the perpetrator had arranged his tattoo appointment on the day he and Laura were moving house, leaving her to organise and move everything on her own whilst 8 months pregnant.

3.1.35 Child A was born in February and the perpetrator was recorded as being present throughout the labour.

3.1.36 A new birth visit was conducted in early March and Laura was seen alone. The Health Visitor recorded asking Laura about domestic abuse and recorded no reports of abuse being disclosed. Laura reported having a good support system of family and friends.

3.1.37 In late March Laura and the perpetrator were visited at home by the Health Visitor for Child A's six-week check-up. There were no concerns raised and Laura reported she felt well and had good family support.

3.1.38 In early April the perpetrator attended the Emergency Department following an epileptic fit which lasted five minutes. The perpetrator sustained a cut to his upper lip and dislocated his left shoulder both of which were treated in the Emergency Department. The perpetrator attended his scheduled appointment at the fracture clinic. He was advised to rest his shoulder for another week and then return for an orthopaedic review. The perpetrator attributed these injuries to a car crash following an epileptic seizure, however, there is no Police record of a road traffic accident involving the perpetrator covering this

time period and the health records document that the injuries were a reoccurring sports-related injury. Laura's family recall damage to the sink unit and cloakroom around this time and question if these could be related.

3.1.39 GP records note further dislocation of the perpetrator's shoulder due to sports and on-going shoulder issues for months. GP records noted 18 recurrent dislocations up until April 2018 resulting in the perpetrator being signed off work and referral back to orthopaedics.

3.1.40 In April the perpetrator's GP sent a letter to the neurology service at the hospital requesting a review following the perpetrator's first seizure in three years. The perpetrator attended his appointment at the fracture clinic and was referred to physiotherapy with a recommendation to return for an orthopaedic review in six weeks. A physiotherapy assessment was completed during this appointment and a subsequent meeting scheduled for the start of May. The physiotherapy notes recorded that the perpetrator was working as a fabricator of metal doors and participated in rugby and cage fighting. Laura's family were not aware of any involvement in cage fighting.

3.1.41 In May, the perpetrator attended physiotherapy where a thorough assessment was carried out and tailored exercises were prescribed. The perpetrator was advised not to go to rugby. In April he reported improvement and agreed that he was happy to self manage and he was discharged in July after being told during a neurology outpatient appointment of the importance of taking his medication as prescribed. A letter was sent to the perpetrator's GP which highlighted that the perpetrator had run out of his medication two weeks prior to his fit in April 2012. The perpetrator continued to play rugby and was again injured later in the year. Laura's family have highlighted they were unaware he played rugby.

3.1.42 Child A was taken by Laura to routine medical appointments throughout this year.

3.1.43 In May there were several behaviour issues related to Ella at her school, this behaviour may have been an indication that there was stress and difficulty at home. Laura was contacted by the Children and Families Worker (CFW) and a home visit was agreed as well as a referral to the Special Educational Needs Coordinator. Ella's birth father was not informed.

3.1.44 The family of Ella recall that during this period, Ella was eager to help with her infant sibling but that she was often not allowed and admonished for trying to help by the

perpetrator. They feel that Ella felt alienated at home and remained unhappy about the perpetrator when speaking about him to her wider family. They feel this definitely affected her behaviour in school. Ella was only allowed to help with her siblings' care when the perpetrator was not around.

3.1.45 In November Laura attended the GP seeking cosmetic nose surgery stating that this was a cause of being bullied when at school and was affecting her self-esteem. Laura was advised that this was not funded on the NHS. Both in 2007 and 2012 when having infant babies, Laura made these approaches to GPs which may indicate low mood and anxiety. Family members of Laura recall that the perpetrator was critical of her appearance and Laura told her family that the perpetrator stated that she had a "nose like a Jew". They did not recall Laura being bullied at school but felt it may have been emotional abuse by the perpetrator that caused this request.

3.1.46 In early December, Laura was seen alone by the GP with anxiety. It was recorded that Laura was working three jobs and had a baby and a young child and was struggling to manage a work life balance. Laura was referred for mental health support and prescribed Citalopram, which was recorded as helping.

2013

3.1.47 Throughout the year Laura took Child A to all needed routine medical appointments.

3.1.48 This year the perpetrator had continued medical appointments, physiotherapy and Accident & Emergency (A&E) visits related to the injury to his shoulder. He also had a non-attendance with the Epilepsy Specialist Nurse.

3.1.49 In late October Ella was seen by the GP after Laura and the perpetrator raised concerns regarding her behaviour. They reported apparent issues previously at Infant School and then at Junior School, as well as at home. Laura and the perpetrator were advised to seek help from the school and a referral was made to Community Paediatrics. There is no record that Ella was sent an appointment or that the appointment was "chased up" by Laura or the perpetrator.

3.1.50 In early November a letter was received from the paediatrician by the GP, requesting an opinion on Ella's behaviour. The letter detailed that since the age of 4-5 years Ella's behaviour was of concern to Laura and the perpetrator and that Ella would lash out and use bad language for up to an hour, then get upset saying 'I don't know what I am doing'. Laura was recorded as saying there were no problems at home. Laura's family refute this and believe she deeply disliked the perpetrator, and his control of Laura, which affected her behaviour.

3.1.51 The family of Laura felt these appointments were initiated by the perpetrator and his feeling about Ella. Ella is described quite differently by her wider family during this time who would say that while she was known to be spirited and to speak her own mind, that she was happy and agreeable outside of the family home.

2014

3.1.52 In early January, Ella was not bought to a scheduled paediatrician appointment and was discharged.

3.1.53 Child A is reported to have medical appointments and sickness very typical of a child of this age throughout this year.

3.1.54 In early March Ella was bought to A&E with a head injury following a road traffic collision. Ella was accompanied by her birth father and paternal grandmother. Ella had been in the car with her father when another car drove into the nearside passenger door. Ella had sustained a small mark to her forehead. A safeguarding risk assessment was completed and no concerns identified. Ella was discharged with head injury advice being provided to her father. Ella's only other medical appointment is this year was due to vomiting later in July.

3.1.55 In late April Health Visitor records recorded Child A being brought into A&E with a nose injury. Family members recall the child walking into a lamppost which was the cause of this injury although it is not noted in the medical record.

3.1.56 Days later, GP records indicate that Child A sustained a fractured nose. There are no records of a follow-up letter being provided to the GP and no clear information recorded about the injuries despite the injuries being considered unusual for a two-year-old child. There was a follow-up check and a two-year check shortly after from the Health Visitor.

3.1.57 In late June, Laura visited the GP surgery and was seen alone after collapsing and was referred to the neurologist however there are no records of Laura being seen. Family recall this period of time when Laura collapsed or passed out several times, they believe this was due to stress.

3.1.58 In early August, Laura attended the GP alone, reporting of knee injury following a fall. Laura was referred to orthopaedics. The cause of ongoing pain was identified as a pre-patella bursa.

3.1.59 On Boxing Day in late December, Police were called after Laura attended a neighbour's address with a facial injury following an assault by the perpetrator at 1 am resulting in a lump to her forehead. Laura was accompanied by Ella. The perpetrator was arrested and Laura declined to support a prosecution. The perpetrator was later released without charge following a Police interview in which the perpetrator denied any wrongdoing. A Domestic Abuse, Stalking, Harassment and Honour Based Violence Police risk assessment (DASH RIC) was completed with Laura by Police which initially graded her risk of harm as "standard" but this was later changed to "medium risk." A DASH RIC is a nationally used and recognised risk checklist that professionals use in order to assess and identify risk factors.[5] This will be further addressed in the analysis section.

3.1.60 On this day, Laura was taken to A&E by ambulance with a head injury following the assault. Laura was treated for Haematoma to the forehead. Laura was reported to be unsure of what happened but remembers waking up at her neighbour's house. Laura disclosed that the perpetrator had a history of domestic abuse towards his ex-partner. A DASH RIC was completed with Laura and assessed as medium risk. Domestic abuse support was given but Laura reported to feel not at risk. Ella and Child A were reported to be with the paternal grandparents of Child A. The perpetrator was believed to be in custody when Laura was discharged home. The Health Visitor liaison form was attached to Laura's SystemOne record 10 days later and sent to the Health Visitor and School Nurse in relation to the whole family. Laura did not meet the clinical criteria for a CT scan.

3.1.61 The hospital's record indicated that there had been an argument between Laura and the perpetrator late in the evening on Boxing Day over the perpetrator returning home late. Laura's family have since clarified that this was not correct as Laura and the perpetrator were given a lift home by the family after a meal together. During the completion of the DASH RIC assessment which was assessed as medium risk Laura disclosed that the perpetrator had 'lost it' (direct quote from Laura noted on the file) and punched her in the face. No immediate loss of consciousness was recorded, but Laura left the property immediately with Ella. Whilst there is no record to indicate that an IDVA referral was discussed, this risk assessment would not have triggered a referral to an IDVA as no consent had been given and the DASH RIC was not graded as high risk. It is not known if Ella witnessed the assault. Once Laura was outside of the address she collapsed, it is not

[5] http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face

known if this was outside Laura's address or the neighbour's address. The neighbour called Police and an ambulance. The notes made several references to the perpetrator being sober at the time of the assault, however, the family have stated that the perpetrator had been drinking during the evening. The family provided a different account of this evening advising that the family had been together for Boxing Day and both had been drinking, Laura's sister had then dropped both Laura and the perpetrator back to their home address at the same time. It was also noted in the hospital records that Laura was working three jobs at this point including being a private hire driver, owning her own business and working in a pub but was experiencing financial problems. Laura's family explained that the perpetrator made Laura pay for everything and they believed that the perpetrator controlled the family finances.

3.1.62 5 days later[6] the Police sent a Multi-Agency Referral Form (MARF) form to Children's Social Care. The DASH RIC referral sent by the Police had assessed the risk to Laura as medium. However, the Social Worker later highlighted that the risk is likely to be high.

3.1.63 It is notable that the entries above describe the incident from the recorded perspective of the Police, Social Worker or medical professionals involved. Laura's family recall this night vividly as many had seen Laura just prior to the incident and Laura's sister arrived at the scene when the Police were still there.

3.1.64 Laura's family have reflected that they feel this was a critical missed opportunity to reach Ella and to address her trauma in seeing her mother in distress. Laura's family provided the following recollection of the night. Both the perpetrator's mother and Laura's sister arrived to help, the perpetrator's mother arrived first and was questioning the neighbour as to why she had called the Police. Laura's sister stood at the Police car as they drove off with Ella and Child A begging for the Police to listen to her so that Ella was not taken to the perpetrator's parents' home. She made her objections clear in particular her objections to the perpetrator's mother's differential treatment of Ella and her challenging the rationale for Police being called but they feel this was ignored. The Police allowed for both Ella and Child A to go home with the perpetrator's mother and the Chair and panel acknowledge that their intention would have been for the children to be cared for in another location as quickly as possible.

[6] This is explored further within the analysis section.

3.1.65 There is no recording of decision making about the placement of the children on the night and with changes and personnel and the length of time since the incident, the full context of this decision is unclear. This level of recording is not unusual. Police make many decisions of this nature spontaneously every day and there is not an expectation that this rationale for this kind of decision making is recorded. However, Laura's family feel strongly this was the wrong decision for a number of reasons. First, Ella was not the grandchild of the perpetrator's mother. Her relationship with her was significantly different than her younger sibling who received gifts from her and was treated as a grandchild. They feel certain that it would have been more comfortable for Ella to have been with her mother's family members or with her biological father during this time. They also highlighted that there were no efforts to contact Ella's birth father. They feel the consequence of this was that Ella shut down and decided not to speak to her wider family about what had happened that night, what she saw or experienced.

2015

3.1.66 Seven days after the Boxing Day incident, Children's Social Care Multi-agency Safeguarding Hub (MASH) received a call from a neighbour and the record of contact was recorded on the Early Help system. The neighbour had raised concerns following the domestic violence incident and concerns for Laura and the children. A plan was made for Children's Social Care to liaise with the School Nurse Team regarding the children. A referral to the Health Visitor was completed with a request to do a follow-up visit in addition to a referral to the multi-agency support team.

3.1.67 In 2014, the Boxing Day incident was recorded by Children's Services five days after the incident and was considered in the MASH the next day. The MASH manager reviewed this case two days later and the information about this incident was sent to partners for information sharing. The case was closed a week later. Partners, including Children's Social Care responded with any information they held between those dates. The MASH manager finalised the case by saying, "*This incident is not high in its own right however the perpetrator has been previously high. Positive Police action has been taken although due to no complaint no additional action has been taken. This is also going to MASH from Social Care and I will discuss consideration of Domestic Violence Disclosure Scheme (DVDS) with them before they carry out any visit".* This will be further discussed in the analysis section.

3.1.68 A standard DASH RIC was completed and recorded as medium risk. Laura did not "wish to press charges". Police reported that the perpetrator had been recorded as a high-risk offender of domestic abuse towards a previous partner. A MASH episode was instigated under the Children Act 2004. A separate MASH record was made in relation to the perpetrator's previous assault towards his ex-partner in April 2010. It was also noted that Laura did not wish to be referred for support from Gloucester Domestic Abuse Support Service (GDASS). An amber RAG rating was recorded and the outcome was to initiate an assessment.

3.1.69 The same day, Ella's school record was uploaded on Children's Social Care records. No specific concerns were recorded however attendance was identified as being low at 88.82% with 7.24% unauthorised absence.

3.1.70 The next day, Gloucestershire Care Services sent a letter to schedule a home visit appointment for 5 days later due to being unable to reach Laura over the phone.

3.1.71 Mid-January, a record was made by Children's Social Care for Ella's case to be stepped up to Children's Social Care, detailing initial assessment to be completed and consent to be obtained to share information. The decision behind carrying out the initial assessment was recorded as being due to the assault on Boxing Day and the perpetrator's previous high-risk domestic abuse history.

3.1.72 In Mid-January the Health Visiting service attended the home address for a scheduled home visit to see Child A who was under universal health visiting services however there was no answer. A new visit letter was sent with a date for the end of January.

3.1.73 At the end of January, Children's Social Care carried out a visit to complete the Initial Assessment. Laura was spoken to alone and advised the Social Worker that there had been no violence and the perpetrator had not punched her. Laura informed the Social Worker that the perpetrator's elbow had slipped and Laura had fallen. Laura said that she went upstairs and lost her footing and hit her nose on the bannister. Laura categorically said that the perpetrator did not hit her in the face deliberately. The Children's Social Care record indicates that Laura was 'drunk'[7] at the time of the incident. However, the Police records recorded that the perpetrator had denied the offence and stated that Laura had

[7] Laura's family recall that Laura was not drunk at the time and both Laura and the perpetrator had been drinking prior to being returned home. The use of language and recording of alcohol factors is explored further within the analysis.

been drinking and the injuries she had sustained were as a result of her "drunken behaviour". This potentially gives perpetrators of abuse the possibility of controlling the narrative and discrediting the account and potentially controlling the narrative, especially in circumstances where the victim is unable to or does not wish to make a statement. Laura's family believe that an assumption was made that Laura was drunk due to her appearance and presentation, however, the family believe that the symptoms that were interpreted as Laura being drunk were more likely to have been that she was stunned as a result of sustaining an assault to her head and the possibility of concussion.

3.1.74 The worker spoke to Ella who said that her "father" elbowed her mother and Laura fell. The perpetrator informed the worker that Laura and he "got on well". It is unclear if Ella described the perpetrator as her father or if this was how her comments were recorded. Laura's family stated that Ella would not have referred to the perpetrator as "father" as she would not describe him as a step-father and would only ever refer to the perpetrator by his first name. January supervision notes are recorded by Children's Social Care that detail the Social Worker challenging Laura's account of the incident and questioning her version of events in relation to the domestic abuse. The notes also detail previous incidents of domestic abuse which the Social Worker was aware of. Actions for follow up were recorded as well as a record of next steps and Claire's Law.

3.1.75 The initial assessment was completed and accompanied by assessment notes. It was noted that Ella had lower attendance at school due to a family holiday. When the Social Worker spoke to Ella about school Ella informed the worker that she liked dance and maths. Ella then went on to tell the Social Worker that the perpetrator and her mother got on well. The Social Worker noted that this had not been prompted by the Social Worker so wondered why Ella had said this. Laura's family believe that the perpetrator would have pressured Ella to say this. Later during the conversation with the Social Worker, Ella said that the perpetrator had hit her mother at which point the Social Worker recalled that Laura looked shocked and paused talking. Laura then stated that he had hit her with his elbow. The Social Worker recorded that Laura had provided several different versions of what happened, and that it was only when Ella had disclosed that the perpetrator had hit Laura that Laura then added that the perpetrator had hit her. The Social Worker also later spoke to Ella's birth father who said that he had seen no change to Ella's behaviour and that Ella was doing well at school. The outcome of this initial assessment was recorded as no further action.

3.1.76 The health visiting service recorded no access to the rescheduled planned home visit. This was followed up with a call to the GP to confirm contact details.

3.1.77 At the end of January, a different number was recorded on the GP records. A call was made to Laura to arrange a visit from the Health Visitor. This contact was successful and a visit was arranged for the following week.

3.1.78 In early February, the health visiting service carried out a family health needs assessment review at the family home. No concerns were raised in relation to Laura's mental health. Laura was recorded as not having any concerns for Ella or Child A's physical health. The Health visitor recorded seeing both Laura and Child A at the home. Domestic abuse was discussed and the incident on Boxing Day was discussed as part of this. Laura disclosed that she and the perpetrator had been drinking at her parents' house and that she was quite drunk[8]. When they got home the perpetrator was at the top of the stairs with the children ready to put them to bed when he turned and caught Laura with his arm. Laura described losing her balance and fell on the stairs hitting her nose on the bannister. Ella screamed and went to the neighbours who then rang the Police. Ella was recorded as speaking to the Police and confirmed how the accident happened. Ella and Child A were recorded as staying with their paternal Grandparents whilst Laura was at hospital and the perpetrator was at the Police station, this refers to the perpetrator's mother as opposed to Ella's paternal grandmother. Laura's family felt that no verification of relationship was sought and therefore did not enable the children an opportunity to disclose. The Health Visitor asked Laura if she was afraid of the perpetrator or if he had ever been physical towards her to which she answered no to both. A good reciprocal relationship was noted between Child A and Laura. No parental concerns were reported for Child A who presented as a lively happy child and was up to date with all immunisations. No further action was taken and the outcome was that Ella and Child A were put on universal health services. The Health Visitor ensured Laura could contact her anytime and had open access to the Health Visitor alongside ensuring that Laura had contact information about GDASS (the domestic abuse service).

[8] Laura's family refute this and believe Laura said this to protect the perpetrator.

3.1.79 In early February, the perpetrator attended the Emergency Department with an injury to his left shoulder after playing rugby the previous day and then falling off stairs on the day of attending. The perpetrator was treated and discharged.

3.1.80 In mid-February, Children's Social Care supervision records note that Laura had been contacted about domestic abuse history but had not responded to the Social Worker. An action was set for the school and health to be contacted for further information for the assessment. The perpetrator had informed the Social Worker that Laura was aware of his domestic abuse history and conviction.

3.1.81 Towards the end of February, the Social Worker exchanged emails with the Local Authority Designated Officer (LADO). The LADO informed the Social Worker that Laura had minimised the impact of domestic abuse and the perpetrator's violent behaviour history and therefore should not be working with other children. The concerns were shared that Laura was minimising the recent incident and denying domestic abuse which was raised as a concern due to Laura working as a driver for Gloucestershire County Council and therefore had contact with children. Laura's family commented that if the Social Worker had safeguarding concerns then this should also have extended to safeguarding concerns to the two children residing in the household.

3.1.82 The same day, the Social Worker called Laura to discuss concerns around the perpetrator's previous history of violence towards an ex-partner and her mother for which he was convicted of assault. It was recorded that Laura believed that the perpetrator had been convicted due to pleading guilty in order to "get it over with". The Social Worker stressed that without evidence, the perpetrator would not have been convicted but recorded that this "made no difference to her".

3.1.83 At the end of February the Social Worker called Ella's father, who informed the Social Worker that he had seen Laura with two black eyes over Christmas and Ella had not mentioned the incident. There was a discussion about the recent incident and the Social Worker informed him that Ella had gone to the neighbour's house with Laura when the incident occurred. This assessment was recorded in supervision notes for the Social Worker which indicates oversight of this issue.

3.1.84 In early March, Laura attended the Emergency Department with an injury to her left knee. Laura was seen in triage and advised that as it was a long wait that evening she would be safe to return in the morning.

