Domestic Homicide Review

Overview Report

REPORT INTO THE DEATH OF 'DAISY' in JANUARY 2016.

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SECTION ONE – INTRODUCTION AND BACKGROUND

1.1 Introduction

This is the Overview Report following the Review of the response and support given by agencies to Daisy prior to her death in January 2016. The Report aims to provide an overview of information received from agencies which had contact with Daisy, with the perpetrator, and with their baby. The Report will analyze that information, identify where lessons can be learned, and make recommendations for the further development of services provided to victims of domestic abuse in Bradford.

1.2 The purpose of this Domestic Homicide Review

Domestic Homicide Reviews (DHR) came into force in April 2011. The purpose of a DHR is set out in Section 9 of the Domestic Violence, Crime and Adults Act, 2004, which states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –*

a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

b) A member of the same household as himself,

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

The purpose of a DHR is to:

- Establish lessons to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescale they will be acted on, and therefore what is expected to change;
- Apply these lessons to services including changes to policies and procedures as appropriate;
- Identify what needs to change to reduce the risk of such tragedies happening in the future;
- Overall, to prevent domestic violence homicide and improve service responses to all domestic violence victims and their children through improved intra- and inter-agency working.

The guiding principles of a DHR are:

- Urgency – taking the action necessary to protect others as quickly as possible;
- Impartiality – those conducting the Review have not been directly involved with the victim or the family;
- Thoroughness – considering all relevant factors and further examining information where required;
- Openness – there should be no suggestion of concealment of information;
- Confidentiality – due regard is paid to the balance of individual rights and the public interest;
- Co-operation – agencies work together under locally and nationally agreed arrangements to produce the Review;
- Resolution – action will be taken to implement the finding and recommendations.

1.3 Summary of the Case

This homicide took place in the early evening. Police were called by a neighbour, who reported that a young woman had come to her home, concerned about Daisy, following a domestic incident. Police attended and broke into Daisy's house where they found Daisy, deceased, close to the front door. Her partner was found, critically injured in the bath; efforts to resuscitate him, failed.

The police investigation established that the friend who reported the incident, was at the home at the request of Daisy, who was concerned about her partner's reaction to the relationship ending. He had left the house at Daisy's request the day before. He returned to the house that morning, having purchased duct tape on his way there, collected the baby from the house, took the baby to stay with relatives, then returned to the house. After a heated argument, he attacked Daisy, tied up the friend in a separate room, further attacked Daisy, then committed suicide. The friend escaped and alerted the neighbour who contacted the police.

Cause of death was subsequently confirmed as multiple stab wounds for Daisy, but she had also been stamped and kicked. Bleeding to death was the cause of death for her partner, who had cut a side artery to his femoral artery.

The police investigation and subsequently the Coroner's Inquest concluded that the perpetrator, her partner, murdered Daisy and then committed suicide.

1.4 Members of the Family

This Review concerns events relating to Daisy, Alex, and the baby, that are relevant in considering the death of Daisy.

Daisy, aged 38, and her partner Alex, aged 37, lived together with their baby, aged two years at the time of the homicide, in a house owned by Daisy. Daisy and Alex had been together for over four years. Daisy was employed as a director of her company, an Occupational Health organization, which she owned together with a business partner. Alex worked as a teaching assistant at a primary school. The day before her death, Daisy had asked Alex to leave her house, and he had spent the night at his mother's address.

Daisy is survived by both parents and a brother, while Alex is survived by his mother and sister.

The names of the people concerned in the Review, and the addresses of home and employment have been anonymized to protect their confidentiality. 'Daisy' is the name chosen by her mother for the purposes of this Report.

1.5 Introducing Daisy

This profile of Daisy is a combination of information provided by police in the case summary, information from family and friends as reported in police information, and information shared by Daisy's mother and Alex's mother with the author.

Daisy was described by her family, in her obituary, as: 'An open-hearted force of nature with a zest for life.' Friends speaking to police described her as outgoing, energetic, intelligent, having a good sense of humour, passionate about current affairs, compassionate, warm and friendly; 'a fire cracker', 'a lovely personality', 'headstrong and feisty' and 'a wacky girl'.