3.1.85 In mid-March, records show that there was a discussion with the Deputy Head who reported that Ella had been in school and had some absences due to a holiday. It was determined that there was no role for the school nurse.

3.1.86 In early April, the health visiting service recorded telephone contact with Children's Social Care as the allocated Social Worker had contacted them wanting information on Child A due to a recent referral for a domestic abuse incident. Whilst notes were not explicit, this appears to be in relation to the incident on Boxing Day (3 months earlier). It was agreed that the level of service would change to Universal Partnership Plus, with an action for the Health Visitor to await the outcome from Social Care. It was noted that Child A's parents needed to provide a conflict-free environment so that this does not impact on Child A's emotional health and well-being. This resulted in the case being re-opened to the Health Visiting Service on the Universal Partnership Plus (UPP). UPP is an enhanced level of service.

3.1.87 In mid-May, a case closure letter was sent from Children's Social Care to Laura and the perpetrator, the school[9] and Ella's father.

3.1.88 In mid-July, Laura booked an appointment with the community midwife. An antenatal assessment was completed and an appointment schedule was drawn up. The midwife's records noted the perpetrator's diagnosis of epilepsy and recorded no social problems or concerns around mental health.

3.1.89 In late July Laura's maternity book was completed with her during a home visit. Laura was asked about domestic abuse during this visit and advised that there was no history of domestic abuse. A lone working community midwifery risk assessment was completed and indicated a low risk of violence or aggression in the home which is the lowest grading available.

3.1.90 In early August Laura attended A&E with a burn to her left index finger. Laura was referred to the burns clinic as the burn involved a joint. Laura was pregnant at the time and was not asked about how the burn was sustained.

3.1.91 Between August and October Laura attended routine ante-natal check-ups and scans.

[9] It is noted there is no evidence the school received this letter. This is further discussed in the analysis section.

3.1.92 In early December Laura was seen in the ante-natal clinic with pelvic pain and was referred to physiotherapy.

3.1.93 Just before Christmas, Laura was seen in the ante-natal clinic and a note was recorded of her plans to travel to Disney the following day.

2016

3.1.94 In mid-January, Laura had telephone contact with maternity seeking advice for pelvic pain and was referred to the GP and physiotherapist. A few days later Laura was seen in the ante-natal clinic and was using crutches for pelvic pain. This contact extended into February as the pain was ongoing.

3.1.95 Child B was born in February. The perpetrator was present with Laura throughout the duration of the labour. Laura's family recall that the perpetrator's mother attended the birth before Laura's existing children had met their new sibling. They remembered that Laura had wanted her children to see Child B before other visitors attended.

3.1.96 In late February, the Health Visiting Service carried out a new birth visit which took place with both Laura and the perpetrator. A discussion was had around maternal wellbeing and the Health Visitor had no concerns over their physical health. Family health was discussed and Best Practice Benchmark was completed where no health needs were identified. Laura stated that she was well and the maternal mental health checks raised no concerns with no history of poor mental health reported. It was agreed that the level of service was Universal. No domestic abuse question was asked due to the perpetrator being present. Attempts were not made to speak to Laura alone. All checks with Child B were completed with no concerns. A follow up was scheduled for six weeks.

3.1.97 In late March, a 6-8 week post-natal check-up was completed with Child B. Discussion took place around maternal wellbeing. No enquiry around domestic abuse was asked due to Ella being present. No health concerns were identified so it was agreed for the level of service to remain as Universal.

3.1.98 In late May, Child B was taken to the Health Visitor Clinic. Records indicate that the domestic abuse question was unable to be asked due to the perpetrator being present. There were no plans recorded as to how this enquiry could be achieved by seeing Laura on her own.

3.1.99 At this appointment, advice was given about weight management and a discussion about maternal wellbeing. The local Health Visitor Service and amenities were explained. A

repeat development review was scheduled for three months time due to Child B not meeting all of their developmental milestones. Laura was advised to contact the Health Visiting team if she needed anything prior to the next scheduled review. Laura disclosed an episode of depression before having Child B when she was setting up her own business. Laura felt that this was due to work stress and reported feeling better after medication. There were no current mental health concerns raised at the time. Advice was given in relation to speech and language development and Laura was advised to see the GP if some raised spots on Child B's nose did not clear in a couple of weeks. It was noted that the perpetrator was present for these visits and contact with the clinic, so no discussion was had in relation to domestic abuse.

3.1.100 Between June and November, there are various services for the three children and for the perpetrator for routine or unrelated medical concerns.

3.1.101 In early December the Junior School recorded that Ella had made comments both verbally and via text message to others in the class. It was recorded that Ella had been affected following the traumatic death of her second cousin in 2015 and had since written text messages that indicated that she was under stress. These were not admitted to by Ella but Laura was informed during a telephone call with the school. Ella had sent a message saying 'life is rubbish and I have no friends'. Laura was encouraged to seek support for Ella via the GP or another agency. It is recorded that Ella had fallen out with her friends at school and Laura stated that Ella's Dad had bought her a phone and Laura didn't agree with this decision. Laura's family recall that it was the perpetrator who was not happy with Ella having a phone and he had intentionally broken two of Ella's phones by smashing them, including once when he smashed the phone with a hammer, however, the school was not made aware of this.

2017

3.1.102 From interviews with Laura's family, they recalled further examples of alienation of Ella. For example, the perpetrator would not allow Child A and Child B to share a room with Ella. Ella had to always sleep in a separate room away from her siblings. Ella was often told by the perpetrator that she "was not a [Perpetrators Surname]". Child A was heard saying to Ella "my dad said you're not [Perpetrator's Surname] you're a "[Ella's biological fathers' surname], you're not part of this family".

3.1.103 In late February, Laura was seen by the GP for acute low back pain. An MRI was completed and a referral made to the musculo-skeletal services.

3.1.104 In late September, the Infant School received a request for unauthorised absence for November as Laura and the perpetrator were unable to secure holiday during the summer months due to work demands. This leave of absence was refused by the school. Laura's family recall that the family had gone on holiday at the perpetrator's insistence.

3.1.105 In late October, the Health Visiting Service phoned Laura to check on Child B's development. Laura reported being happy with Child B's development and felt that their speech was progressing. Laura declined a visit from the Health Visitor at this time and was happy to see the Health Visitor at the two-year check-up.

3.1.106 In early November, Laura phoned Ella's school to advise that Ella would be on holiday for two weeks. Laura was advised that a possible penalty notice would be issued.

3.1.107 In mid-December, a penalty notice was issued as a result of Child A's unauthorised absence from school (for the November holiday).

3.1.108 In late December a letter was sent to Laura and the perpetrator regarding the amount of incidents that Child A had been late after the registration had closed. This was recorded as four incidents totalling 95 minutes.

2018

3.1.109 In January the teacher phoned Laura regarding an incident during class and a meeting was scheduled for the following day to discuss Ella's school progress. Laura did not attend this meeting due to having another appointment and was happy not to rearrange the meeting.

3.1.110 In late January Ella was recorded as being upset at school. Ella disclosed that she 'was taking on too much' and 'supporting mum'. When asked what she was upset about Ella said she was upset over her step-dad's affair. Ella was asked if she was "ok with [the perpetrator]" and Ella said yes. Ella was asked if she was worried about the perpetrator and she said she was not worried but that she was confused over the affair. This was followed up with a telephone call to Laura who explained that the women the perpetrator had had an affair with had called the family home over the weekend and had told her about the affair. This was why Ella was upset in school as Ella did not understand why her mum was still with the perpetrator after the affair. Laura also asked if the school could look

into some issues that Ella was having with some other students. Ella was offered support from the school.

3.1.111 Laura's family recalled an incident in March where the perpetrator had attempted to isolate Laura from her support network as he had tried to prevent Laura from seeing her mother for Mother's Day and had threatened her stating *"if you go to see your mum on Mother's Day we're finished".*

3.1.112 In mid-March, Laura was seen by the GP regarding weight-loss related to stress which was associated with her divorce. A review appointment was booked but not kept.

3.1.113 On two occasions in March Child B was not bought to the developmental clinic. A follow-up text was sent to Child B's parents to rearrange.

3.1.114 In late March, a telephone call was made to Laura regarding Child B's two-year check, Laura stated that she had no concerns and declined. This is consistent with Child A's two-year check that was also declined.

3.1.115 Laura's family recall that in late April the perpetrator sent flowers to multiple female family members of Laura with a note saying "my sincere apologies" which they describe as his way of apologising to the family for having an affair.

3.1.116 In early May Laura had received a steroid injection which the family explained Laura had received due to having a back injury that had been causing her pain. Laura's family recall that at the same time Laura was bought a new car however the perpetrator would not allow Laura to drive this stating that this was due to her poor health as Laura was experiencing problems with her leg which kept giving way. They felt that these injuries could potentially have been as a result of domestic abuse as Laura had also lost a significant amount of weight and was reported as being frequently exhausted.

3.1.117 Laura's family described how Ella's behaviour visibly changed about two weeks prior to the homicide.

3.1.118 In mid-May, the perpetrator attended the Emergency Department and was diagnosed with a displaced fracture of the base of his 4th finger. This required surgery to repair so he was admitted. Temporary improvement was achieved and the perpetrator asked to go home overnight as his wife had to go to work. The surgeons agreed to an overnight leave and for the perpetrator to come back in for surgery because they were not able to take him to theatre until the following day and there was nothing clinical to be gained by him staying overnight in the hospital. The perpetrator reported falling awkwardly against a wall on an

outstretched right hand. The perpetrator was at no stage asked to clarify his account despite the discrepancies between the injuries and the reason given. The panel was advised that the injuries sustained to his hand would only occur if his hand had been closed into a fist. Therefore, the injury could only have occurred if he were holding an object tightly in the hand as he fell or if he had punched something. The panel discussed that the injury did not fit the explanation but that medical staff would tend to accept the reason given by a patient in this circumstance and that any referral made would be done with the consent of the patient.

3.1.119 During this time Child A told the school that their Dad had broken his hand and was in hospital. Child A was asked if the perpetrator had had an accident and Child A said that he smashed the door with his hand and Child A could see the big lump. Child A was asked if they had seen it happen and Child A confirmed that they had seen it happen and it was a bit scary. It was recorded that Laura and the perpetrator had been having a row and they were shouting, the perpetrator then hit his arm on the wall. This does not appear to have resulted in any follow up with either Police or Children's Social Care in relation to children witnessing aggression in the household.

3.1.120 Laura's family noted that following Child A's disclosure to the school the perpetrator started doing all of the school pickups whilst Laura would be required to remain in the car. This has not been able to be verified by school records but is Laura's family's recollection. Laura's family believe this was in order to ensure that the school were unable to speak to Laura on her own regarding the disclosure.

3.1.121 A few days later the perpetrator had surgery to fix the fracture to his hand. He was discharged with a plan to review at the end of May and remove the wiring after four weeks.

3.1.122 The next week the perpetrator attended a follow-up appointment in the Fracture Clinic where checks were made and a new plaster fitted.

3.1.123 Laura's family recall Laura had ended the relationship and had been heard saying to the perpetrator "you've got a week to get out, it's over".

3.1.124 In late May the perpetrator murdered Ella and Laura at their home and was arrested after initially fleeing the scene.

3.1.125 The same day of the homicide the Police brought the perpetrator into the Emergency Department with cuts to both hands and legs. Later that day he was brought back again

with Police, claiming to have taken excess medication for the last week. The perpetrator was returned to Police custody after no toxic features were found in blood tests.

4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks:

4.1.1 The chair and report author met with the family of Laura and Ella on three occasions, and the panel met with the family on one occasion. The Chair also took part in two Zoom meetings; one prior to a meeting with Children's Services and the other with the family and Children's Services. Throughout this report, the views of the family are embedded in both the Chronology section and the Analysis and Lessons to be Learned. The chair and panel thank them for their valuable insight and engagement throughout this process. Their contributions have greatly enhanced this review.

4.2 Summary of Information from Perpetrator:

4.2.1 The perpetrator was interviewed for this review on 30/04/2019.

4.2.2 He described his upbringing as happy. He was the only child of a couple who were married for 26 years and had separated when he was an adult. Both parents were active in his adult life.

4.2.3 He described that his seizures started at age 17 and had lasted for 5 years. He said that his last seizure was in 2012 when a seizure caused a car crash and when he broke his shoulder. Health records indicate that these dislocations were primarily as a result of the perpetrator continuing to play rugby despite repeat dislocations.

4.2.4 Laura's family note that they believe his shoulder broke during an incident at home, rather than in a car accident. They also highlighted that the perpetrator had been told on multiple occasions not to play rugby and that he should have submitted the details of his alleged epilepsy to the DVLA.

4.2.5 He described his profession as a data engineer. He worked in Newcastle before Gloucester and worked long hours. Attempts were made to contact Network Rail as the perpetrator's employer but these were unsuccessful so this was unable to be verified.

4.2.6 When asked about any early source of support or help, he referred to an incident many years before meeting Laura when he sustained injuries to his hand after breaking a mirror in frustration and anger shortly after a relationship breakdown. His father accompanied him to the GP and he was prescribed anti-depressants but there was no discussion of his relationship breakdown. He felt this medical intervention worked. He was able to move to Newcastle and work.

4.2.7 When asked about his understanding of domestic abuse, the perpetrator clearly understood that the range of abusive behaviours included coercion and control. However, he denied this was a dynamic of his relationship with Laura. When asked about the known Police incidents of domestic abuse with his previous partner and with Laura, he described them as isolated incidents and was unable to connect these behaviours with any other wider controlling behaviours.

4.2.8 The perpetrator noted that he had accumulated £30,000 of debt and had an Individual Voluntary Arrangement (IVA) by the time of the murders. He noted that despite financial worries, their decision to take costly holidays was due to the pressures on the family and so they needed to get a break.

4.2.9 Laura's family have stated that the perpetrator had told Ella that she was not allowed on the holidays that were booked which the family described as the perpetrator's further attempts to isolate Ella. They also recalled how £28,000 of this debt was the perpetrator's and £2,000 was Laura's prior to this debt being linked. They explained that Laura was not aware of the extent of the perpetrator's debts until after her bank card was stopped and she had gone into the bank to enquire why her card had been blocked. Further examples of economic abuse were also present as Laura's family recalled that all of Laura's money was always directly transferred into the perpetrator's bank account. Every month when Laura received her wages they were automatically transferred into the perpetrator's account.

4.2.10 The perpetrator said that over a period of two years while working, he often felt suicidal and remembers considering jumping in front of trains. This was due to his financial issues and the pending divorce of his parents. The perpetrator felt he would have sought help from his employer but knew that they had strict policies which would mean that he would not be able to work if he disclosed his suicidal thoughts. He knew that any medication he would be prescribed would be disclosed to the on-call chemist at his work which could have meant that he would have been unable to work.

4.2.11 The perpetrator was active in rugby and had a network of friends through this sport, but he did not feel able to speak to teammates about his feelings or problems.

4.2.12 The perpetrator disputes that he and Laura were separating at the time of the murder. He states they had a planned trip to Mexico.

4.2.13 It is noted that it is now known that he had been asked to move out by this time.

4.3 Summary of Information known to the Agencies and Professionals Involved

4.3.1 **Primary Care and health information regarding Laura**

4.3.2 Laura sought health services when she had sustained injuries which may or may not have been related to domestic abuse. In the period from July 2011 to April 2012 Laura reports one fall onto her abdomen and further episodes of low abdominal pain to the GP surgery. Through this time period, Laura is pregnant (with Child A).

4.3.3 In November 2012, Laura self-reported low self-esteem. One month later (December 2012) she was seen for anxiety, and seemingly a discussion about stressful home circumstances and work/life balance. Anti-depressants were prescribed alongside a mental health referral.

4.3.4 In June 2014, Laura is referred to neurology following a collapse but there is no evidence that she was seen there. In August 2014, Laura reports falling and injuring her knee.

4.3.5 In January 2015, Laura is noted as being assaulted, she initially disclosed to Police she was punched in the face, but later says she hit her nose on the bannister on Boxing Day 2014.

4.3.6 In February 2017, Laura is seen for low back pain, initially started as an acute episode but prolonged and then referred for specific support. Although not disclosed or recorded by agencies, Laura's family believe her back pain was due to the perpetrator's abuse.

4.3.7 In March 2018, Laura presented with stress issues and weight loss, expressing that she has stress related to her divorce.

4.3.8 **Gloucestershire Care Services NHS Trust information regarding Laura**

4.3.9 Laura was supported by health visiting staff throughout the early lives of all of her children. Records indicate proactive follow up for routine visits and care for all three children. Routine questions regarding domestic abuse were asked when Laura was alone.

4.3.10 After the Boxing Day incident in 2014, Laura was seen in A&E with a head injury following an alleged domestic assault by the perpetrator. From the Paediatric Liaison Health Visitor (PLHV) record, Laura reported to hospital staff that she was unsure how this injury had happened and had woken up at a neighbour's house. A DASH RIC was undertaken and noted as medium risk. The score was not recorded within GCS records. The perpetrator was taken into custody. The children were noted by Police to be with their paternal grandparents and Laura was discharged home (although it is important to note that while

Ella was with her siblings, she was noted to be in the care of her paternal grandparents, the perpetrator's parents). The GCS recorded planned liaison with School Nurse and a referral to the Health Visitor was made.

4.3.11 Heath Visitors were made aware of the Boxing Day incident in 2014 and were proactive in following up with Laura and her family. After three no access visits, the Health Visitor was able to visit the family in early February 2015. The visit took place at home and a family health needs assessment was undertaken and Laura was asked about the recent alleged domestic abuse incident. It is recorded that Laura stated she and the perpetrator had been drinking at her parents' house and she was quite drunk[10]. When they got home the perpetrator was at the top of the stairs with the children ready to put them to bed, when he turned and caught Laura with his arm, Laura lost her balance, fell down the stairs and hit her nose on the bannister. Ella was spoken to by the Police, and she confirmed this was how the accident happened. The Health Visitor asked Laura if she was afraid of the perpetrator or if he had ever been physical towards her and she said no to both enquiries.

4.3.12 **Primary Care and health information regarding Ella**

4.3.13 All the records regarding Ella from her infant/early years reflect the range of appointment and health services that one would expect during infancy and early childhood. The panel found that as notes are not always clear, it is not fully understood when the perpetrator was present or not which poses a challenge for understanding the context of the appointments.

4.3.14 In February 2011, there were a series of GP consultations from Laura's concerns about Ella's behaviour being hyperactive, with sleep problems and some challenging issues from Ella (biting and hitting other children). This would be the same period of time when the perpetrator moved in with Laura and Ella (two months into the relationship between Laura/the perpetrator). A referral to a CAMHS support team appears to be declined but with a signposting to parental support and a parenting programme.

4.3.15 A letter from Ella's GP to the Community Paediatricians at Gloucestershire Healthcare Trust (GHT) dated early November 2011 asking them to review behaviour as parents had noticed that, Ella did not listen when they talked to her and that she would get very angry if repeatedly asked to do something. The letter stated she would then lash out and use

[10] Laura's family have advised that both Laura and the perpetrator had been drinking but were not drunk.

bad language for up to an hour and then get upset saying 'I don't know what I am doing'. This behaviour was occurring at home and at school. At this point, Child A was aged 21 months and Laura had told the GP there were no problems at home or overt sibling rivalry. An appointment was arranged, but Ella was not brought to this. Laura's family's reflection on this is that they saw Ella on a regular basis and did not witness any evidence that would corroborate this account of Ella's behaviour. They felt as though this account was fabricated by the perpetrator as a means of discrediting Ella as this account did not actively reflect any of their experiences of Ella. They feel that Laura had potentially been coerced into supporting the perpetrator's account or did not feel able to contradict this.

4.3.16 In October 2013, the perpetrator and Laura attended the GP with concerns about Ella's behaviour. They discussed previous issues at Infant School, now at Junior School as well as problems at home. Alongside advice to seek the help of the school, the GP made a referral to Community Paediatrics, which is expected practice, but it is unclear about the status of follow up with this appointment or whether the child was taken to this. Laura's family stated that the perpetrator always accompanied Ella to the GP so Ella would not have had the opportunity to speak to the GP alone. GPs do not regularly record if an adult accompanies a child to an appointment. GPs should consider seeing a child alone when he/she may seem reluctant in front of the parent and will have to employ professional judgement in these situations. Learning from this review should highlight the need for GPs to consider when to speak to teens alone to fully understand how they relate to parents and or step-parents, in order to understand the protective factors or potential risks to the child.

4.3.17 **Gloucestershire Care Services NHS Trust information regarding Ella**:

4.3.18 In February 2011, Ella attended Gloucestershire Walk-In Centre due to vomiting. Noted to be seen with 'Dad', but it is not clear whether this is the biological father or the perpetrator. 'Dad' has stated that Ella is 'vomiting pure blood', although hospital records from this presentation are clear this was not observed. Laura's family have confirmed that this was not Ella's biological father but instead refers to the perpetrator.

4.3.19 **Primary Care and health information regarding the perpetrator**

4.3.20 Most of the perpetrator's contact with medical professionals stem from the treatment of epilepsy and injuries related to sport. There are indications throughout the perpetrator's contact with medical professionals that he reported stress and disclosed he had conflict with others including intimate partners. The perpetrator was regularly recorded as not

attending appointments and non-compliance with his medication in relation to his epilepsy which was described by panel members with experience of responding to epilepsy as not being untypical of how many patients with a similar diagnosis behave.

4.3.21 In July 2009, the perpetrator presented to GP for dressings to hand, with knuckle injury following punching a mirror. The perpetrator has disclosed stress issues, related to losing his job, relationship and financial worries. The GP refers to mental health and treats for anxiety. There is mention of the GP surgery discussing further with the perpetrator's father, this is noted to be supportive and caring practice. There is no reference to who the perpetrator is in a relationship with, which would not necessarily be an expected question to ask in these circumstances.

4.3.22 In December 2010, the perpetrator was subject to probation but the GP Practice did not record what this related to, so it is unclear what they knew about this and whether it may impact on any relationships or family contacts.

4.3.23 **Gloucestershire Hospitals NHS Foundation Trust regarding the perpetrator**

4.3.24 The perpetrator has attended GHT frequently over the period in question mainly for treatment and assessment of epilepsy and for shoulder injuries related to rugby. In 2008, he started having epileptic fits and subsequently had several appointments with neurologists and the Epilepsy Specialist Nurse. It is evident at the beginning of this period that the perpetrator has been involved in domestic abuse with a previous partner as mention is made of a pending court case. Throughout this period the staff involved endeavoured to ensure that the right medication and dosage was prescribed to keep the perpetrator fit-free. The perpetrator did not attend all his appointments, but notes show that letters sent to his GP and him after each appointment, whether or not he attended.

4.3.25 **Children's Social Care (CSC) summary of information related to all parties:**

4.3.26 Children's Services became involved following the Boxing Day incident in 2014 when Laura was injured and fled to her neighbour's house. In the assessment by CSC there was consideration of both the incident and the perpetrator's previous conviction for assaulting a previous partner. The Social Worker recorded that Laura minimised the risk from the attack to the perpetrator's previous partner and her mother in front of her two young children. Laura told the Social Worker that: "*she said that it was a lie and he pleaded guilty to get it over with. I stressed that without evidence, he would not have been convicted but this made no difference to her. Laura stated that there are no concerns within her relationship with the perpetrator".*

4.3.27 At the end of January CSC carried out a visit to complete the Initial Assessment. Laura advised the Social Worker that there had been no violence and the perpetrator had not punched her. The Social Worker spoke to Ella and recorded Ella as saying that her father elbowed her mother and Laura fell. January supervision notes are recorded by CSC that detail the Social Worker challenging Laura's account of the incident and questioning her version of events in relation to the domestic abuse. The notes also detail previous incidents of domestic abuse which the Social Worker was aware of. Actions for follow up were recorded as well as a record of next steps and Claire's Law.

4.3.28 The initial assessment was completed and accompanied by assessment notes. It was noted that Ella had lower attendance at school due to a family holiday. Later during the conversation with the Social Worker Ella had said that the perpetrator had hit her mother at which point the Social Worker recalled that Laura looked shocked and paused talking. Laura interjected stating that he had hit her with his elbow. The Social Worker recorded that Laura had provided several different versions of what happened, and it was only when Ella had disclosed that the perpetrator had hit Laura that Laura then added to the version that Laura had already given to the Social Worker. The Social Worker also spoke to Ella's birth father who said that he had seen no change to Ella's behaviour and that Ella was doing well at school. The outcome of this initial assessment was recorded as no further action.

4.3.29 **Education and school nursing summary of information related to all parties**

4.3.30 The School Nurse met with both Laura and the perpetrator in school in March 2011. At this time, in 2011, the School Nursing service ran regular drop-in sessions at Primary Schools. Laura and the perpetrator reported to the School Nurse that Ella had been displaying behavioural issues in school and at home. Ella had good attendance at school and appeared well cared for. At home, Ella tended to wake in the night/early morning and refused to go back to sleep again. Ella slept on the 3rd floor away from her mother. Ella tended to be obsessive at home e.g. lining up pens and toys and liked everything in its place[11]. Ella was not mixing well with children her own age but preferred to engage with older children. Ella's general health was described as good by Laura and the perpetrator,

[11] As noted previously, Laura's family did not recognise this behaviour.

however, she had tantrums and screamed at home until nearly sick. Laura's family believe this was due to Ella's dislike of the perpetrator.

4.3.31 Early in 2012 changes in Ella's behaviour had started to become noticeable whilst on roll at her Infant School. This was 6-8 months after the perpetrator moved into the family home with Laura and Ella. Ella was taking things that didn't belong to her, and when questioned could not remember the incidents[12]. The Child Family Worker arranged to go out and see the family at home and referred Ella to the school Special Educational Needs Coordinator (SENCO). Whilst there is a record of contact with Laura it is not clear from school records as to whether either the home visit or the SENCO referral happened. There are no SENCO records on file.

4.3.32 In May 2012 Laura expressed her frustration to the school about coping with Ella's behaviour whilst at home. Records indicate that in school at this time Ella seemed unhappy, shutdown and not engaged. Laura was contacted by the Child Family Worker and a meeting arranged, but Laura cancelled due to just giving birth to Child A. It was also recorded by the school that Ella seemed very agitated by the end of May 2012 culminating in a need for increased one to one supervision and support at lunchtime from the Child Family Worker at the school.

4.3.33 There is a 'cause of concern' recorded in the Junior School files dated 02/12/2016. It stated that Ella had an old iPad that was linked to Laura's shop computer. Laura saw the messages related to self-harm and distress. School staff spoke to Ella at this time, but Ella said she didn't know who had written the messages. The school spoke to Ella's friend, who had received some of the texts, and her mother. Laura then rang Ella's birth father to discuss the messages found on the iPad. From the meeting with the family, Ella's biological father was not noted as being aware of this information and was also not involved in the discussion with the school despite having parental responsibility. This would have been in line with the school's practice since they had already spoken to Ella's mother.

4.3.34 In September 2017, the perpetrator put in a request for an authorised absence to the Infant School for 2 weeks during November 2017 for Child A as both parents could not get leave in the summer months due to work demands. The request was refused by the Head

[12] It is noted that Laura's family also refute this.

teacher. There was no similar request submitted to the Secondary School attended by Ella.

4.3.35 In early November 2017, Laura phoned the Secondary School to say Ella was on holiday for two weeks in Florida. It was recorded by the school as an unauthorised absence. Whilst a penalty notice was not issued, it was indicated this was a potential course of action in a letter sent to Laura after the phone call.

4.3.36 By mid-November 2017 Child A's attendance had dropped to 81.4%, falling further to 75% by the end of November 2017.

4.3.37 In December 2017 and again in January 2018, the Infant School wrote to parents regarding the number of incidences where Child A was arriving late to school after the register had closed. Laura's family have noted that around this time, in January, Laura found out about the perpetrator's affair.

4.3.38 In mid-January 2018, Ella's behaviour was recorded by her Secondary School as being disruptive, with minimal school work completed. By the end of February 2018, the Designated Safeguarding Lead (DSL) at the Secondary School took a phone call from another school as students there had raised some concerns with regards to Ella which suggested that there were problems at home during the February half-term. It was suggested that Ella had threatened to harm herself by jumping out of a window. The Designated Safeguarding Lead (DSL) spoke with Ella who disclosed that she had self-harmed before. Although there is no record of when this might have been, it is recorded that she had not done so for a long time. Ella assured the DSL that she had no intention of doing so again.

4.3.39 Towards the end of January 2018, an incident was recorded by the Secondary School where Ella was alleged to have pushed another student over in the locker area. Laura was contacted by phone and a meeting was arranged. The record shows she did not attend due to another appointment.

4.3.40 A few days later the Secondary School recorded that Ella was upset in school as she felt that she was taking on too much with supporting her mother. When asked by staff what was troubling her, Ella disclosed that her step-father, the perpetrator, had had an affair. It is further recorded that Ella was not worried about the perpetrator, but was just confused over the affair. The school spoke to Laura, who explained that the woman with whom the

perpetrator had had the affair with had phoned Laura on her mobile. Ella was upset as she couldn't understand why her mother was still with her stepdad following the affair.

4.3.41 In mid-May 2018, Child A disclosed to the Infant School that their Dad had broken his hand and he was in the hospital. This was recorded on a Cause for Concern Monitoring Record. The School asked if the perpetrator had had an accident to which Child A said no, "he smashed the door with his hand" and that they, "could see the big lump". School asked if they had seen it happen, to which they replied, "yes it was a bit scary".

4.3.42 The incidents recorded by the schools were by and large treated in isolation as this is how they were experienced at the time. With hindsight, there was a pattern of behaviour which could have been further explored and certainly would have been had the initial assessment and closure letter been received by the school. In the absence of the initial assessment, each incident was dealt with appropriately and seen as 'behavioural' rather than safeguarding. The panel felt that if the records made also included the school's observations and concerns such as a detailed account of the changes in behaviour, there may have been sufficient concern to trigger involvement with the schools safeguarding lead and school escalation processes.

4.3.43 During interviews carried out with the school during the completion of the IMR a discussion was had with the school who had advised the IMR author that they had sought professional advice following the disclosure made by Child A. This was subsequently reviewed with the Head Teacher of the school following the panel meeting with the family where it was clarified that this was not the case and they did not obtain advice from the MASH. Further consultation was had between the Education Service and MASH to find out if the disclosure would have met the threshold and it was determined that the information available to the school at the time would not have met the MASH threshold. The school note that if the closure letter had been received the disclosure would have been considered in line with safeguarding practice.

4.3.44 **<u>Gloucestershire Constabulary summary of information related to all parties</u>**

4.3.45 There were three **key** domestic incidents/crimes that the IMR focused on;

- A domestic crime in early April 2010 with the perpetrator recorded as the perpetrator of an assault on his previous partner (not Laura) and her mother in front of her two younger children. There is also an associated crime relating to a separate assault on his previous partner's mother as part of the same incident.

- A domestic crime on Boxing Day 2014 with Laura recorded as the victim of an assault by the perpetrator at their home address in front of Ella and whilst Child A was in the house.
- The murder of Ella and Laura by the perpetrator at their home address at the end of May 2018.

4.3.46 **Early April 2010:** At just after midday an Emergency Care Practitioner called the Police to report concerns she had for a patient (the perpetrator's previous partner). In particular, she detailed that this patient had been 'beaten up' in front of her two young children by her current partner, the perpetrator. The patient's injuries were described as possibly including a fractured jaw as well as soft tissue injuries to her head and body. She had been in a relationship with him since August 2009 but the relationship had deteriorated and she had told him she wanted to end their relationship. An argument started which ended when he attacked her by pushing her into a set of shelves, then kicking and punching her repeatedly. The perpetrator also damaged her mobile phone. The perpetrator then further assaulted his former partner's mother when she asked him to leave following the assault on her daughter. The perpetrator was charged with offences of assault actual bodily harm (s47) and criminal damage and common assault (s39). The perpetrator pled guilty to the three charges and received a 9 and 4 month concurrent suspended sentence order for 24 months with a supervision order and unpaid work requirement, he was also required to pay compensation charges to the victims.

4.3.47 **Boxing Day 2014:** At 1 am Police were called by Laura's neighbour stating that she had just been woken up by Laura knocking on her front door in a very distressed state. The neighbour stated she had been asleep in bed when she heard the noise downstairs. The neighbour stated that Laura was in the company of her daughter Ella, who was 8 years old at the time. Laura had a visible lump on her head which she stated had been caused by the perpetrator hitting her. Laura also told her neighbour that the perpetrator was still at home with their youngest child. Police attended, and Laura was taken to hospital by ambulance for her head injury and the perpetrator was arrested. When Police attended, the perpetrator's mother was on the scene after being called by her son.

4.3.48 The morning after the incident on Boxing Day, Laura was again spoken to by Police at her home address. She provided a statement in which she confirmed that she would not support any action in regard to the perpetrator. In that statement, she detailed that she had consumed too much alcohol during the evening and that her memory was less than

clear. It is noted that her family, who were with her that night, are clear that they do not believe she had too much to drink. Laura said she did not regard the perpetrator as a violent man and would not support any action against him. She stated that she believed the injury she sustained to her head was a non-intentional act. Laura also clarified that Ella was still awake at the time of the incident although she did not state if she witnessed the actual incident leading to the injury. Laura was offered and declined a GDASS (domestic abuse service) referral. As a result of this further interview with Laura, a supervisory officer amended the DASH RIC from standard to medium.

4.3.49 A referral was made by Police to Children's Social Care following the incident that took place on Boxing Day, this was picked up at the MASH 5 days following this. The incident recorded that Laura had returned from a family meal at Laura's mother's house and the perpetrator had punched her. She went to a neighbour's house with her daughter Ella to ask for help. It is not clear where Child A was when Laura and Ella went to the neighbour's house. Ella said '*Mummy has had too much to drink and the perpetrator hit her*'.

4.3.50 When Police asked Laura for a statement she informed them that she had not been punched but had hit her head on the bannister. She told them that she did not want to make a statement to the Police about the incident. A DASH RIC was completed by Police and the outcome recorded on Children's Social Care file as 'standard' or medium. This indicates that *"there are identifiable indicators of risk of serious harm. The offender had the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances".* The statement supervisory review signed by a supervising officer from Police indicates that, *"I have reviewed this form, the risks identified and the quality of the investigation to date. I confirm that they have been completed to a satisfactory standard and all reasonable risk management actions have been taken. Parties have been separated which will remove any immediate risk."*

4.3.51 **End of May 2018:** At approximately 1.10 am Laura arrived home following a night out with a friend. This coincided with Laura having recently told the perpetrator to move out after the perpetrator's recent affair and breakdown of their relationship. At some point between 1.10 am and 4.30 am the perpetrator murdered both Laura and Ella using a knife to inflict multiple stab wounds to their faces and bodies, while the other children were in the house. Later examination of the scene by an expert offered the explanation that the assaults had started in the kitchen near the dining table and that Laura had been attacked first. It would appear the perpetrator also went upstairs after the attack to speak to his

younger children and tell them what he had done. The knife used in the assaults was seized from another bedroom. At 4.30 am the perpetrator called his mother to disclose that he had killed Laura and Ella. There are twenty minutes between the call from the perpetrator to his mother, her attending the scene with her partner, and him calling Police. She was then allowed to leave the scene with the children. Laura's family believe that the children should have been placed in care for the night.

5. Analysis

5.1 Domestic Abuse/Violence

5.1.1 The cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

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

5.1.2 **Domestic Abuse towards Laura**: Taking into account the government definition above, information gathered by the Police as part of the murder investigation, information provided by agencies on this panel as well as information provided by family indicates that Laura had been a victim of domestic abuse from the perpetrator extending beyond the one reported physical incident. In addition, Ella was also subjected to abuse from the perpetrator including a range of coercive and controlling behaviours in addition to psychological abuse. Exposure to domestic abuse or violence in childhood is considered child abuse whether this is directly or indirectly witnessed[13].

5.1.3 It is clear that the perpetrator used a range of coercively controlling tactics throughout his relationship with Laura. This ranged from physical abuse to emotional abuse, intimidation, financial abuse, and isolation. Laura's family noted how the perpetrator tried to ensure that she had little contact with her family and they were so concerned that they made enquiries

[13] https://learning.nspcc.org.uk/child-abuse-and-neglect/domestic-abuse/

about Clare's Law. Clare's Law was relatively new to policing in general at the time and her family were not aware that they could make a 3rd party request for information.

5.1.4 Despite the abuse, Laura maintained an active life with busy work activities and was a loving parent. She understood that her family was sceptical of the perpetrator and at times she protected him but because of the strong bond with her family, she was always able to maintain good relationships with them. They could see the toll the relationship was taking on Laura by her increased anxiety, weight loss and exhaustion towards the end of her life. After finding out about the perpetrator's affair, Laura was in the process of ending her relationship with him. She was speaking to her friend about this on the night of her murder.

5.1.5 Laura is noted throughout this report as not wishing to engage in the help of services, denying the perpetrator's previous conviction of domestic abuse or denying the incident of known domestic abuse against her. This does not mean that Laura accepted or condoned the perpetrator's behaviour. She had three young children and was juggling many responsibilities and privately spoke to trusted friends and family about her situation. She did not want involvement from services or professionals and kept them at bay by her denials to them. She trusted her supportive network of friends and family and did not feel the need to involve professionals whom she may have perceived would bring more complications to her already stressful circumstances. Laura's family described a significant extent of control within the relationship one example was that there was only one house key for the property which Laura was responsible for. This meant that Laura's movements were controlled by the perpetrator as Laura was required to always be home before the perpetrator arrived home. A further example given was that the perpetrator bought multiple family pets as a means of further limiting her independence as she was responsible for providing care for the animals. Both of these were viewed by the family as controlling Laura's movements and trapping Laura making it harder for her to be away from the family home for long periods.

5.1.6 There are many practical and psychological barriers that stand in the way of a woman leaving an abusive relationship, be it psychological, emotional, economic or physical threats, and women will often attempt to leave several times before making the final break. "One of the most important reasons women don't leave is because it can be incredibly dangerous. The fear that women feel is very real – there is a huge rise in the likelihood of violence after separation. 55% of the women killed by their ex-partner or ex-

spouse in 2017 were killed within the first month of separation and 87% in the first year"[14] [15].

5.1.7 Economic abuse as an aspect of domestic abuse is notable in Laura's experience. There were times when the perpetrator actively impeded Laura's business activity by placing constraints that made it difficult for her to work. One incident described by a family member demonstrates this clearly. Laura had a wedding reception to set up and the perpetrator would not allow her to take her van. In a panic, she called her sister to use her car and to help her set up the reception. There were also expensive family holidays that at times Laura and Ella would tell various family members that they did not wish to go on but were instigated by the perpetrator.

5.1.8 Laura's family are aware that at any family outing the perpetrator always had Laura's bank card and would use it to buy food and drinks. There were also debts taken out in Laura's name and monthly transfers of cash from Laura's bank account to the perpetrator's account. At one point she was shopping with her sister and found her bank card not working. They went into the bank and found that the perpetrator had made arrangements to consolidate their debt. She did not indicate that she knew about this arrangement. Her family assert that a small portion (£2k) of the £30k of debt was actually Laura's and that most of this debt was accumulated by the perpetrator. Perpetrators of economic abuse often use debt to gain power and control over their partner. In this case, Coerced Debt was used as a means of increasing Laura's isolation by causing increased financial instability which can increase someone's risk due to being trapped in a relationship that they are unable to leave. Perpetrators will often use controlling behaviour in relation to debt. This may include hiding the extent of their debt or hindering payments being made on time. This can therefore be linked to credit damage which can result in long-term effects[16].

5.1.9 Laura had also sustained injuries, for example, the incident on Boxing day in which she had visible injury to her head at the point in which Police had arrived to the property. The perpetrator had informed professionals that Laura's presentation was due to the fact that she had been under the influence of alcohol. However, Laura presentation may have been

[14] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/

[15] https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/domestic-violence/barriers-to-leaving/

[16] https://survivingeconomicabuse.org/wp-content/uploads/2019/09/What-is-coerced-debt.pdf

due to blows to her head. During this incident, Laura's family believe the perpetrator controlled the narrative of this incident using alcohol as a means of discrediting Laura and this resulting in the perpetrator's account being used to form the basis or referrals and assessments with partner agencies without consideration being given for an alternative viewpoint. This may have impacted on how agencies interacted with Laura following the assault and could have reinforced the perpetrator's control and contributed to the decision of Laura recanting her allegation. Attending officers noted there was some evidence that she had been drinking, however, they acknowledge that overall her intoxication level cannot be judged accurately.

5.1.10 **Domestic Abuse and Ella:** There is no doubt that Ella did not like or feel comfortable with the perpetrator. This is most vivid in speaking to Ella's extended family who were clearly her refuge from her home environment with the perpetrator. It is evident that Ella's school behavioural issues began just as the perpetrator came into her life and moved into her home. Laura's family find it regrettable that the school did not investigate the reasons behind issues with Ella.