Daisy was born in 1977 and was brought up as a Catholic though was not practising. Her family originates from Portugal, and has close relationships with family there, but for most of Daisy's life she lived in England. Her parents are well established and highly successful business people, being directors of their own company. Daisy was privately educated at primary level, then attended Grammar School. She did well, obtaining twelve O Levels, a number at A*, and A Levels in Languages, Business and Philosophy. She graduated from Glasgow University in 2001 with an Honours degree in Philosophy, Politics and Economics.

Whilst at University, Daisy married, but this was short-lived and she was divorced at 21. After graduation, she took a half year gap in Australia. On her return, after a number of temporary jobs, she became an administrator for an Occupational Health company in Leeds. The company hit financial difficulties and Daisy and a work colleague bought the business. She became a director of the company and business manager. Daisy qualified in counselling at Leeds Metropolitan University and had begun to work as a therapist. She worked with a private therapist as part of her personal development as a therapist. She had many hobbies and interests in music and sport.

Daisy met Alex online. They had been together for two years, and Daisy was 36 when their baby was born. Friends said that Daisy wanted to have a child for many years.

Some friends said that Daisy had low periods, becoming withdrawn and losing weight, and was possibly depressed, from the middle of 2015. These references contradict all other descriptions of Daisy by friends and family members who knew her for many years. However, the concerns of these friends do cross-reference with information presented to the Review which suggests Daisy started to experience panic attacks and anxiety because of relationship issues. The information available suggests that Daisy was an independent woman who kept her worries to herself, and would not have disclosed domestic abuse; indeed, one of her close friends noted in her statement that Daisy would not have considered herself to be a victim, or to have been experiencing domestic abuse.

1.6 Agencies Involved in the Review:

The initial scoping identified that the following agencies would be asked to provide IMRs:
West Yorkshire Police (WYP)

The fourth largest police force in the country, WYP serves the five metropolitan districts of West Yorkshire. Local Policing services are delivered by District Command Units which are co-terminus with local authority areas. Most calls from the public are received at the central Customer Contact Centre (CCC) where staff record reported incidents on the Command and Control system, (Storm), and pass them to District Control Rooms, (DCRs). DCRs dispatch resources to the incident in accordance with the Force's Demand Management Policy.

Management of Domestic Abuse incidents is directed by the Force's Domestic Abuse Policy, a comprehensive document covering all operational areas of the Police response such as role/description of the agency/ organisation, the receipt of initial calls, attending incidents, conducting risk assessments and providing specialist services. The force implemented the Domestic Abuse, Stalking, Harassment and Honour Based Abuse (DASH) risk assessment in May, 2011. Developments reflecting national best practice and legislative change during the time period under review include guidance on the operation of new legislation and procedures such as the Domestic Violence Disclosure Scheme (initially introduced in March 2014); Domestic Violence Prevention Notices and Orders (introduced by Sections 24–33 of the Crime & Security Act, 2010 in June 2014); and Section 76 of the Serious Crime Act 2015 (Controlling or Coercive Behaviour) implemented in December 2015.

Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)

BTHFT provides services from two main hospital sites, Bradford Royal Infirmary and St Luke's Hospital (SLH), community hospitals, and a range of community locations providing specialist services on an outreach basis. In relation to this Review, the Trust provides ante natal and midwifery services.

In this case, BTHFT provided a midwifery service. On the midwifery pathway, routine questions are required to be asked of mothers regarding domestic abuse and emotional well-being. Concerns are discussed in safeguarding supervision with the safeguarding nurse and a Safeguarding Care Plan would be devised.

Bradford District Care Foundation Trust (BDCFT)

BDCFT is an integrated mental health and community services trust providing specialist support for people of all ages who have community health and mental health needs. BDCFT

was responsible for providing the health visiting service to this family during the time period under Review.