5.1.11 The female role models in her life are all strong characters and Ella is described as a strong and determined person. She did not express fear of the perpetrator but that does not mean that she was not fearful of him. She felt a strong sense that her extended family were supportive and understood her and her situation and she would have felt great comfort in that. Laura's family recall that Ella was extremely pleased when on Mother's Day in 2018 Laura announced she was ending her relationship with the perpetrator.

5.1.12 Ella spent a lot of time in the home of her paternal grandparents and father and the home of her aunt and maternal grandparents. Notably, just before the murders, she asked to stay at home with Laura which demonstrates that she was potentially concerned about her safety and put herself in a role of protector which is consistent with the theory that she was killed when intervening and trying to protect her mother.

5.1.13 It is unclear if Laura fully understood the alignment between Ella's behavioural changes and the perpetrator's involvement in her life. She met with the school and GP often with the perpetrator to discuss these concerns. She may have felt coerced to do this or it may be that she was genuinely concerned about Ella's behaviour and wanted support. She may have been influenced by the perpetrator's assessment of Ella's behaviour. It is noted that Laura's family are concerned with the amount of influence the perpetrator had with

the school and that they did not question his role in the family or involve or inform Ella's birth father.

5.1.14 It is important for health professionals to know who has parental responsibility for a child as well as other adults who play a key role in that child's life e.g. stepparents. It is good practice to always ask, clarify and document who the adult is accompanying a child to appointments or who is ringing the practice about a child.

5.1.15 There are two common issues noted in the RCGP Child Safeguarding toolkit[17]:

5.1.16 "'Not seeing the child' reflects the reality that the needs of the child can easily be overshadowed by those of the parents, the needs of the child should always come first. It can be helpful to consider 'what is the daily lived experience of this child?' and act accordingly. When working with adults, it is always important to consider whether there might be any children who could be at risk of abuse or neglect as a result of the adult's health, behaviour or circumstances – see the child behind the adult. It is important to remember that the children who may be at risk may not always be within the family and may not be living locally or even in the UK."

5.1.17 And; 'Not seeing the adult' - It is important to establish who is in the child's life. Practitioners need to bear in mind that there may be new adults in the child's life such as new partners of their parents or friends/family members who may be staying within the household who may pose a risk to the child – 'see the adult behind the child'."

5.1.18 Furthermore, the 2015 NSPCC briefing[18] highlights the risk factors for hidden men in Serious Case Reviews and learning for improved practice:

- Lack of information sharing between adults' and children's services
- Relying too much on mothers for essential information
- Not wishing to appear judgmental about parents' personal relationships
- Overlooking the ability of estranged fathers to provide safe care for their children.

5.1.19 There were missed opportunities to accurately record and capture the voice of Ella and her siblings. It was noted through various agency IMRs that the records relating to disclosures made by Ella had been written in the professionals interpreted language as opposed to accurately recording Ella's individual account. This, therefore, resulted in

[17] https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit/types-of-abuse-and-indicators.aspx

[18] https://learning.nspcc.org.uk/media/1341/learning-from-case-reviews_hidden-men.pdf

inconsistency of record-keeping as it was not always clear who the records were referring to and what the exact disclosure had been. Many of the records refer to Ella's disclosures about the perpetrator however the family were clear that this is not the language that Ella would have used when referring to the perpetrator as she would have referred to him only using his first name. However, when this information has been recorded these disclosures have been adapted, losing the voice of the child. There were also occasions whereby Ella was spoken to, however, this was not done in a safe way to enable disclosure due to either the perpetrator or Laura being present which may have hindered Ella's disclosures.

5.2 Analysis of Agency Involvement:

5.2.1 **Evidence of good practice of primary care**

5.2.2 Consistent support, advice and treatment was offered to Laura as she attended for help with a variety of concerns. There was continuous support and GP treatment for her low mood, anxiety and depression. There is some recognition that her home and relationship situation is acknowledged, in regard to her stating a relationship break up (August 2009). However, there is no clear indication of routine domestic abuse enquiry from any of the contacts that Laura has with the GP surgeries.

5.2.3 GPs appear to have supported and referred Ella in a timely and effective manner when Laura raised concerns about Ella's development as a baby. Where the family did not attend the Community Paediatrics, Public Health Nurses followed up and communicated to Primary Care.

5.2.4 In regard to Ella's early school years and Laura and the perpetrator's concerns about her challenging behaviour, GPs monitoring of her symptoms was followed by referral for specific behavioural support. Although CAMHS service was deemed not appropriate, there was signposting to parenting support and a parenting programme. It is unclear from GP records whether this was taken up by the family, but it is referred to in a later GP consultation in 2013.

5.2.5 As a young man (19 years) the perpetrator had disclosed stress issues, related to losing his job, relationship and financial worries. The GP referred him to mental health and treated him for anxiety as well as discussing family support with his father which is supportive and caring practice.

5.2.6 **Wider context of primary care current good practice**

5.2.7 It is not clear whether the circumstance of this family raised sufficient concern for the Practice to discuss their circumstances at their planned Liaison/Safeguarding meetings. From a recent Gloucester Clinical Commissioning Group (GCCG) audit (July – Oct 2018) the medical practice highlighted a clear protocol set out to enable sharing information amongst all clinicians. The medical practice also reported holding regular Practice Liaison meetings to discuss both adult and child safeguarding concerns and domestic abuse notifications.

5.2.8 Both surgeries involved with this case have confirmed that both clinical and administrative staff undertook the domestic abuse training offered by GDASS, and continue to engage with training offered. This was rolled out to all GP Practices over 2017/18. The Safeguarding Lead GP (Adult and Child) attended training on October 2017 & February 2018, and advocated the value of this training in illuminating how people can access help, advice and support. The GP Practice displays GDASS posters and information in waiting areas and toilets.

5.2.9 With regard to GP Practices engagement and links with the Multi Agency Risk Assessment Conference (MARAC) process, the process for GPs to provide research evidence to contribute to MARAC is currently reliant on a contact from the MARAC coordinator, dependent on whether the GP is named and identified within the domestic abuse referral.

5.2.10 GCCG and GCS (Gloucestershire Care Services – the NHS Community Health Trust) are working together to improve the research administration process to enable all GPs to routinely be contacted by the MARAC administrator. That stated, the Domestic Abuse Lead Nurse (a GCS Specialist role) is a link professional making contact with GPs by telephone contact direct to the surgeries.

5.2.11 **Further analysis of the CCG and primary care**:

5.2.12 Very little is known, or it is not clear, what the GP Practice knew about Laura's relationships or the father of all 3 children. GPs will not routinely know the status or connection of family relationships, and may not ask when attendance is for a physical problem. In the case of Laura, she was attending for emotional support whilst Ella was quite young, and Laura shared some information about relationship difficulties in relation to stress. The question of relationships is again raised in 2009 when Laura attends. When being seen for mental health concern, there is, of course, a potential to ask about important others she can speak to, and family support.

5.2.13 In May 2014 Child A is noted to have a fractured nose. The diagnosis was made by the Emergency Department and follow-up was apparently arranged with an Ear Nose Throat (ENT) specialist for a week later. A nose fracture would be very unusual in a child of this age, but there is further uncertainty about the clinical accuracy of this as a diagnosis. An X-Ray was not taken as this would cause an unacceptability high dose of radiation to the child's developing eyes and brain, therefore diagnoses are always made clinically based on the visual appearance of the nose. It would be expected that this event on a 2-year-old child would have created a Health Visitor Liaison follow-up by the allocated Health Visiting Team.

5.2.14 Laura's family have confirmed they were told that this injury was sustained by an accident.

5.2.15 There is no clear note about the assault incident on Boxing Day 2014, informing about who may be the perpetrator of the assault and what information was shared and thoughts about referrals made that consider the needs of all three children. It is most likely that a multi-agency referral form (MARF) would be submitted to Children Social Care (via the MASH) if this information was alerted now.

5.2.16 The assault that Laura experienced on Boxing Day 2014 was an opportunity to further support Laura and the Health Visitor followed this up and communicated with the GP. There is significance in this injury, occurring over a holiday period with a possible delay in supportive follow-up. Laura's family have reflected that because it is generally known that domestic abuse incidents increase at Christmas and escalate in terms of severity – this should be reflected in staffing rotas.

5.2.17 It is unclear from the GP records whether Laura had made a disclosure about domestic abuse to any health professional (pertaining to the assault in December 2014). Currently, Gloucestershire uses a Mid-Wife / Health Visitor/ GP liaison form that captures information on the vulnerability of women whilst pregnant, sharing this across these 3 key services for information. These forms are in routine use now, but may not have been formulated at that time (2014/15).

5.2.18 Further, it is unclear from the GP records whether this assault was disclosed to professionals, through routine enquiry, or whether an assumption was made.

5.2.19 There is an Early Intervention and Health Pilot delivered by GDASS which is noted above which has been well received and accepted as improving the health response to domestic abuse. This pilot was based on evidence from IRIS (Identification and Referral to Improve

Safety). IRIS is a general-practice based domestic violence and abuse training, support and referral programme for primary care staff. The funding for this was due to expire in March 2020 but has since been agreed for additional funding to continue.

5.2.20 It is not clear from the GP records if Laura had been accompanied to all of her appointments or if she was given an opportunity to meet with the GP alone. This could potentially have acted as a barrier to disclosure due to the perpetrator being present at appointments.

5.2.21 **Evidence of good practice of the Gloucestershire Hospitals NHS Foundation Trust**

5.2.22 The care offered matched the need presented and was routine. Laura and the perpetrator presented as engaged and caring parents, interacting well together and with their children. The one known incident of domestic abuse was thoroughly assessed and actions followed guidelines and policies to the letter. Laura was offered a referral to GDASS (domestic abuse support) and was given an information leaflet in case she later changed her mind. The children were referred for follow-up by their Health Visitor, who visited the family.

5.2.23 Maternity care was routine. Laura attended all her appointments and the perpetrator was present at the birth of both of his children. Communication between Midwives, Health Visitors and GP was routine and unremarkable.

5.2.24 **Further analysis of Gloucestershire Hospitals NHS Foundation Trust**

5.2.25 Of most particular note is the domestic assault on Laura by the perpetrator on Boxing Day 2014, witnessed by Ella. This was recognised as domestic abuse on presentation to hospital and a DASH RIC form was completed. This was assessed as medium risk at the time. The DASH was re-assessed by a Safeguarding Nurse the following day and categorised as ‘Medium – no consent to share’ and therefore they would require consent from Laura to share information with other agencies.

5.2.26 The clinical assessment on Boxing Day 2014 was extremely thorough and the history was carefully documented. The children were referred for Health Visitor follow-up as a result.

5.2.27 Laura’s family feel that the disclosure made to hospital staff in relation to the injuries being sustained as a result of a punch should have triggered information sharing and an onward referral. However, as noted in 5.2.25 this would have required Laura’s consent.

5.2.28 This Trust should maintain and strengthen its links with GDASS and consider the emerging tools from DOHSC funded Pathfinder sites as the interim and final evaluation of Pathfinder sites culminates in 2020.

5.2.29 Laura's family commented that it would also have been beneficial for national services to have been provided as an alternative avenue to accessing support in addition to the local GDASS provision. Laura was known amongst the community and her family felt that it may have potentially been a barrier for Laura to access a local service for a variety of reasons such as knowing people accessing support from or working for GDASS, therefore, her anonymity may not have been completely achievable.

5.2.30 **Evidence of Good Practice with Gloucestershire Care Services**

5.2.31 Laura and her children were open to Universal health services (GP, Health Visitor, and School Nurse). Laura's attendance at appointments or being at home for planned visits were inconsistent. For working, busy parents some non-attendance is to be expected and would not normally raise concerns unless there were known safeguarding issues.

5.2.32 There were occasions when Laura was asked about domestic abuse when the perpetrator or Ella was not present, which is clearly good practice as per GCS practice benchmark (2017).

5.2.33 The School Nurse made a detailed action plan for Laura and the perpetrator, giving advice on strategies and boundaries. Ella's birth father however was not invited to these meetings as they did not have his information on record. The School Nurse planned to monitor through school if there were further concerns. There were no further concerns raised by school to the School Nurse. Contact with the School Nurse was another opportunity for Laura to disclose, however, none was made. Laura's family note that the perpetrator did not allow Laura to be alone at school, impeding her ability to safely disclose.

5.2.34 After the Boxing Day incident, the Health Visitor discussed with her team whether the domestic abuse incident required a home visit follow up. The outcome of this was that the Health Visitor assessed that a home visit was required due to the nature of the incident. To speak with the mother on her own at home was considered best practice and would have allowed Laura to understand that she could contact Health Visiting in the future if she wished, or seek specialist domestic abuse services as appropriate. The Health Visitor could have considered rescheduling the meeting to a time when the perpetrator was not present.

5.2.35 There was good practice identified in terms of asking the domestic abuse question when possible, and recording when and why this was not possible. The follow-up visit by the

Health Visitor to Laura at home following the domestic abuse incident on Boxing Day 2014, was also good practice. This allowed the Health Visitor to ensure Laura had the relevant information on how to get specialist domestic abuse support from GDASS.

5.2.36 In 2011, the GCS School Nurse Service provided drop-in sessions for parents at Primary Schools countywide. This was a good opportunity in this case for the School Nurse to meet Ella's mother and birth-father and provide parenting advice and support. It also provided effective communication between school staff and health where there were concerns about a child's emotional wellbeing. This was normal practice at that time and followed The Healthy Child Programme (2009) guidance.

5.2.37 There is a rolling programme of GCS domestic abuse training available to all staff, delivered by the Specialist Nurse for Domestic Abuse.

5.2.38 Where there is known domestic abuse following a high-risk DASH, a red flag is added to child's/children's record. Previously the flag would be removed after one year, however, the flag is now maintained to denote historic or current domestic abuse within the household.

5.2.39 The Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Care Services have a joined-up service by way of a Paediatric Liaison Health Visitor. This post was likely to have been in place at the time of Child A's nose injury. Currently, this service has undergone development to deliver more effective communication and liaison service between Emergency Departments, Walk-in-Centres and the Public Health Nursing service.

5.2.40 **Wider context of the Gloucestershire Community Services NHS Trust good practice**

5.2.41 Domestic Abuse Policy (2017), is designed to ensure a consistent and systematic response to clients/patients and colleagues who are, or have been affected by domestic abuse and may require information and assistance.

5.2.42 GCS is committed to training all staff in the use of the DASH RIC screening tool, and raising staff confidence in supporting victims of domestic abuse.

5.2.43 A previous Gloucestershire DHR 'Rosie' (2015) highlighted the need for organisations to have a single point of contact for domestic abuse. GCS employ a full time Specialist Nurse for Domestic Abuse within the Safeguarding Children Team, who is involved in both delivering of single and multi-agency domestic abuse training and supervision.

5.2.44 Responding to domestic abuse: a resource for health professionals (2017) highlights it is often health services that are the first point of contact for victims of domestic abuse. We know that those suffering from abuse find it very difficult to speak out. However, many drop hints or display behaviours which may indicate an issue. It is essential staff are trained adequately and feel confident to pick up these indicators and to enquire in a safe manner in order to elicit information and provide appropriate assessment and referral, as they are in a key position to recognise indicators of abuse and to offer support and referral for protection.

5.2.45 Gloucestershire Domestic Abuse and Sexual Violence Guidance for Professionals on Identifying and Responding to Domestic Abuse (2018) provides countrywide best practice, including procedures for identifying domestic abuse by both routine and selective enquiry, and guidance on how to respond in the most appropriate manner, by way of risk assessment and signposting.

5.2.46 Training: public health nursing staff in GCS are offered both single and multi-agency training, which is deemed 'Essential to Role'. This is set out within by National Institute of Health and Care Excellence (NICE). Domestic violence and abuse: multi-agency working NICE Public Health Guidance 50 (2014). The training aims to provide a universal response to give staff the basic understanding of the dynamics of domestic abuse and the legal framework which it relates to, underpinned by an awareness of diversity and equality issues. It provides staff with the skills and knowledge to undertake routine enquiry of domestic abuse and what they need to do next if a disclosure is made. NICE guidance (p.20) sets this out as:

'Level 2: Staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people's lives and the role of professionals in intervening safely. Staff should be able to respond with empathy and understanding, assess someone's immediate safety and other referral to specialist services.'

5.2.47 Routine enquiry asking clients about domestic abuse is part of GCS public health nurses benchmarks for all core contacts with families following the birth of babies to explore any past or present experiences of domestic abuse (GCS Best Practice Benchmarks, 2017). All GCS staff have access to this.

5.2.48 **Further analysis of the Gloucestershire Care Services:**

5.2.49 Although the follow-up home visit by the Health Visitor to Laura following the domestic abuse incident on Boxing Day 2014 was good practice, there seemed to be a delay between the time of the assault and the contact from the Health Visitor (9 days). Also, it is not fully clear whether this was raised to Children Social Care or shared with the Police. Laura suffered a significant physical injury to her face, hitting it on the bannister. This event must have been significant for Laura and the children and it is unclear what follow up ensued.

5.2.50 While much of the progress at GCS is commended, there still remains an element of professional curiosity that is lacking in some instances. Domestic abuse questions were asked and recorded when Laura was alone but there is less evidence that staff feel supported and confident to address domestic abuse if the victim/survivor denies or minimises the abuse. Often this is done for logical reasons and an enhanced level of skill is needed to continue with the conversation about potential abuse if cut short by the victim/survivor.

5.2.51 The GCS domestic abuse policy requires a review, to ensure it includes advice on what to do if a practitioner cannot ask the domestic abuse question, and if indicators are present but the victim is denying/minimising the risks to themselves and/or their children. And for the policy and training to approach denial and minimisation in a non-blaming way.

5.2.52 GCS should assess the indicators which would measure adherence to their domestic abuse policy to ensure there is adequate oversight throughout the services provided.

5.2.53 **Children's Social Care Analysis:**

5.2.54 This section contains particular analysis of Children's Social Care for two reasons. The first is the strength of feeling of Laura and Ella's family in terms of how Children's Social Care and the Police addressed particular situations involving Laura and Ella. Secondly, there are aspects of this case that are similar to previous SCR's in Gloucestershire.

5.2.55 In June 2017 – An Ofsted report found Gloucestershire County Council Children's Services to be 'inadequate'. The report noted that areas such as "Assessments, decision making and planning for children are poor and frequently adult-focused." "Management oversight is inadequate. It lacks rigour and direction. It continually fails to identify key weaknesses in social work practice or ongoing risks to children." (Ofsted June 2017).

5.2.56 The above Ofsted report is likely to reflect the practice in 2015. However, the most recent Ofsted monitoring visit notes that "Increasingly, effective management oversight of

decision-making by Social Workers and the quality and timeliness of assessments are leading to improvements in children's circumstances" (Ofsted Monitoring Visit Report 25th October 2018). Therefore, Ofsted has reflected the improvement in practice within the system since June 2017.

5.2.57 The Social Worker noted that Laura was not providing an accurate account of the incident that took place on Boxing Day 2014. Laura and the perpetrator were spoken to separately and this is good practice in cases of domestic violence where the victim may not feel able to disclose in front of the perpetrator. This could be evidence of coercive control within their relationship whereby Laura is minimising either on the basis of what the perpetrator has told her and she simply believed him, or minimising through fear. The analysis does not sufficiently explore the impact that domestic violence/abuse is likely to have had on Laura, Ella and Child A. The records suggest that it is likely that the Social Worker did not explore the possibilities of coercive control and the dynamics of domestic abuse relationship beyond physical abuse. The records also show that Ella was not spoken to alone which would have provided her with an opportunity to speak more openly about what had happened on Boxing Day and her home life in general.

5.2.58 The Gloucestershire Safeguarding Children's Levels of Intervention Guidance (LOI) document would have provided the framework for making threshold decisions. The referral was responded to in the MASH Information was shared by agencies including Police about the perpetrator's history of violence against his previous partner. These procedures were followed appropriately. Laura's family expressed concern over the reliance on the DASH RIC which did not adequately highlight the risks to Laura or Ella, this is further discussed in 5.2.86.

5.2.59 At the point of the Police making a referral into MASH following the Boxing Day incident, there were no daily domestic abuse meetings. Current practice consists of a daily domestic abuse meeting chaired Monday to Friday in the MASH that considers all Standard and Medium VISTs. All High-risk VISTs are referred to MARAC. The 5-day delay was reviewed by the MASH manager who determined that this incident pre-dated the use of Unifi Enquiry (2017), at the time the Access database was used. There were no recorded delays or backlogs at that time. Christmas duties would create a delay in any referral process. Boxing Day 2014 was a Friday which would have meant that it was likely that with bank holidays there would have been no staff in until the 30th December. Records show that this case was recorded on the 30th December which is when any referral to

Children's Services was also made. At that time domestic abuse cases were put into the MASH in cases where it was the first recorded incident between the parties, which it was for Laura and the perpetrator. This report was subsequently input into MASH on 31st December and was reviewed on 2nd January 2015. This was sent out at 08:00 am on the 2nd January to all partners and was finalised on 8th January. Partners, including Children's Social Care responded with any information they held between those dates. Ultimately this meant that the initial delay in referring to partners was 5 days predominately caused by the staffing over the Christmas period. As previously noted, Laura's family feel that because it is known that incidents often increase during the holiday period, staffing provisions should reflect this.

5.2.60 Staff working for Gloucestershire Children's Social Care have access to the Gloucestershire Safeguarding Children's Board training on domestic violence. The training provides Social Workers with detailed information about perpetrator profiles, the impact of domestic violence on the children and victims. The two-day course includes interviewing victims and others. Current statistics of attendance by Social Workers to these courses are that they are low and it is likely to have been the case in 2015 when the same courses were made available to Social Workers. There has been much discussion in previous SCRs, and in the workforce subgroup in Gloucestershire about training required to address the issues highlighted above for both front line and supervisory/management staff. A thoughtful approach to workforce development is required to fully address the need for both training and oversight tools so all Children's Social Care and all safeguarding professionals can work in a more nuanced and trauma-informed way to address domestic abuse with adult and child victims as well as perpetrators of abuse. This should be done working closely with the newly established social work academy and workforce subgroup of the safeguarding board. While training alone will not fully achieve the workforce development needed, agreed mandatory training and refresh training for particular roles should be agreed. Multi-agency approaches that have worked in the city of Gloucester should be considered countywide.

5.2.61 **Voice of the Child:** The analysis section of the Initial Assessment recorded the discussion held with Ella. However, it does not highlight the voice of the children and the impact of domestic violence on Ella and Child A. This is a key feature that could have been explored further. For example, professional curiosity could have been exercised to understand what Ella and Child A's lived experience was like and how vulnerable they were within the household. The Social Worker had highlighted that Ella had provided some conflicting

information; this line of enquiry should have been further explored within the Initial Assessment. In addition, Ella had presented as a child who was 'doing well' at school and when she was with her birth father, he had reported no concerns about her well-being. When Ella's birth father was interviewed by the Social Worker, he informed the Social Worker that Ella had not told him about what happened on the night of Boxing Day 2014. This suggested that Ella did not share the difficult experiences of life in the family home with her birth father. However Laura's family assert that this assumption is untrue and it was the fact that Ella was left in the care of the perpetrator's family after the Boxing Day incident that shut down Ella's confidence to speak about the truth of what was happening in her family home, they believe Ella's voice was lost when she was spoken to about the Boxing Day incident.

5.2.62 A follow-up interview and a more detailed assessment could potentially have highlighted further evidence of domestic violence in the home and its impact on Ella. A Single Assessment, in line with Working Together 2013, could have provided further insight into Ella's lived experience in a household with domestic violence and the impact of this on her. A Single Assessment would have required at least two visits to see Ella alone. It is unlikely that there was no impact on her given that she had witnessed two domestic violence incidents that were reported and as the MASH contact indicates that there are likely to have been more unreported incidents.

5.2.63 The decision was taken not to re-visit Ella or meet with her in school to discuss the incident and its impact on her as a child. There is a record of a discussion with the Child Protection and Safeguarding Lead at the school and this recorded that there were no concerns about Ella. This could have been explored further in order to build a clearer understanding of the history and potential continued risks.

5.2.64 It is not clear in any of the Children's Social Care records if the perpetrator and Laura were separated after this event. Police records indicated that when called they had asked the perpetrator to leave the family home. The risk that the perpetrator potentially posed to Laura, Ella and Child A because he continued to live in the same household after the incident on 26th December 2014 was also not sufficiently highlighted in the Initial Assessment.

5.2.65 Children's Social Care record of DASH RIC is followed by a statement about a previous incident when the perpetrator had attacked his ex-partner at the time and her mother. At that time, the assessment of risk was identified as medium to high. He had punched his

ex-partner and her mother in front of her two young children and had caused criminal damage, the record indicated that he was, therefore, a 'high-risk perpetrator' of domestic violence and he received a suspended sentence of imprisonment for Actual Bodily Harm, Battery and Criminal Damage. The risk posed by the perpetrator would have warranted a strategy discussion, section 47 enquires and an Initial Child Protection Conference to discuss the likelihood of significant harm to Ella.

5.2.66 The referral was progressed to an Initial Assessment. The outcome of the Initial Assessment was 'no further action' and the case was closed. The conclusion section of the Initial Assessment is analysed in another part of this review.

5.2.67 The referral was recorded mid-January 2015, 13 days after the incident, following the receipt of consent to share information. The decision in the MASH was appropriate, although it was delayed by MASH. Laura's family believe this was too long a gap between the incident and the meeting. The MASH manager stated that the reason for delay should have been recorded on case records but this did not happen and this is likely to "reflect practice at the time". She also informed that at the time, the front door had limited resources and there were only two decision making Social Workers – this has now changed and there are twelve Social Workers in the MASH. This is no longer an issue in the MASH. The recent Ofsted visit noted that progress has been made in the MASH on timeliness.

5.2.68 The management decision in MASH was to progress to an Initial Assessment "based on information held within the MASH". This followed arrangements set out in Working Together 2010, however at the time Working Together 2013, which introduced a Single Assessment should have been applied – that is to be carried out within 45 days of the referral.

5.2.69 The improvements to the MASH in the past year are accepted by all partners. The MASH is now adequately staffed. The domestic violence agency, GDASS, is now based in the MASH, alongside Children's Social Care and Police. All three agencies are engaged in assessing and reviewing the support needs of victims of domestic violence. Where a threshold has been met for a strategy discussion or a Section 47, this is progressed with Children's Social Care.

5.2.70 Where there are concerns that the victim/survivor of domestic abuse is reluctant to progress with a statement or support and there are concerns identified, the outcome of the contact is progressed to single assessment in line with Working Together 2018 to assess

the safeguarding needs of the children. In line with Working Together and the Gloucestershire Threshold document, a single assessment may be completed even if the victim/survivor does not consent. These decisions will be made at Team Manager level in the MASH. Where it is assessed that a victim/survivor may benefit from Early Help support this is offered if the victim has given consent to access the support.

5.2.71 An Independent Domestic Violence Advisor is based in the MASH to provide support to those subject to domestic abuse.

5.2.72 Government guidance on Working Together 2013 stated that 'All Local Authority Children's Services were required to use the framework no later than 1st April 2013". Ella and Child A's Initial Assessment was completed in April 2015. It appears that Gloucestershire Children's Social Care as a whole had not implemented Working Together 2013 two years after the required timescale. The reason for this is not known, but the liquid logic system records prompted Social Workers to complete an Initial, not a Single Assessment in 2015.

5.2.73 The referral form decision section sets out the following: "IA [Initial Assessment] needed to be allocated as a priority as mum may not be reporting DV, young baby in the home, older child (Ella) called Police, partner a perpetrator appears to have a violent history". This decision is appropriate and relevant and set out clearly what the potential risks were and took account of the perpetrator's history of violence. The decision also recorded that Laura "may not be reporting Domestic violence incidents to the Police". The reason for the late completion of the Initial Assessment is recorded on the electronic file as 'lack of worker availability'.

5.2.74 The decision recorded by the MASH manager was not appropriately and fully followed through to the Initial Assessment. The MASH manager informed that the use of Initial Assessment instead of Single Assessment was an oversight. However, the record of the 'Initial Assessment' notes that it was commenced on 15th January 2015 when the contact was completed and it was due on 22nd January 2015 (timescale for Initial Assessment) and yet it was completed on 28th April 2015, three months later than the due date. It is not possible to determine why the Social Worker had carried out an Initial Assessment or the team manager did not challenge this because they were not available to comment on this issue. The Initial Assessment was completed after interviewing Ella once in the family home. She was interviewed alone (in line with Working Together 2013) and she told the Social Worker that her mother was punched by her step-father. The Social Worker notes that "It also became apparent that Ella was primed on what to say and was upset when

she accidentally told me, through chatting away, that the perpetrator hit her mother and also stated that the perpetrator and her mother were getting on well." The conversation was interrupted by Laura entering the room and Ella did not discuss the incident further. This is of concern and good practice would indicate that this required further discussions with Ella.

5.2.75 The Initial Assessment included the perpetrator's account of what happened. The perpetrator told the Social Worker about how Laura sustained the injury – "they had argued at the top of the stairs as Laura wanted another glass of wine. The perpetrator said he accidentally extended his arm and his elbow caught Laura in the face and she stumbled back to the bannister causing injuries to her head. The Social Worker questioned this account in the Initial Assessment and also appropriately challenged the perpetrator about his account. She mentioned his previous conviction for attacking his ex-partner and her mother, in front of her two young children, by punching and kicking her. When asked about this, the perpetrator responded that the description was "'far-fetched' and told the Social Worker that "he had no reason to lie and he is honest". It is noted this was clearly his way to distract from concerns regarding his previous conviction of violence.

5.2.76 The Social Worker reported that when the two incidents were assessed together, they caused her concerns about the perpetrator. When she raised her concerns with the perpetrator, he responded that he had a good relationship with Laura and they were fine. These concerns were not progressed further.

5.2.77 The risks to Ella are set out in the Initial Assessment and recorded as "domestic abuse and the impact of this on the child development – risks surrounding emotional harm". The risk section noted that Laura minimised concerns as she may not be "fully protective". The risk section does not sufficiently review the perpetrator's previous conviction for domestic violence/abuse offences. In other parts of the Initial Assessment, the Social Worker notes that the mother was 'protective' of her children.

5.2.78 If coercive control and other forms of domestic violence/abuse were considered, the Social Worker could have considered the complexities of domestic violence and how these impact on victims. It is unlikely that the Social Worker would have concluded that Laura was acting protectively towards her children. The Social Worker would be expected to assess risk and vulnerability of Ella, Child A and Laura. Research into understanding victims of domestic violence suggests that there are indicators and outcomes that could

have led Laura to believe she was acting protectively by not raising concerns about domestic violence. She may have remained in the relationship as a means of protecting herself and her children because in her view, leaving the relationship could potentially mean that they would be at even higher risk. The information provided to Laura by the Social Worker was to give her information about GDASS - domestic violence specialist support.

5.2.79 The Initial Assessment noted that there was one interview with Ella and this was not followed up by having a discussion with her about what she saw, especially as the first interview was interrupted by Laura entering the room. Laura's family believe that by failing to follow up on this Ella's voice was lost.

5.2.80 **Parenting Capacity and the voice of the perpetrator and Laura**. The parenting capacity of Laura as a victim of domestic violence was not fully explored in the Initial Assessment. For example, the only times that she had contacted Police was when she was in immediate danger. The impact of the control that may have been exercised on Laura as a victim of domestic violence and how this would have impacted on Ella and Child A should have been further explored in the Initial Assessment.

5.2.81 The Initial Assessment recorded discussions with the perpetrator as the perpetrator of domestic violence both in the incident in 2014 and with his previous partner. He minimised the impact on both blaming his previous partner and not fully explaining why Laura would have gone without him and with Ella to a neighbour if the incident was an accident. He was recorded as being articulate in presenting how the injuries occurred when discussing the incident on 26th December 2014. The Initial Assessment records that "Parents have been in a relationship for several years and there have been no other reports of concern". "Mother acted protectively". The Initial Assessment appropriately identified research about the risks to children living in homes where domestic violence took place but did not sufficiently follow up the risk identified in the MASH episode that mother may not be reporting other incidents.

5.2.82 The Initial Assessment decision was that there should be 'no further action'. If underlying risks and the likelihood of risks had been further explored, then the outcome could have been to progress to an in-depth assessment or potentially an Initial Child Protection Conference. The perpetrator was living with Laura and her children and the Initial Assessment did not contain any insight into the impact of domestic violence/abuse on the children in the family and his partner.

5.2.83 The Initial Assessment was carried out by a qualified Social Worker in line with Working Together 2013: Page 19 which sets out the components of a good assessment. This should be child-centred and based on the safeguarding needs of the child. Section 38 notes that "Children should, wherever possible, be seen alone and local authority children's social care has a duty to ascertain the child's wishes and feelings regarding the provision of services to be delivered. It is important to understand the resilience of the individual child when planning appropriate services". Whilst Ella was seen alone when she inadvertently informed the Social Worker that the perpetrator had punched her mother, this was not later followed up by the Social Worker.

5.2.84 The Social Worker's Initial Assessment noted that Ella is 'doing well' at school and the school reported that she had missed days at school due to a family holiday. Ella had presented as 'coping well' at school and this was recorded in the Initial Assessment. Further evidence of how she presented at school and the impact of domestic violence/abuse on her in the school environment could have improved the Initial Assessment. The statement provided insufficient insight and evidence of what "coping well" meant for Ella. The Child Protection and Safeguarding Lead in the school was not asked for further information about Ella's presentation with evidence-based questions. This was a missed opportunity because Ella may have shared information with the school or the school may have had an understanding about the impact of the home situation on her presentation and behaviour.

5.2.85 Domestic violence was reported to Police and they made a referral to Children's Social Care which progressed to an Initial Assessment. A DASH form was completed. Children's Social Care records indicate that based on the previous attack on his ex-partner and her mother in front of two young children, the perpetrator was assessed as of medium to high risk. The purpose of the DASH is to set out the risk as identified by the victim; however, the Social Worker could have exercised professional judgement about what happened and how this would have impacted on Ella, Child A and Laura. Front line professionals should ensure there is not an over-reliance on the DASH assessment, they should recognise that risk is fluid and keep in mind that professionals will often not know the whole situation.

5.2.86 It is noted that the GDASS DASH training specifically highlights the importance of professional judgment and that it should not be viewed as a tick box exercise. Although this training was paused at the beginning of the COVID-19 pandemic, at the point of

writing it is due to be continued virtually due to the ongoing pandemic. This will sit alongside guidance already produced since by the Gloucestershire Domestic Abuse and Sexual Violence (DASV) Strategic Coordinator which states the importance of recognising fluid risk and the role of professional judgement.

5.2.87 Detailed information from the school was not requested by the Social Worker and as such, the school's information regarding how Ella presented at school was not used in the assessment. The information would have been helpful to understand her relationships at school, whether she presented with any behaviours that were challenging and whether she had discussed domestic abuse with teachers or friends or discussed her relationship with the perpetrator as she was the one who had supported her mother and gone to the neighbour's house with her on 26th December 2014. Children's Social Care records do not clarify whether education colleagues/school teachers were aware of the domestic violence incident and how this may have impacted on Ella at school. The school staff at the time have said that they were not made aware of the nature of the incidence and that there was nothing on the social care file to suggest that information regarding this was shared with them.

5.2.88 Gloucestershire Children's Social Care closed the case on 23rd April 2015 once the Initial Assessment was completed. Laura was offered a referral to a domestic violence support service and she informed the Social Worker that she did not want to attend. Laura's family believe that at this point, something should have been offered to Ella, however, there was no further enquiry with the school at the time of assessment. No other support was provided for and there are no records of discussions with Laura about the impact of domestic abuse on Laura and her children.

5.2.89 It is important that front line workers gain the confidence of the victim to engage with services in respect of domestic violence as well as ensuring that a referral is made to specialist services. If the victim chooses not to engage with specialist services, it is still incumbent on the front-line worker, in this case, the Social Worker, to engage with her on the impact of domestic abuse.

5.2.90 **Management oversight:** Supervision took place on a monthly basis during the time that Ella was allocated to a Social Worker, in the first supervision session on 28th January 2015 the team manager reports that the school and Health Visitors should be contacted for the assessment and "a reflective discussion took place which included disclosing about domestic abuse and Claire's law".

5.2.91 Claire's Law, or DVDS, has two functions: 'right to ask' - this enables someone to ask the Police about a partner's previous history of domestic violence or violent acts. A precedent for such a scheme exists with the Child Sex Offender Disclosure Scheme; and 'right to know' - Police can proactively disclose information in prescribed circumstances. At the time of writing, the Domestic Abuse 2020 bill is being debated and within it, proposes to change Claire's Law to allow concerned family and friends to access information as well. This review is supportive of this change which may have allowed Laura's family to become away of the perpetrator's past domestic violence.

5.2.92 Claire's Law was discussed in supervision and information about the perpetrator was shared by the Police. That is, the perpetrator had previously attacked his ex-partner. The supervision notes refer to the discussion with Laura where she told the Social Worker that she knew about the conviction and she was not concerned about it.

5.2.93 The discussion held in supervision about Claire's Law was not progressed or does not appear to have been discussed with Laura. Protection orders such as Non-Molestation Orders, Restraining Orders or Domestic Violence Protection Orders were not discussed or applied for. "The perpetrator contacted and outlined that mother does know about his past DA history". The supervision session discussed Ella being seen alone and this is good practice, however, there is no discussion about Ella disclosing that the perpetrator punched her mother and then said that her mother and stepfather 'got on well' when her mother entered the room.

5.2.94 The following supervision session in mid-February 2015, noted that the perpetrator has a domestic violence criminal conviction and that "mother knows about his past domestic violence history". Robust planning about what action to take as a result was not discussed in supervision.

5.2.95 The supervision session does not reflect upon the risk posed by the perpetrator given his violent behaviour towards his ex-partner and her mother in front of her two young children. The Social Worker informed her manager that she had challenged the mother about going to the neighbour's because he had punched her and later retracting the statement when the Police asked her to make a statement. The supervision session could also have reflected upon the need to protect Ella and her siblings from domestic abuse and Ella's disclosure that the perpetrator had punched Laura in the face.

5.2.96 The final supervision on file is in mid-March 2015 and reported the perpetrator had called his previous partner a liar and Laura had agreed with this assessment of the perpetrator's

ex-partner. Ella's biological father informed the Social Worker that he was concerned about not knowing what happened that evening. In a previous note on file Laura's ex-partner (Ella's birth father) had informed the Social Worker that he had seen Laura with two black eyes over the holiday period. This was referring to the visible injuries following the Boxing Day assault in 2014. This does not appear to have been followed up.

5.2.97 The Initial Assessment noted that Ella's birth father was "a protective factor". The Social Worker could have been encouraged to exercise greater professional curiosity about why Ella did not inform her birth father that she had gone to the neighbour with her mother if he was a protective factor.

5.2.98 The reasons for outcome in the Initial Assessment is recorded "the perpetrator has a past domestic abusive conviction which raises concern and makes me question whether he did assault Laura, rather than it be an accident". The reasons for no further action are provided as the school has no concerns, "she sees her father regularly throughout the week which is a protective factor and therefore there is no current role for social care, in future if domestic violence comes to our attention, the case may need to be escalated in order to ensure the children are not at risk of emotional or physical harm". The fact that the children were living with the perpetrator is not identified as a risk in the assessment. The contact with Ella's biological father is recorded as a protective factor for her. The children continued to live in a home where there has not been sufficient review of risk.

5.2.99 The Social Worker was aware that the perpetrator was considered a high-risk perpetrator to his former partner as he had a previous conviction for attacking her and her mother in front of her two young children. This should have raised her concern for the risk to Laura and the children in this family.

5.2.100 Laura was offered the domestic violence service but she did not have any one to one or bespoke support to reflect on what had happened to her and the impact of this on her and her children. It is essential that front line Social Workers assess domestic violence and its impact on victims and work with this as part of completing assessments.

5.2.101 The communication between agencies was appropriately minimal because of the journey of the child followed from referral to MASH episode completion of initial assessment and then closure. However, more work could have been carried out in engaging with the Health Visitor and the school for assessing whether there were latent domestic violence behaviours such as coercive control and indicators that may have supported the Social Worker to come to a different conclusion at the end of the initial assessment.

5.2.102 Ella had learnt to conceal domestic violence and to tell professionals what she was likely to have been told to say. She inadvertently tells the Social Worker that the perpetrator did in fact punch her mother and as her mother comes into the room she stops the discussion. It is essential that children's voices are heard, they are seen alone and if they disclose an incident they are seen again to follow up on the discussion that they held with their Social Worker. This was a missed opportunity as the Social Worker may have had more access to information about what was happening in the household in respect to domestic violence. Child A's lived experience is not sufficiently evidenced in the initial assessment.