Health Visitors provide a wide range of services to support families and children aged 0-5 years or until a child enters school. Health visiting practice is based on principles of identifying and addressing the health needs of individuals, families and communities (Well Child Quality Service Standards BDCT 2011). As part of this duty Health Visitors are expected to undertake a holistic assessment of the child's needs and to have an understanding of parenting capacity and wider family circumstances. In accordance with the publication, Health For All Children, (Hall & Elliman 2006) and the Healthy Child programme (DOH 2009) families are offered a core universal programme of care. Extra support for families and children with additional needs identified will be offered above the core universal service. Individual practitioners are expected to work to current local and national Health Visiting standards including BDCFT safeguarding policies and procedures and those of the Bradford Safeguarding Children Board. The service is offered to parents who have the right to opt out; it is not a statutory requirement to engage.

General Practice

One Practice, providing primary health services to the three family members, was involved with this Review. The Practice works with Bradford District CCG to provide primary health services to 11,500 residents in the area where the family lived. There are four male and one female GPs, and practice nurses, offering consultations face to face and by telephone, and an online booking, prescription and record viewing system. Services include smoking cessation, minor surgery, ante-natal, baby massage, and a baby clinic with health visitors. The Practice uses SystmOne, an electronic medical record, which is shared with midwives and health visitors. The Practice achieves 90% on the Friends and Family Test and a 'good' CQC rating. A second Practice, in Leeds, provided GP services to A prior to his move to G's home. The IMR author for Practice 1 reviewed these records and advised the Overview Panel that there was nothing relevant to the Review contained in those records. On the basis of this expert advice, the Overview Panel agreed not to request an IMR from the second Practice.

Whereas routine enquiry regarding domestic abuse is established guidance and practice in the health visiting and midwifery pathways, it is not expected practice for GPs. There is current work to consider how and when GPs could ask questions, in part as learning from a previous

DHR, however, during the timescale under Review, this was not in place. Since Sept 2015, a Domestic Violence Manager has been employed by the CCG, to promote good practice, raise awareness and advise practitioners in relation to domestic violence situations across primary care.

Children's Social Care (CSC)

The 'front door' to Children's Social Care in relation to safeguarding children is the Integrated Assessment Team (IAT). This team is part of the Multi-Agency Safeguarding Hub (MASH) in which partner agencies including police, health and education, are co-located, working together to safeguard and protect children as required by statutory guidance. The MASH is a single point of contact for all concerns regarding children to be reported and is co-located at Bradford CSC. The team accepts telephone referrals and uses the Bradford Children's Safeguarding Board's Common Referral Form and CSE risk assessment.

All contacts are triaged by CSC duty social workers and either allocated for assessment or directed towards a more appropriate service. If the assessment deems there is potential for significant harm to the child, then a strategy discussion is conducted with the MASH Police.

The MASH has been established since the time period under review. At that time, contacts were received by the duty team within CSC, recorded as a contact, and either advice given such as signposting to other services, or referred for assessment and/ or strategy meeting where the situation was urgent.

CSC was asked to provide a Statement of Facts pertaining to two contacts about the family, once it became clear from initial information that there had been no intervention and no individual records were held concerning any member of the household.

SECTION TWO – PROCESS AND DEVELOPMENT OF THE REVIEW

2.1 Process and Development of the Review:

2.1.1 This DHR has been commissioned by the Bradford Community Safety Partnership and coordinated by the Bradford Domestic Abuse Partnership in line with the expectations of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 2011. This guidance is issued as statutory guidance under s9(3) of the Domestic Violence, Crime and Adults Act, 2004.

2.1.2. Following notification of the homicide, a Briefing was provided to the Community Safety Partnership and a decision taken to proceed with a DHR. The Home Office was informed of the decision to conduct a DHR in March 2016. Subsequently, local capacity issues meant the process was held until staff resources could be identified. In July, the DHR Panel commenced the scoping and initiated a tendering process for an Independent Chair/ Overview Author. The Overview Author was commissioned in August 2016.