5.2.103 The correlation between the DASH outcome and the decision made by Children's Social Care could have been better linked. For example, the outcome of the DASH was that the risk of domestic violence even in 2015 is medium to high. This may have warranted further work rather than the case being closed and could potentially have assessed the likelihood of significant harm. Social Workers should complete their own risk assessment and safety plan when completing a Single Assessment.

5.2.104 Although there is no formal risk assessment – the single assessment identified the following two risks:

(i) Domestic abuse and the impact of this on child development - risks surrounding emotional harm.

(ii) Laura's minimisation - concerns she may not feel able to be fully protective.

5.2.105 The initial assessment concluded that there was no previous involvement with Children's Social Care, the couple had been together for several years and the risk of abuse was mitigated by Laura seeking help next door as a protective measure. Ella had contact with her birth father and this was seen as a protective factor.

5.2.106 Professional Supervision took place in line with supervision policy once a month. However, there was insufficient challenge in supervision and reflective practice. They discussed Claire's Law, but it was not explored fully nor was a discussion held about how it connects with Laura, Ella and Child A.

5.2.107 **Evidence of Good Practice with Gloucestershire Children's Social Care**: When the initial referral was made into MASH, the MASH assessor appropriately progressed the referral for an initial assessment. This was based on information that was held in the system in respect of the perpetrator and his previous domestic abuse.

5.2.108 The decision making in the MASH was based on an accurate assessment of the risk posed to Laura and Ella by the perpetrator's violent behaviour. The records indicate that an assessment was required because "mum may not be reporting DV and there is a young baby in the household and the perpetrator appears to have a violent history".

5.2.109 The assessment was progressed and the Social Worker attended the family home to interview Laura and Ella and to gather information about the incident of domestic abuse.

5.2.110 The Social Worker appropriately probed Laura about the domestic violence and challenged the perpetrator about his violent behaviour. When referring to his violent behaviour towards his ex-partner, the perpetrator informed her that his previous partner's perspective about what happened was "farfetched and he has no reason to lie". Children's Social Care records indicate that the Social Worker remained concerned about the perpetrator's violent behaviour and progressed with the assessment.

5.2.111 The Social Worker assessed that Laura had acted protectively and appropriately, that Ella's birth father was a protective factor in supporting her, and that she had presented as a child who could talk to her birth father "if things were difficult".

5.2.112 Supervision took place in line with supervision policy and management oversight considered different approaches to supporting Laura, including the use of Claire's Law to gather information to protect Ella and Laura.

5.2.113 **Analysis for Education:**

5.2.114 Children that live with domestic abuse face increased risk for their physical safety as well as harm to their emotional well-being and all aspects of their life. The Adoption and Children Act (2004) states that witnessing the ill-treatment of another person constitutes significant harm, therefore causing enormous disruption and trauma.

5.2.115 For schools, gaining an insight into children's home/social circumstances depends on the information they receive via disclosures from children or adults; the presentation of children in school; and the behaviour of children. It also depends on identifying patterns over a period of time which is in turn dependent on keeping good records in line with the schools safeguarding policy. Teachers, Designated Safeguarding Leads and Head Teachers also have to make the judgement about what they are seeing and whether or not it meets the threshold for intervention through either early help or statutory children's social services.

5.2.116 In reviewing the actions of the three schools Ella attended it is important that events are considered as they were at the time rather than through the lens of hindsight. It is also important to see them in context; for example, all schools now record safeguarding and other behavioural incidents on CPOMs – an electronic recording system. This has greatly improved the retention and recoding of information. Recording at the time was through the filing of handwritten forms and associated notes.

5.2.117 Ella attended Infant, Junior and Secondary School. Each school operated a safeguarding policy in line with and based on the GSCB policy at the time. In the case of both the Infants and Junior School, a key element of the policy was to use a 'case of concern form' (CoC). The CoC would be initially filled in by a teacher who may be concerned about a pupil's behaviour or presentation, or have received information from a child /adult /parent. The CoC would be reviewed by either the designated safeguarding lead (DSL) and/or the Head Teacher who would determine whether the matter was a 'safeguarding' or a 'behavioural' issue. Safeguarding issues led to the establishment of an individual safeguarding file and behavioural issues into a class file with a chronology of records on the cover.

5.2.118 The School nursing service operated a school 'drop-in' service in 2011 and in March Laura and the perpetrator attended such a session as they were concerned that Ella was displaying 'difficult' behaviour. A plan was agreed, and school nursing decided that they would reassess should the Infant School identify further concerns. The Infant School had no cause to raise any further concerns. This was an appropriate action within the policy and practice in place at that time.

5.2.119 There are three CoCs concerning Ella. Two concern a period in May 2012 whilst at the infants' school, they are dated 22nd and 29th May 2012 and also refer to an incident on 28th May 2012. The issues were to do with Ella's behaviour both at home and in school. The school responded by working with Laura via the Child and Family Worker based in the school. Some of the required action coincided with the birth of Child A and this meant that a meeting with Laura was cancelled. The Infant School acted within its policy framework and the matter was deemed 'behavioural' and filed appropriately.

5.2.120 The third CoC was in December 2016 whilst Ella was at the Junior school. This concerned disclosure from another pupil who knew Ella that she had sent her some 'worrying texts'. The school acted appropriately and discussed this with Ella, Laura and the other pupil's mother. It was established that Ella was struggling to come to terms with the death of her

uncle and this was impacting on her mood which was reflected in some of the texts. Laura was encouraged to seek support for Ella via her GP and that was appropriate. The CoC form was filed as a 'behavioural issue' in line with the school's policy.

5.2.121 In between these CoC recorded incidents phone contact was made with the Junior School by the Social Worker conducting the Initial Assessment following the events of Boxing Day 2014 detailed elsewhere in this report. Records held by Children's Social Care do not record whether or not the Social Worker revealed to the Designated Safeguarding Lead the events that had led to the initial assessment but accurately records that the school had no safeguarding concerns. Given no safeguarding file was ever opened for Ella it must be assumed that this was the case and without the contextual knowledge the response of the school was correct. Social care records also record that a closure letter and Initial Assessment was sent to the school but there is no record of the school having received it. There is no doubt that under the school's policy at the time information regarding this incident whether given in the phone conversation, or via the closure letter and Initial Assessment, would have resulted in a safeguarding file being created. With the benefit of this additional information the response to any future events, including the transfer of safeguarding information when Ella moved to Secondary School, would have been different.

5.2.122 Whilst at Secondary School there were again some behavioural issues as detailed elsewhere in this report. In the absence of there being any safeguarding concerns known and /or recorded, the actions of the school were in line with their policy and practice.

5.2.123 There was also a disclosure made in May 2018 by Child A to the infants' school in relation to witnessing the perpetrator smash the door with his hand during an argument. The school recorded this on a CoC as a safeguarding disclosure and it was considered by the Designated Safeguarding Lead. The Designated Safeguarding Lead recalls following up with Child A who gave the same account, presented normally, was 'jolly' and 'happy', and said words to the effect that 'everything is okay/better now'. In the absence of any other information on this family which gave concern and no other paperwork or previous concerns from any stakeholders, a decision was made, by the Designated Safeguarding Lead and the class teacher, to 'monitor'. This was in line with the school's safeguarding policy where the school would make one of three decisions on disclosures: to discard; monitor; or, refer. The school decided that this incident, on its own, would not meet the threshold for a referral to the MASH. Without any other information, it is unlikely that this

incident, should it have been referred to the MASH, would have met the threshold for multi-agency investigation, assessment or action.[19]

5.2.124 Laura's family spoke at length about the relationship between Laura and the schools. They felt that Laura may not have viewed the school as a safe space in order to make a disclosure in relation to the domestic abuse and difficulties she was experiencing at home. The felt that this was largely stemming from the dispute with the school due to a fine being issued for unauthorised absence following a family holiday. They felt that this could in turn have hindered the school's response in relation to safeguarding concerns not being shared due to the school potentially further corroding the rapport between Laura and the schools.

5.2.125 Given that the schools were unaware of the events of Boxing day 2014, they did not consider Ella's behaviour to be a safeguarding issue. Whilst each incident was taken seriously and appropriate action involving the parents and other services, they were spread over a period of time and in the absence of any other disclosure or information were seen as the sort of behaviours some children display whilst going through school. The critical observation is that the initial assessment in 2015, if it had been shared, would have alerted the schools to the fact that Ella's behaviour may have its roots in what would have been deemed safeguarding issues. It is noted that Operation Encompass[20] now has a helpline for teachers which can be consulted when concerns arise.

5.2.126 Whilst it is recognised that there will often be an adjustment following a new step-parent figure this should also be considered in light of the fact that there is an increased risk posed to children from non-biological parents such as step-parents[21]. Safeguarding training does include such information, but we must not underestimate how hard it is for schools to make the link between school behaviour and home circumstances when as in

[19] The Home Office Quality Assurance panel asked for further exploration regarding this disclosure. The school provided additional commentary and the Chair was satisfied that the Panel sufficiently explored this and notes that correct procedure was followed, and in light of previous incident information not being known, this was a proportionate response. The school confirmed they have initiated a higher level of domestic abuse training which has been built into their safeguarding training. They also agree, and are committed to the need for increased information sharing and good communication between police, social services and schools. They note that the high level incidents that occurred previously should have been shared with the school to ensure we are informed and therefore empowered to be extra vigilant in monitoring the child's wellbeing and acting in line with our duty of care.

[20] Operation Encompass directly connects the police with schools to ensure support for children living with domestic abuse in their homes when there has been a police attended incident of Domestic Abuse. For more information: https://www.operationencompass.org/

[21] https://www.psychologytoday.com/gb/conditions/child-abuse

this case the parent/step-parent do appear to be acting in the interests of the child and engaging with the school and other services.

5.2.127 Finally, it is worth stating that in all records where Ella is asked about her experience of school she talks positively about being happy in school and how she enjoys her favourite subjects.

5.2.128 **Police Analysis**

5.2.129 Gloucestershire Constabulary was subject to a targeted domestic abuse HMIC Inspection in 2013 which was critical of the force's response. In June 2014 the force was re-inspected and inspectors 'commended the force on the strong progress made to date' in respect of 13 recommendations that had been made by the 2013 Inspection. These 13 recommendations are available via the HMIC report 'Gloucestershire Constabulary's approach to tackling domestic abuse'[22].

5.2.130 In assessing Police involvement it is also important to place in context the age of some of these incidents which stretch back over many years. The policing response to domestic abuse and multiagency practice in Gloucestershire have changed significantly over that time, not least with the inception of the MASH in April 2014 and subsequently the instigation of the daily domestic abuse meeting in February 2016.

5.2.131 **The 2010 incident between the perpetrator and his former partner and her mother:** The Police response to this case was effective. The suspect was quickly arrested and later prosecuted for the offences committed against the perpetrator's former partner and her mother. A DV1 was submitted (the appropriate paperwork for this type of incident). It is not recorded if the perpetrator's former partner was offered specialist Domestic Violence/Abuse support services. This conviction is important as it meant the perpetrator had a relevant conviction for domestic assault held on file.

5.2.132 **DVDS/Claire's Law**: DVDS is of interest to the family of Laura and Ella as they would like to have known of the perpetrator's previous conviction themselves and also to be reassured that Laura was told. The DVDS was rolled out to Police Forces in March of 2014. Although this is referenced on the MASH enquiry it does not appear that Police completed a formal disclosure to Laura in reference to the perpetrator's previous, relevant

[22]https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/gloucestershire-approach-to-tackling-domestic-abuse-revisit.pdf

conduct. It is likely that the force's use of DVDS was in its infancy. Gloucestershire Constabulary now have a mature and robust system for DVDS which has recently been commented upon by the Home Office and HMICFRS as national best practice. However, as noted in this report, the previous conviction of the perpetrator was discussed with Laura by Children's Social Care during their assessment in early 2015. Additionality, it is worth noting that in Gloucester DVDS disclosures can only be made directly to the person in the relationship.

5.2.133 **The 2014 Boxing Day incident**: This incident is significant in that it is the only known precursor crime committed by the perpetrator against either Laura or Ella prior to their murder in 2018. The initial Police response was effective and swift with the incident being graded as immediate response and officers arriving at the scene within minutes. This incident was however viewed as a missed opportunity to hear the voice of the child.

5.2.134 The perpetrator was quickly arrested and removed. Statements were taken from the neighbours to whom Laura had fled. Photographs were taken of Laura's injuries and she was spoken to away from the suspect. Laura disclosed an assault but did not wish to support Police action.

5.2.135 At around midday the following day, officers from the Domestic Abuse Safeguarding Team interviewed the perpetrator. He denied the offence and stated that Laura had been 'drunk' and the injuries she had sustained were as a result of her 'drunken behaviour'. There were missed opportunities at this stage to link in with other agencies involved at the time who could have provided additional information to support a victimless prosecution, for example, the information known to the hospital in relation to the disclosure of Laura being punched in the face. A Domestic Violence Protection Notice (DVPN) was considered but not deemed appropriate in the circumstances. The perpetrator was released without charge. Laura's family felt that the use of a DVPN may have been a useful intervention at this stage.

5.2.136 Laura was offered a referral to GDASS but she stated that she did not wish to contact the service. A DASH RIC form was completed and re-graded from standard to medium risk following reconsideration by the Domestic Abuse Safeguarding Team after revisiting the victim. This would not meet the threshold for consideration by MARAC which considers only high-risk cases.

5.2.137 The initial sharing of information about the Boxing Day incident was 4 days after the incident and a formal request for information sharing was made 2-3 days later.

5.2.138 **Evidence led prosecution**: This case was not considered for a Crown Prosecution Service (CPS) decision by Police despite a good evidential picture being available to officers. In particular, the accounts provided by witnesses, the injury photographs taken from Laura, the comments made by Ella and others at the scene, the perpetrator's bad character and the initial account provided by Laura which confirmed the assault had occurred. This decision was made by the custody sergeant in consultation with the officers who were dealing with the case. Those officers were domestic abuse specialists. While this complied with force policy at the time and was a subjective decision, it is clear that there may have been evidence to proceed with a prosecution. Laura's family noted that there was additional evidence that could have been gathered at this stage from other professionals in order to support a victimless prosecution using information from other agencies.

5.2.139 No attempt was made to secure evidence from Ella which may have further supported the case. Listening to the voice of any children involved is an important action. The Constabulary has invested significant training into this area since 2017 under the banner of Op Guardian.

5.2.140 Nationally and locally CPS are now more supportive of evidence led prosecutions and one of the key tools to facilitating such outcomes is body-worn video which would have significantly assisted this case.

5.2.141 Police made a decision at the scene to place Child A and Ella for the night in temporary accommodation with the perpetrator's mother. The decision making by the Police was not recorded and the Chair and panel acknowledge that the intention of the attending officers was to ensure the children were safe and were able to go to the home of a family member as soon as possible. The fact that Child A and Ella went to the home of the perpetrator's mother is of huge consequence to the family of Laura and Ella. The family assert that were members of Laura's family who arrived at the scene and offered to take Ella and the other children home with them. Instead, they were placed in the care of the perpetrator's mother. The family strongly believe this was a key reason why Ella did not speak to her father or others about this incident. They feel she was encouraged not to speak about it as Ella disclosed this to the family in 2017 when the perpetrator's affair come out. The family was able to communicate their views on the handling of this situation directly to the review panel when they attended the panel meeting. While it is acknowledged that full understanding of family ties and context is challenging for Police in the middle of an arrest

of this nature, the decision of where the children should be placed temporarily should be considered in light of safeguarding policies and their ties to family members and their potential to be a witness.

5.2.142 The decision to interview a child as a witness to a criminal offence requires an exploration of a multitude of factors so cannot be restricted to a simple age threshold. Some children will naturally be more confident and capable at a younger age and much will also depend upon the circumstances of the case. There are a number of guidance documents that set out for officers what should be considered and how an interview should be planned and approached. Invariably the main issues that are considered are the competence of the witness, the severity of the offence, the nature and weight of the evidence that the witness is believed to possess, the potential impact on the child witness of firstly the interview and then secondly the court process. In this case, Child A was very young and was not believed to have witnessed the incident. Ella was not interviewed although she may have witnessed the incident, she certainly witnessed the immediate period after the assault. In 2014, evidence led prosecutions were not commonplace in Gloucestershire and once Laura declined to support a prosecution, this was not pursued. It is likely that parental consent would have been required for an interview with Ella. Given the perspective of Ella now known from her family during this review, this example should be considered by Gloucester Constabulary in how to carefully weigh up considerations related to interviewing children in relation to domestic abuse incidents. The author acknowledges that the decision to interview is subjective and dependent on the circumstances of each case. This would include if there is sufficient evidence for evidence led prosecution that would not depend on the child's account. And sadly, we will never know for certain if Ella witnessed this particular incident.

5.2.143 The DASH was considered by the MASH and on the 2nd of January 2015, a MASH enquiry was completed that involved Children's Social Care, Police and GDASS sharing information. The outcome of that enquiry was recorded as follows: "*This incident is not high in its own right however the perpetrator has been previously high risk. Positive Police action has been taken although due to no complaint no additional action has been taken. This is also going into the MASH from Social Care and I will discuss consideration of DVDS with them before they carry out any visit."*

5.2.144 The perpetrator was a serial perpetrator and Gloucestershire Constabulary do not have an offender management process in place to specifically address serial perpetrators of

domestic abuse. Gloucestershire Constabulary should consider the emerging practice from MATAC (Multi-Agency Tasking And Coordination) and DRIVE and the Secondary School of Policing practice guidance on their next steps in improving practice in relation to serial perpetrators. Gloucestershire Constabulary visited Northumbria Constabulary in September 2018 to look at MATAC. This works on a Recency, Frequency, Gravity (RFG) matrix[23]. Gloucestershire Constabulary note that it is unlikely that the perpetrator would have scored highly enough to warrant intervention prior to 2014 and may not have done so after that date, however, this is in hindsight and cannot be confirmed. The Constabulary continues to assess the best way forward in this area for something that makes a meaningful difference and is sustainable.

5.2.145 Gloucestershire Domestic Abuse and Sexual Violence Coordinator has produced guidance documents that aim to build a coordinated approach to Domestic Abuse & Sexual Violence (DASV) across all organisations, ensuring all professionals are confident and competent in their response to DASV. The documents provide support on creating DASV policies, dealing with disclosures of DASV and understanding what DASV is and how it may present. Employers should be able to offer a proactive and supportive response which leads to improved outcomes for adults and children affected by DASV.

5.2.146 The guidance documents come with a training standards pathway that maps out the level of awareness or training of DASV we would recommend staff are accessing depending on their role in an organisation.

5.3 Equality and Diversity:

5.3.1 The Chair of the Review and the Review Panel considered all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

5.3.2 Throughout discussions with the review panel and Laura's family, Laura did not appear to have suffered any negative consequences due to her age, race, marital status, beliefs or sexual orientation. She was grounded in her home community and with family support

[23] https://middlesbrough.gov.uk/sites/default/files/One-Minute-Guide-10-MATAC.pdf

and appears to have successfully avoided services that she did not wish them to be involved with her or her children.

5.3.3 Age is a key consideration. Ella was a child but old enough to have a clear understanding of her experiences at home, but she was overlooked by Children's Social Care and the Police to speak to alone and to fully understand her circumstance. Likewise, the schools seemed to take on the views given to them by others, including Laura and the perpetrator, rather than considering her circumstances as a whole. The impact of the perpetrator on her life is clear in the chronology sections where her behavioural issues in school begin at the same time as he moves in with the family.

5.3.4 Ella's status as a stepchild is overlooked as is the potential for increased harm to her as a stepchild from a convicted perpetrator of domestic abuse. Her status as the perpetrator's stepchild is overlooked by the Police on the night of the Boxing Day incident in 2014 when she is sent home with the perpetrator's parents instead of Laura's family.

5.3.5 Sex should always require special consideration. Analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[24] This characteristic is therefore relevant for this case, the victims of these homicides were female and perpetrator of the homicide was male.

5.3.6 The perpetrator's epilepsy and engagement with services were identified throughout the report and demonstrate a proactive and supportive response to his condition. The perpetrator's diagnosis, treatment and management in relation to his epilepsy were in line with NICE guidance[25].

[24] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole Standing Together DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

[25] https://www.nice.org.uk/guidance/cg137

6. Conclusions and Lessons to be Learnt

6.1.1 The role of the family and friends of survivors who require support to understand and safely address domestic abuse as they are often the first and sometimes only source of support for survivors of domestic abuse.

6.1.2 The consideration of the voice of the child victim requires more prominence in safeguarding analysis and decision making, specifically with officers and Social Workers seeking to understand whether the wider family would seek to suppress disclosures or influence child witnesses. It is positive to note that at the point of writing the new Domestic Abuse Bill due to be passed in 2020 will note children as victims in their own right within the statutory definition of domestic abuse. Locally, this has already become a feature of awareness and training amongst staff.

6.1.3 The importance of considering the impact of the introduction of a step-parent and his/her background into a child's life.

6.1.4 The importance for GPs, or any health professional, to know who has parental responsibility for a child, as well as the other adults who play a key role in that child's life e.g. step-parents. It is good practice to always ask, clarify and document who the adult is accompanying a child to appointments or who is ringing the practice about a child.

6.1.5 The need for all services to ensure they have adequate policy, training and record-keeping procedures to adequately address domestic abuse. And for these services to ensure they benchmark themselves to the best practice or national guidance in these areas.

6.1.6 The ability for all front line professionals to confidently speak to survivors of domestic abuse about their situation despite any denial or minimisation and to understand where these barriers come from and to address domestic abuse beyond basic inquiry.

6.1.7 For strategic boards for domestic abuse, safeguarding and health and wellbeing to work together to adequately resource and support multi-agency and best practice in relation to domestic abuse.

7. Recommendations

The recommendations below should be acted on through the development of an action plan, with progress reported on to the Area Community Safety Partnership within six months of the review being approved by the partnership.

7.1 Overview Report Recommendations:

7.1.1 **Recommendation 1:** All agencies to ensure Domestic Abuse training for their staff includes in depth detail about economic abuse, and District Councils to ensure DA training is available to all staff in debt advice services locally.

7.1.2 **Recommendation 2:** Gloucester City Community Safety Partnership and Safer Gloucestershire to ensure stronger links between the SG executive, the countywide CSP/ delivery board for domestic abuse, and the health and wellbeing board.

7.1.3 **Recommendation 3:** Gloucester City Community Safety Partnership and Gloucestershire Safeguarding Children's Partnership Executive (GSCP) to ensure that the mapping identified through the National Panels countrywide data which found that domestic abuse is present in 41% of all child fatalities and 42% of all serious safeguarding incidents nationally is applied countywide for wider understanding and learning of the implications of domestic abuse in front line safeguarding services.

7.1.4 **Recommendation 4:** Health professionals to seek to know who has parental responsibility for a child, as well as other adults who play a key role in that child's life e.g. stepparents. Agencies should always ask, clarify, and document who the adult is accompanying a child to appointments or who is ringing the practice about a child. Details of the child's birth parent should be recorded and the status of the child's relationship with that parent should also seek to be recorded.

7.1.5 **Recommendation 5**: For all agencies to ensure the learning from the homicide timeline work is built into all DA training, and for Safer Gloucestershire to explore the best dissemination of Jane Monckton Smith's formal training.

7.2 Progress on Overview Recommendations at the point of conclusion of the DHR

7.2.1 **Recommendation 1:** Across Gloucestershire, work is already underway to improve links between the key strategic boards, Safer Gloucestershire, Health and Wellbeing Board and Children's safeguarding executive. These boards all share DA as a strategic

priority and now ensure some shared key membership, regular reports across boards and also recently held a joint development session to agree approaches to shared priorities and the differing perspective and roles each board takes. This work is ongoing and development days are planned to become a regular occurrence to ensure a robust strategic response to shared priorities such as DA.

7.2.2 **Recommendation 2:** Recent work undertaken by the Children's Safeguarding Executive Business Unit has highlighted that DA is present in 65% of 293 child protection cases in the county. This has now been shared across the key strategic boards (Safer Gloucestershire, Health and Wellbeing Board and Children's safeguarding executive) and work is now underway to develop initiatives to address this. Work already in development includes, roll out of face to face training, e-learning, workshops and practitioners briefings to increase awareness of DA and how to appropriately identify and response. Much of this training is being linked across the South West. Increased resources for DA in the MASH are also being explored.

7.2.3 **Recommendation 3:** Recent work undertaken by the Children's Safeguarding Partnership Business Unit has highlighted the National Panels data that DA is present in 42% of all Serious Safeguarding incidents Nationally and 41% of all child fatalities nationally. This has now been shared across the key strategic boards (Safer Gloucestershire, Health and Wellbeing Board and Children's safeguarding Partnership) and work is now underway to develop initiatives to address this

7.2.4 **Recommendation 4:** The GHFNHST recording system within the Acute Trust now has embedded the process whereby the mother is consistently added as next of kin to every baby born in Gloucestershire since December 2016. When audited in November 2020, this process was shown to be effective: all the under 5s had mum on their records as next-of-kin. As a high priority, GHT are working with project leads for the Trust IT systems set up so that staff can ask and record who any patient comes to hospital with, capturing both their name and role in the patient's life. The Gloucestershire Health and Care NHS Foundation Trust (GHC) Safeguarding Team are working with its Quality Improvement Team to develop a solution to make it easier for staff across the Trust to record who is in the childs household and family/personal network. This includes documentation of who has parental responsibility.

7.2.5 **Recommendation 5:** Homicide timeline included in training delivery to new police recruits and the training delivered by the Safeguarding Children's Partnership. The new

DA strategy for the county prioritises training for all agencies and there will be a focus on investment in Lot 5 of the commissioning framework for fund a multi-agency DA training pathway

7.3 Individual Management Review Recommendations:

Gloucester Clinical Commissioning Group

7.3.1 **Recommendation 1:** Primary Care should always discuss concerns about suspected or known issues of domestic abuse amongst the Multi-Disciplinary Team to ensure awareness of cases, and the opportunity to join up discussions or concerns about all children and household members, and their fathers and partners. Primary Care information will benefit from improved MARAC liaison (knowledge of domestic abuse incidents and contribution to MARAC research). All discussions should be noted within records.

7.3.2 **Recommendation 2:** There must be continued, consistent and strengthened links between the work of GDASS and Primary Care in order to maintain awareness of domestic abuse issues and the impact that this has on victims and children. This should include consideration of continued service provision for the GDASS pilot beyond March 2020.

7.3.3 **Recommendation 3:** Where there are out of hours' attendances to unscheduled care settings (both for adults and children) GP Practices should have a clearly identified process in place that supports recognition for potential follow up to significant illness or injury. Specifically, the role of hospital paediatric liaison needs to be further clarified in relation to effectiveness and how this currently links with Primary Care.

7.3.4 **Recommendation 4:** Practice and learning from IRIS should be considered by the CCG as domestic abuse practice is developed for primary care settings.

Gloucestershire Care Services NHS Trust

7.3.5 **Recommendation 1:** To review the GCS Domestic Abuse Policy as the current focus is for staff to know what to do in the event of a disclosure. More guidance is required within this policy about the indicators of potential domestic abuse to enable effective signposting to specialist services.

7.3.6 **Recommendation 2:** GCS domestic abuse training needs to encompass all the indicators of domestic abuse which may be evident prior to a disclosure. This training

model is for a continuous rolling programme available to all GCS staff, within both adult and children services.

7.3.7 **Recommendation 3:** Where there is a known history of domestic abuse within a relationship, GCS practitioners take every opportunity to explore this with the victim when safe to do so and demonstrate consistent professional curiosity. This should be reinforced within the domestic abuse training, group safeguarding children supervision, GCS Domestic Abuse Policy and all GCS staff forums.

Gloucestershire Hospitals NHS Foundation Trust

7.3.8 **Recommendation 1:** Staff need to retain professional curiosity at all times and to ensure continued training is in place for Trust staff.

7.3.9 **Recommendation 2:** For the Trust to consider the tools and findings from DOHSC funded Pathfinder sites to ensure that they are maintaining and further developing best practice in relation to domestic abuse.

Gloucester Education Services

7.3.10 **Recommendation 1:** All schools in Gloucestershire to reassure themselves through refreshers or by implementing mechanisms that their staff understand domestic abuse and the context of professional curiosity in the wider family context.

7.3.11 **Recommendation 2:** All schools to agree a system with Children's Social Care whereby receipt of key safeguarding information is recorded so that there is no doubt on whether that information has been received and acted upon.

7.3.12 **Recommendation 3:** That the learning from this review be incorporated into school safeguarding training to enable the difficult issue of the threshold between 'behavioural' and 'safeguarding issues' to be constantly reviewed by schools in the light of the evidence of this and other SCRs.

Gloucestershire County Council Children's Social Care

7.3.13 **Recommendation 1:** All GSCB domestic abuse training should help Social Workers to develop skills to engage children who may conceal domestic violence.

7.3.14 **Recommendation 2:** Social Workers to have updated training on patterns of domestic violence to better understand how Laura and her children were impacted upon by the abuse and what actions they would take as a result of the training.

7.3.15 **Recommendation 3:** To explore and challenge what has happened and why. For example, the school and Health Visitor were involved but the sharing of information about the children could have improved. A Multi Agency GSCB briefing on the outcome of this IMR to all partners and MASH.

7.3.16 **Recommendation 4:** The assessment of Parenting Capacity in Social Worker Single Assessments to be strengthened to include evidence based strengths, risks and vulnerabilities to children.

7.3.17 **Recommendation 5:** All Social workers, their managers and leaders to have workshop, team discussions (facilitated by practice learning team) on ACE's wellbeing of parents and what resources are available for work with parents.

7.3.18 **Recommendation 6:** All Social Workers and their managers to attend a workshop or training on perpetrators of domestic abuse (with use of restorative practice methods) to ensure appropriate responses to perpetrators and awareness of current service provision.

7.3.19 **Recommendation 7:** All Social Workers and their managers to attend a workshop or training to include interviewing techniques to ensure the child's voice is heard and identify the wide range of indicators of domestic violence and coercive control. Programme to be started immediately and outcomes reported to Gloucestershire Safeguarding Delivery Board.

<u>Gloucestershire Constabulary</u>

7.3.20 **Recommendation 1:** Gloucestershire Constabulary should maximise the use of Body Worn Video in situations of suspected Domestic Abuse.

7.3.21 **Recommendation 2:** Gloucestershire Constabulary, in conjunction with the Crown Prosecution Service, should continue to recognise and progress evidence led prosecutions.

7.3.22 **Recommendation 3:** Gloucestershire Constabulary should ensure that officers at Domestic Abuse incidents recognise the evidence that can be provided by children and, where appropriate, seek to secure and preserve that evidence.

Appendix 1: Domestic Homicide Review Terms of Reference

Domestic Homicide Review/ Serious Case Review Terms of Reference: Case of Laura and Ella

This Domestic Homicide Review/ Serious Case Review is being completed to consider agency involvement with Laura, Ella and the perpetrator following the death of Laura, Ella in May 2018. The Domestic Homicide Review/ Serious Case Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR/ SCR

1. To review the involvement of each individual agency, statutory and non-statutory, with Laura, Ella and the perpetrator during the relevant period of time Ella's birth in 2006 to the date of the homicide. To summarise agency involvement prior to Ella's birth.
2. 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.
3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Definitions: Domestic Violence and Coercive Control

8. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross government definition states that domestic violence and abuse is:

> "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
>
> Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
>
> Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
>
> This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

9. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Laura, Ella and the perpetrator (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child).
10. The Review Panel identified the following protected characteristics of Laura, Ella and of the perpetrator as requiring specific consideration for this case; age of Ella and the sex of Laura.
11. Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014.
12. If Laura, Ella and the perpetrator have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR/ SCR can improve the engagement with those communities.
13. The Review Panel will not reflect on immigration status as it is not deemed an issue.
14. The Review Panel agrees it is important to have an intersectional framework to review Laura, Ella and the perpetrator life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Key Lines of Inquiry

15. In order to critically analyse the incident and the agencies' responses to Laura, Ella and/or the perpetrator, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Laura/ Ella / the perpetrator [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

16. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Gloucester City Safer Partnership on their action plans within six months of the Review being completed.
17. Gloucester City Safer Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Appendix 2: Action Plan

DHR/SCR LAURA AND ELLA- ACTION PLAN							
Recommendation	**Scope**	**Action to take**	**Lead Agency**	**Key milestones in enacting the recommendation**	**Target Date**	**Date of Completion and Outcome**	**RAG**
Gloucestershire Multi-Agency Recommendations							
All agencies to ensure Domestic Abuse training for their staff includes in depth detail about economic abuse and District Councils to ensure DA training is available to all staff in debt advice services locally.	Local	-Review of current DA training and ensure economic abuse is covered clearly. -Training rolled out to all key staff -debt services to receive specific training	Safer Gloucestershire and Gloucester City Council	-Training reviewed and implemented. -plans for training roll out developed -training delivered to key staff as per training plan Item to be taken to the GSCP Districts Subgroup 2022 to review a collective response to understanding of Economic Abuse and Domestic Abuse. and evidence of cascade of Briefing supplied by DASV strategic Coordinator.	April 2021 and ongoing	Economic abuse has been a key feature in the county comms plan for 2020/21 as well as information circulation to professionals. Plans around training are ongoing. The new DA strategy for the county prioritises training for all agencies and there will be a focus on investment in Lot 5 of the commissioning framework for fund a multi-agency DA training pathway. **Outcome:** to ensure that all relevant professionals are able to effectively identify and respond to economic abuse and offer support at an early stage.	
Gloucester City Community Safety Partnership and Safer Gloucestershire to ensure stronger links between the SG executive, the countywide CSP/ delivery board for domestic abuse, and	Local	-Develop clear shared priority and strategic leadership. -Run development sessions between boards. -Shared board membership and reporting to ensure connections are	Safer Gloucestershire	-Clear processes in place for boards linking and working together. -Clear roles and responsibilities to tackling share priority outlined.	Ongoing	Ongoing: Across Gloucestershire, work is already underway to improve links between the key strategic boards, Safer Gloucestershire, Health and Wellbeing Board and Children's safeguarding executive. These boards all share DA as a strategic priority and now ensure some	

the health and wellbeing board.		maintained.				shared key membership, regular reports across boards and also recently held a joint development session to agree approaches to shared priorities and the differing perspective and roles each board takes. This work is ongoing and development days are planned to become a regular occurrence to ensure a robust strategic response to shared priorities such as DA. The new countywide DA strategy will be owned collectively by these partnership boards.	
Gloucester City Community Safety Partnership and Gloucestershire Safeguarding Children's Partnership Executive (GSCP) to ensure that the mapping identified through the National Panels countrywide data which found that domestic abuse is present in 41% of all child fatalities and 42% of all serious safeguarding incidents nationally is applied countywide for wider understanding and	Local	-Raise awareness of mapping -promote learning -include into training plans	Safer Gloucestershire (alongside Gloucester City CSP) and the GSCP	-Circulation of key learning -Training rolled out with key learning incorporated.	April 2021 and ongoing	Recent work undertaken by the Children's Safeguarding Partnership Business Unit has highlighted the National Panels data that DA is present in 42% of all Serious Safeguarding incidents Nationally and 41% of all child fatalities nationally. This has now been shared across the key strategic boards (Safer Gloucestershire, Health and Wellbeing Board and Children's safeguarding Partnership) and work is now underway to develop initiatives to address this. Work already in development includes, roll out of training, e-learning, workshops and practitioners	

learning of the implications of domestic abuse in front line safeguarding services.						briefings to increase awareness of DA and how to appropriately identify and response. Much of this training is being linked across the South West. Increased resources for DA in the MASH are also being explored. Data relating to DA and the impact n the lived experience of children forms a section of the GSCP's data reporting schedule to ensure the partnership is proactively looking at DA and the impact on children	
For all agencies to ensure the learning from the homicide timeline work is built into all DA training, and for Safer Gloucestershire to explore the best dissemination of Jane Monckton Smith's formal training.	Local	-DASV coordinator to circulate necessary information with the request that agencies include this in their training. -Safer Gloucestershire to request updates from agencies as to their training plans and how this work is embedded. -Safer Gloucestershire to discuss options for disseminating any formal training and agree approach.	Safer Gloucestershire		September 2021	Information circulated by DASV strategic Coordinator. Homicide timeline included in training delivery to new police recruits and the training delivered by the Safeguarding Children's Partnership. The new DA strategy for the county prioritises training for all agencies and there will be a focus on investment in Lot 5 of the commissioning framework for fund a multi-agency DA training pathway. Discussions ongoing in relation to the future of Safer Gloucestershire in light of its postponement during the pandemic and PCC elections.	

						Outcome: Homicide Timeline work is included in training to support understanding of DA	
Individual Agency Recommendations							
Gloucestershire Constabulary							
Gloucestershire Constabulary should maximise the use of Body Worn Video in situations of suspected Domestic Abuse.	Local	Since commencement of DHR BWV has been taken into standard use in force. -Ensure compliance with procedural guidance on use. -Review sufficiency of training, procedures and operational knowledge. Ensure all officers are utilising product where possible dealing with perpetrators. Ensuring use of BWV in securing DVPN/O's and other protective orders. Use of BWV footage in training.	Gloucestershire Constabulary	BWV has now been comprehensively rolled out by the force. Focus is on reviewing practice, identifying the operational reality and if necessary providing further training/instruction or guidance on best practice.	April 2021	BWV has now been comprehensively rolled out by the force with full training and guidance in place. **Outcome:** BWV is in consistent use.	
Gloucestershire Constabulary, in conjunction with the Crown Prosecution Service, should continue to recognise	Local	-Procedural guidance for DA has been amended in support of this recommendation.	Gloucestershire Constabulary	-As per column three. Data specifically for EL prosecutions is needed, there may be limitations on this due to data availability. Tracking of	April 2021 and ongoing	-Procedural guidance developed alongside specific ELP guide. ELP and taking positive action a key feature in all DA training	

and progress evidence led prosecutions.		-This is now part of standard training for new recruits. -DA Best Practice Framework offers a system for CPS and Police to monitor referrals and scrutinise on a quarterly basis. -CPS dip sampled DA cases in 2019 to ascertain if threshold was pitched at correct level for referrals. -Ongoing monitoring of data required. -DA refresher training.		proportion of cases and intervention where necessary. Dip sampling to ensure compliance.		delivered to new recruits, with practicals also required as part of the training. CPS and police dip sampling ongoing to monitor cases NFA for opportunities to learn re: ELP. **Outcome:** Increased use of ELP	
Gloucestershire Constabulary should ensure that officers at Domestic Abuse incidents recognise the evidence that can be provided by children and, where appropriate, seek to secure and preserve that evidence.	Local	-Since the incident that generated this recommendation the force has enacted Op Guardian. This was in response to a HMIC CP Inspection in 2017. This contained training and awareness material for officers. -To be incorporated in training for new recruits and	Gloucestershire Constabulary	-Incorporation in relevant training plans. -Awareness raising via a communications plan. -Dip sampling of cases to ascertain compliance.	June 2021 and ongoing	Op Guardian enacted with communications across the force raising awareness of the 'voice of the child' and the requirements of officers, including frontline responders and investigators. Importance of 'voice of child' included in training to new recruits and ABE training. **Outcome:** **1.** The constabulary needs to have a consistent	

		refresher training. -To be incorporated in ABE training. -To be briefed to frontline responders and investigators. -To ensure the specialist DAST officers advocate this approach where appropriate.				programme of ABE training available for appropriate constabulary roles and consideration for appropriate Social Workers **2.** The Voice of the child should be present in VIST	
Children's Social Care							
GSCP domestic violence training to be attended to include direct work, communication and engagement skills with children who may conceal domestic violence. (ED did not want to discuss domestic violence with the Social Worker and so social workers need to be equipped to address this especially when children feel pressure from parents about sharing information about domestic violence and/or abuse in relationships and the family home.	Regional	This element of training to be incorporated in the domestic violence training provided by safeguarding boards and executives	GSCP in Gloucestershire and other safeguarding boards or executives in the South West Region	Yes there has been progress made within the GSCP to enact this action in the domestic violence work carried out by the practice manager	December 2021.	This has now been included in the on line child protection interagency agency training by GSCP and the new virtual DA Training package will address the possibility of unrecognised and unreported DA. This virtual package will be available in 2022. In the Social Work Academy the Essentials 3.0 Critical Learning Module is aimed specifically at Social Workers and designed to be a gateway into the multi-agency training. It focuses specifically on types of Domestic Abuse, impact, likelihood and evidence based intervention with a specific focus on the child. Following content moderation the module has been shared and cross referenced with GSCP	

						Multi Agency Training. **Outcome:** Social Workers feel confident and competent in dealing with Domestic Abuse as evidenced through supervision.	
Social Workers to have updated training on patterns of domestic Abuse to better understand how LB was impacted upon by the violence and what actions they would take as a result of the training	Regional	This element of training to be incorporated in the domestic violence training provided by safeguarding boards and executives.	GSCP in Gloucestershire and other safeguarding boards or executives in the South West Region	Yes there has been progress made within the GSCP to enact this action in the domestic violence work carried out by the GSCP Practice Development Manager	December 2021.	This is now included in the on line multi agency training provided by the GSCP. The pilot Child Protection Interagency course started in September 2020 with a complimentary Domestic abuse eLearning course. Attendance on Virtual and eLearning has increased from 4000 enrolments to 12,000 individual enrolments across the virtual curriculum showing an increase in multi-agency training through 2020 and into 2021 **Outcome:** 1. Social Workers feel confident and competent in dealing with Domestic Abuse as evidenced through supervision. 2. This case is included as a case study within training.	
The assessment of Parenting Capacity in Social Worker Single Assessments to be	Local and regional	Training on Essentials in Gloucestershire to include professional	Gloucestershire Children's Social Work Academy	To incorporate in Essentials 2.0 Programme	December 2021	This has been included in Practice Standards and Essentials 2.0 Programme and is reviewed annually by	

strengthened to include evidence-based strengths, risks and vulnerabilities to children.		curiosity in completing parenting assessments.				the Social Work Academy as part of its annual review. Essentials 2.0 Programme modules support professional curiosity (using the Anchor Principles etc.) Following mandatory completion of these modules staff can access the Essentials 3.0 Programme including a 'Critical Learning' module about the ability to change. **Outcome:** Supervision sessions to include support and challenge on parenting capacity in single assessments.	
All Social workers, their managers and leaders to attend workshops, facilitated discussions and team meetings (facilitated by the Academy or managers) on ACE's perspective on the wellbeing of parents and what resources are available for work with parents.	Local.	Incorporate ACE's in work of Academy and working with parents.	Gloucestershire Children's social care	Yes there has been progress made within the Gloucestershire Safeguarding Children Partnership on impact of ACE's on parenting.	December 2021	Work has started on this and all GSCP safeguarding courses include understanding of ACE's. This has now been included in the on line multi-agency Child Protection Inter agency training started October 2020 and showing a significant enrolment of practitioners across the partnership. Included the Partnership has been assessing and working on a trauma informed assessment approach and impact of ACE's on both children and parents. The Essentials 3.0	

						Programme 'Critical Learning' modules offer specific focus on key ACEs – including Parental Mental Health, Parental Substance Misuse, Domestic Abuse and Neglect Evidence Informed Practice will also focus on a trauma informed approach when working with children and young people. Part of the Children's social care transformation Plan includes a new Trauma Informed Model of Practice with Dr Ana Draper from the Tavistock Clinic. The TIMOC training started to be delivered in early November 2020. **Outcome:** ACE's perspective on the wellbeing of parents is communicated to all Social Workers to assist in informing practice, specifically single agency assessments.	
All Social Workers and their managers to attend a workshop or training on working with perpetrators of domestic violence. The aim of these workshops/training sessions is to improve social worker's confidence levels in	Local Gloucestershire Children's Social Care	Training on Essentials in Gloucestershire to include professional curiosity in completing parenting assessment	Children's Social Work Academy.	To incorporate in Essentials 3.0 Programme	Module to be completed by December 2020 and training to be completed by December 2021.	A programme has been developed by the Social Work Academy with a focus on 'Working with Males'. This include male perpetrators of domestic violence/abuse in the Family module) which forms part of the wider PQS curriculum and is rolled out as part of the suite of training for social workers and their	

engaging with perpetrators (both male and female) of domestic violence to support them to identify patterns of abuse and its impact on victims.						managers. Training on female perpetrators of domestic violence/abuse work will be included in the domestic violence programmes led by the Social Work Academy and the GSCP. **Outcome:** Social workers reporting a better understanding of domestic abuse and all its aspects through supervision	
All Social Workers and their managers to attend a workshop or training to include practice led learning and development opportunities for practitioners to increase skills, knowledge and confidence in identifying the wide range of indicators of domestic violence and coercive control. Programme to be started immediately and outcomes reported to Social Work Academy Board.	Local Gloucestershire Children's Social Care and Early Help, Family Support Staff	Training on essentials in Gloucestershire to include professional curiosity in completing parenting assessment	Gloucestershire Children's Social Work Academy and GSCP	To incorporate in Essentials training	To be completed by end of September 2021	This work has started as part of the domestic violence development programme led by the Social Work Academy and there will be further training which will be based on the learning from this DHR from now until End of September 2021. The Essentials 3.0 Programme includes a 'Communication in Practice' module which incorporates courageous and difficult conversations and further supports the mandatory 'Relational Practice' module. **Outcome:** Social workers reporting a better understanding of domestic abuse and all its aspects through supervision	

GSCP domestic violence training to be attended to include direct work, communication and engagement skills with children who may conceal domestic violence. (ED did not want to discuss domestic violence with the Social Worker and so social workers need to be equipped to address this especially when children feel pressure from parents about sharing information about domestic violence and/or abuse in relationships and the family home.	Regional	This element of training to be incorporated in the domestic violence training provided by safeguarding boards and executives	GSCP in Gloucestershire and other safeguarding boards or executives in the South West Region	Yes there has been progress made within the GSCP to enact this action in the domestic violence work carried out by the practice manager	December 2021.	Work has now been included in the on line multi agency Child Protection Interagency training rolled out in Gloucestershire as a new virtual platform in 2020. All training reflects the impact of DA on the lived experiences of the child. Attendance at GSP training is showing an increase through the Virtual Platform and ongoing attendance will be monitored via the Quality and Improvement in Practice Subgroup. In the Social Work Academy the Essentials 3.0 Critical Learning Module is aimed specifically at Social Workers and designed to be a gateway into the multi-agency training. It focuses specifically on types of Domestic Abuse, impact, likelihood and evidence based intervention with a specific focus on the child. Following content moderation the module will be shared with the GCSE. **Outcome:** professionals reporting a better understanding of domestic abuse and all its aspects through supervision	

Gloucestershire Education Services							
All schools in Gloucestershire to reassure themselves through refreshers or by implementing mechanisms that their staff understand domestic abuse and the context of professional curiosity in the wider family context.	Local	Domestic Abuse and Intimate Partner Violence e-learning training to be launched and promoted to Educational and Early Years settings. A bespoke webinar on Domestic Abuse, that includes definition of DA, and includes coercive and controlling behaviour. Looks at impact on parenting and key tools available to be commissioned, and delivered. Operation Encompass to be rolled out to Early Years Nurseries. Training to be developed promoted and delivered to both Education and Early Years settings.	Gloucestershire Safeguarding Children Partnership Practice Development Manager with support from Safeguarding in Education Manager Gloucestershire Safeguarding Children Executive Practice Development Manager with support from Safeguarding in Education Manager and County Domestic Abuse and Sexual Violence (DASV) Strategic Coordinator Safeguarding in Education Manager in partnership with GDASS, Senior Education MASH researcher and	• E-Learning course to have been commissioned. • Training to be promoted to educational settings • Uptake to be monitored through completion of S175 audit • External expert to be commissioned to write webinar. • Date to launch to be agreed. • Webinar to be promoted • Webinar to be delivered. • Webinar to be recorded • Review of current Training materials to ensure they meet the requirements for Early Years. • Dates of delivery to be confirmed. • Training dates to be promoted. • Training to be delivered. • Operation Encompass to go live for Early Years settings. • Training to be reviewed and updated.	June 2020 June 2020 February 2021 September 2020 September 2020 November 2020 December 2020 December 2020 November 2020 October 2020 October/November 2020	June 2020 To date 291 Education Professionals have undertaken the E-Learning module. June 2021 over 7000 education staff have attended all GSACP eLearning courses with an 88% completion rate. The DA Course forms a part of the learning suite which supports the DA course to provide context around DA in the safeguarding arena. June 2020 – an email was sent to all Designated Safeguarding Leads. Information included on the Education Bulletin Board. August 2020 – Tess Biddington a DA specialist commissioned to undertake this piece of work. A two part webinar was delivered by Tess Biddington and Clare Roche in December 2020 and January 2021. September 2020 – agreed to launch as part of 16 days of action. Whole School Training has been reviewed and is currently compliant with actions from	

		Review of training offered to schools to that Professional Curiosity is woven through all elements of training. (whole school training, CPIA, Safeguarding Admin course)	Inclusion Service Gloucestershire Safeguarding Children Executive Practice Development Manager with support from Safeguarding in Education Manager		November/December 2020 December 2020 November 2020	this and other reviews relating to DA. Safeguarding Admin Course was delivered in September 2020 with further courses delivered since to all school admin staff linking to their role in supporting the DSL and SLT in their safeguarding responsibilities. Child Protection Inter Agency training is rolled out and now being delivered successfully to approximately one thousand practitioners with 544 education colleagues attending during 2020/2021. Ongoing monitoring of training will be undertaken by the QiiP. November & December 2020 – Operation Encompass Training rolled out to Early Years sector. 14th December 2020 – Operation Encompass went live to the Early Years sector. Professional Curiosity brought into whole school training and the Safeguarding Administrators course. Practice briefing circulated to all schools.	

						Outcome: Schools report that staff feels confident and competent in recognising and responding to Domestic Abuse.	
All schools to agree a system with Children's Social Care whereby receipt of key safeguarding information is recorded so that there is no doubt on whether that information has been received and acted upon.	Local	The Joint Working Protocol between Education and Children's Social Care to be embedded into practice.	Education and Early years Sub Group in collaboration with the JWP task and finish group.	• The JWP to be agreed by both Education and Children's Social Care. • The JWP becomes integral to the work between partner agencies	April 2021	Ongoing work needed – delayed due to COVID-19 **Outcome:** Effective safeguarding record keeping is implemented across all educational settings	
That the learning from this review be incorporated into school safeguarding training to enable the difficult issue of the threshold between 'behavioural' and 'safeguarding issues' to be constantly reviewed by schools in the light of the evidence of this and other safeguarding Reviews.	Local	Review of current school training and ensure that the issue of threshold between 'behavioural' and 'safeguarding issues' is covered clearly and regularly reviewed. Training to be continued to be offered for settings every 3 years. CPIA Training will include learning from this SCR and others both nationally and locally	Gloucestershire Safeguarding Children Executive Practice Development Manager with support from Safeguarding in Education Manager	• Training reviewed and being offered virtually in light of Covid 19. • Reminders to be sent to schools where 3 yearly training has lapsed. • Training reviewed and being offered virtually in light of Covid 19.	November 2021 April 2021	Whole School Training has been reviewed and is currently being piloted. Ongoing – systems implemented to send reminder to schools regarding expiry of 3 yearly training. Scrutiny of compliance undertaken through S175 Audit arrangements Child Protection Inter Agency training is rolled out and now being delivered successfully to approximately one thousand practitioners with 544 education colleagues attending during 2020/2021. Ongoing monitoring of training	

						will be undertaken by the QiiP. **Outcome:** Schools report that staff feels confident and competent in recognising and responding to Domestic Abuse	
Gloucestershire Clinical Commissioning Group							
Primary Care should discuss concerns about suspected or known issues of domestic abuse amongst the Multi-Disciplinary Team to ensure awareness of cases, and the opportunity to join up discussions or concerns about all children and household members, and their fathers and partners. Primary Care information will benefit from improved MARAC liaison (knowledge of DA incidents and contribution to MARAC research). All discussions should be noted within records.	Local	GCCG facilitates GP Safeguarding Forums x3 per year each for adult and child GP SG Leads. a) Continue same – GPs already have regular MDT meetings for vulnerable adults – and this is frequently reminded and discussed at GP forums b) CCG are supporting GPs involvement with MARAC and sharing of MARAC information through training at GP Forums. We aim to scope the role of a health MARAC specialist nurse c) Rolling out the 'Ardens' SG adult template will support	CCG	a) Usual practice at Forums b) MARAC information sharing capacity is on the CCG risk register – an 'all health' scoping to be undertaken – date TBC c) Roll out training on adults SG template to ensure info recorded within patient notes	a) ongoing BAU b) GPs continue to respond to MARAC as requested from direct MARAC requests for information. This is BAU. Scoping / Review of an integrated 'all health' MARAC research process will be progressed in Jan 2021. c)Ardens template training is 14th October	Actions denoted a) is business as usual. b) Scoping / Review aimed for Jan 2021 with outcome and recs March 2021. c)completed - GP Forums 14th October (children) and 4th November (adult) Of note: CCG is progressing a project that will bring together the work of the 3 health Safeguarding Teams for each organisation (CCG/ GHC / GHT) that will include addressing combined MARAC responses and research within health. **Outcome:** 1. Practitioners report they are confident and competent in recognising and responding to Domestic Abuse. 2. Primary care will be	

		identification of SG incidents				always approached for information in MARAC Research including information on MARAC outcome	
There must be continued, consistent and strengthened links between the work of GDASS and Primary Care in order to maintain awareness of domestic abuse issues and the impact that this has on victims and children. This should include consideration of continued service provision for the GDASS pilot beyond March 2020.	Local	CCG confirm that this service is now commissioned until end of June 2023. GP Development Workers (through GDASS) are funded to support surgeries – processes and training that increase DA awareness, improve the uptake of DA champions, and direct practice changes (safe space, management of high risk cases, as well as direct 1;1 support routes).	CCG/GDASS			As per column 3 – this is in place. **Outcome:** Consistent commissioning of domestic abuse support for primary care	
Where there are out of hours' attendances to unscheduled care settings (both for adults and children) GP Practices should have a clearly identified process in place that supports recognition for potential follow up to significant illness or injury. Specifically, the role of hospital	Local	Process in place is that the GP gets a written notification of the attendance from OOH, MIU of ED in the form of a discharge summary or attendance sheet. It is not the role of GPs to follow up beyond normal analysis but MDT discussion must be considered when	CCG	a)in place as Business as usual b)Designated Dr is completing work with PHVL and Acute Trust. Opportunity to link / clarify GP liaison	a)ongoing BAU	Outcome is given and BAU / routine practice **Outcome**: This work is BAU within the PLHV / GHT Named Nurse / Des Dr to evidence data – shared to Strategic Health Group and onwards to QIIP.	

paediatric liaison needs to be further clarified in relation to effectiveness and how this currently links with Primary Care.		necessary. Strengthen links between PHVL role and GPs - The role of the paediatric liaison is with GHC/GHT					
Practice and learning from IRIS should be considered by the CCG as domestic abuse practice is developed for primary care settings.	Local	Confirmation that GDASS model covers this work	as covered above	as covered above	as covered above	as covered above Within commissioned service, but not the IRIS specific programme **Outcome**: Consistent commissioning of domestic abuse support for primary care that incorporates best [practice approaches in this field.	
Gloucestershire Health and Care NHS Foundation Trust (Formerly Gloucestershire Care Services and 2gether Trust)							
Health professionals to seek to know who has parental responsibility for a child, as well as other adults who play a key role in that child's life e.g. stepparents. Agencies should always ask, clarify, and document who the adult is accompanying a child to appointments or who is ringing the practice about a child. Details of the child's birth parent should be			Gloucestershire Health and Care NHS Foundation Trust (GHC)	CCG Safeguarding Team will undertake a scoping exercise across all Practices in Glos to ascertain how and when GPs request evidence of PR. -On the basis of this SCR/DHR recommendation, the CCG Safeguarding Team will request that all GPs use the 'gold standard' registration form forthwith. - CCG Safeguarding Team will undertake a scoping exercise across all Practices in Glos to ascertain how and when GPs request evidence of PR. - CCG Safeguarding Team will continue to encourage the use		Ongoing - As a high priority, GHT are working with project leads for the Trust IT systems set up so that staff can ask and record who any patient comes to hospital with, capturing both their name and role in the patient's life. For the GHT Safeguarding Team, this helps with additional background whereby they may be able generate a genogram where needed. -The Gloucestershire Health and Care NHS Foundation Trust (GHC) Safeguarding	

recorded and the status of the child's relationship with that parent should also seek to be recorded.				of Ardens as good practice, both the Child Template and the Safeguarding Template. Our work with GP Practices (through the GP Forums) will promote the need to ask who is accompanying a child, their relationship with the child, and thus add this to the consultation record.		Team are working with its Quality Improvement Team to develop a solution to make it easier for staff across the Trust to record who is in the childs household and family/personal network. This includes documentation of who has parental responsibility. This is part of GHC audit programme which will provide assurance for quality improvement. **Outcome**: All records will be contemporaneous with details of the child's birth parent and the status of the child's relationship with that parent.	
To review the GHC Domestic Abuse Policy as the current focus is for staff to know what to do in the event of a disclosure. More guidance is required within this policy about the indicators of potential domestic abuse to enable effective signposting to specialist services.	Local	The GHC Domestic Abuse policy to be reviewed. Review all mandatory safeguarding training packages at all levels, and group safeguarding supervision, to ensure these issues are fully explored.	GHC	The GHC DA Policy outlines specific guidance in relation to not only routine enquiry but also selective enquiry e.g. for example where there is a history of DA or where there are specific indicators i.e. • Inconsistent relationship with health services • Physical symptoms • Reproductive/ sexual health issues • Emotional/psychological symptoms	December 2019	Complete, with ongoing review Further review completed July 2021. Policy now includes - • A 5 minute guide on how to respond to domestic abuse • Flow chart of domestic pathway • Range of support services available • High risk indicators	

				• Intrusive 'other person' present These factors Alongside professional curiosity are emphasised and reinforced throughout training and GHC group supervision. Regular review by the GHC Safeguarding Sub Committee.		• Cites the new Domestic Abuse Act **Outcome**: Policy to include most up to date guidance in line with domestic abuse best practice	
GHC domestic abuse training needs to encompass all the indicators of domestic abuse which may be evident prior to a disclosure. This training model is for a continuous rolling programme available to all GCS staff, within both adult and children services.	Local	The GHC Domestic Abuse policy to be reviewed. Review all mandatory safeguarding training packages at all levels, and group safeguarding supervision, to ensure these issues are fully explored.	GHC	There is clear and consistent guidance in the GHC Domestic abuse policy which advises Trust staff what to do in the event of disclosure, what the indicators of DA are, and where to signpost, both in the event of an emergency or follow on support from local Support Services. Revision of the policy remains ongoing given the recent guidance outlined in the Pathfinder Assessment Tool DHSC June 2020 which provides a template for not only	December 2019	Complete, with ongoing review Level 2 mandatory safeguarding training explores domestic abuse within a family situation. GHC Domestic Abuse policy includes indicators for domestic abuse in adults and children. There will be further development of this with the Local Domestic Abuse Partnership, and workforce development is part of the Gloucestershire Domestic Abuse Strategy. **Outcome:** Practitioners report they are confident and competent in recognising and responding to Domestic Abuse	

				policy but also training, most of which our current policy and training is aligned Regular review by the GHC Safeguarding Sub Committee.			
Where there is a known history of domestic abuse within a relationship, GHC practitioners take every opportunity to explore this with the victim when safe to do so and demonstrate consistent professional curiosity. This should be reinforced within the domestic abuse training, group safeguarding children supervision, GCS Domestic Abuse Policy and all GCS staff forums.	Local	The GHC Domestic Abuse policy to be reviewed. Review all mandatory safeguarding training packages at all levels, and group safeguarding supervision, to ensure these issues are fully explored.	GHC	As above action points. The GHC Domestic Abuse Lead Nurse delivers bespoke training available to all staff, including at staff forums, and it is also included in mandatory Safeguarding training at all levels.	December 2019	Complete, with ongoing review GHC Mental Health staff and Public Health Nurses (PHNs) routinely ask about Domestic Abuse at assessment. PHNs further enquire at every core appointment as per Practice Benchmarks. This is underpinned within mandatory safeguarding training and supervision. The GHC Safeguarding Advice Line is available for all staff and would provide support and advice regarding domestic abuse issues, and promote and encourage professional curiosity. **Outcome:** Practitioners report they are confident and competent in recognising and responding to Domestic Abuse	
Gloucestershire Hospitals NHS Foundation Trust							

Staff need to retain professional curiosity at all times and to ensure continued training is in place for Trust staff.	Local	Weave professional curiosity into every aspect of safeguarding training	GHFT	- Strengthen professional curiosity in all training packages	November 2020	Safeguarding training restructured as a result of COVID with greater emphasis on professional curiosity as a cross-cutting theme **Outcome:** Practitioners report they are confident and competent in recognising and responding to Domestic Abuse	
For the Trust to consider the tools and findings from DOHSC funded Pathfinder sites to ensure that they are maintaining and further developing best practice in relation to domestic abuse.	Local	Compare tools from Pathfinders sites to current practice in Trust and complete gap analysis	GHFT	compare tools currently used to tools available elsewhere establish options for gaps identified	December 2021	Ongoing activity **Outcome:** Practitioners report they are confident and competent in recognising and responding to Domestic Abuse	