2.1.3 The accountability for the Review rests with the DHR Panel. This is a sub-committee of the CSP and comprises the following agency representatives:

- Bradford Metropolitan District Council:
    - Directorate of Place/ Safer Communities
    - Children's Services
    - Adult Services
- West Yorkshire Police
- National Probation Service
- NHS: Bradford City, Bradford District and Airedale, Wharfedale and Craven CCGs
- Bradford Teaching Hospitals NHS Foundation Trust
- Bradford District Care Foundation Trust
- Airedale Hospital Foundation Trust
- CAFCASS

2.1.4 Oversight of the process is delegated by the DHR Panel to the Overview Panel, chaired by the Independent Chair. In addition to the Chair, the Domestic Abuse Coordinator and an Administrator, the Overview Panel comprises the following agency representatives:

Andrew Howard	Detective Chief Inspector, West Yorkshire Police (WYP)
Maggie Smallridge	Head of West Yorkshire NPS (Bradford and Calderdale) National Probation Service
Amanda Lavery	Safeguarding Service Manager, Bradford District Care NHS Foundation Trust (BDCFT)
Sally Scales	Deputy Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)
Matt O'Connor	Head of Safeguarding Adults, Bradford District Commissioning Group (CCG)
Susan Tinnion	Service Manager, Multi-Agency Safeguarding Hub, and Bradford Assessment Teams, Children's Specialist Services, Children's Social Care (CSC)

2.1.5 The DHR Panel commissioned Kate Mitchell to undertake the roles of Independent Chair of the Review and Author of the Overview Report. Kate Mitchell is a qualified social worker and manager with thirty years' experience as a practitioner and senior manager in the Probation Service and in Adult and Children's Social Care. As an independent consultant for nine years, she has undertaken several reviews of domestic abuse practice and policy, and of children's services; has previously chaired and authored two Serious Case Reviews and two DHRs, and is currently chairing Serious Case Reviews in other areas. Having not worked in the Bradford area at any time previously, Kate Mitchell is independent of all the agencies and personnel involved in this Review.

2.1.6 The Domestic Abuse Coordinator undertook the initial scoping, which identified the agencies listed in paragraph 1.6 who would be required to provide Internal Management Reviews (IMRs).

2.1.7 These agencies nominated IMR authors who were experienced in the methodology and report writing required for preparing an IMR, and had no connection to the case or the individuals involved in the case. All except one were experienced IMR authors and therefore individual briefing was offered to one author. All authors were offered support and advice as required during the writing of their reports, by the Domestic Abuse Coordinator and Overview Report Author. At the first Overview Panel meeting it was identified that CSC had

just two contacts, none face to face, and no assessment or interventions with members of the family. CSC was therefore asked to provide a summary of facts relating to the contacts, not a full IMR.

2.1.8 Agencies prepared a Chronology of Agency Involvement, which was merged into one chronology and discussed at the first Overview Panel meeting. This Chronology was then summarized to events that are significant in relation to the homicide.

2.1.9 The first Overview Panel meeting identified family members, employers and others who would be invited to contribute to the Review. The task of contacting and inviting involvement was assigned to the Overview Report Author.

2.1.8 Agency authors prepared a draft IMR. At a round table meeting with the Independent Chair/ Author, Domestic Abuse Coordinator and Overview Panel members, the IMR authors presented their key factors for discussion and challenge. A number of queries were raised, which IMR authors were asked to explore and include in the final IMRs. The findings from the Quality Assurance process was fed back to individual authors where relevant. Final IMRs were then received within the timescale.

2.1.9 As stated above, the timescale of the Review was influenced by local capacity issues and has not met with the requirements of Guidance to complete within 6 months of the death of Daisy. However, it was completed within 6 months of the commencement of the process in August 2016.

2.2 Time Period under Review

Following the initial scoping, the time period of this Review was set at the date of Daisy's engagement with services prior to the birth of the baby, as it appeared this was the first contact between the couple and the public sector agencies. When the chronology was completed, it became clear that there was prior contact with the perpetrator which was relevant to the Review, and the timescale was taken back to 15th July 2012. In addition, a summary of relevant information concerning the perpetrator, prior to 2012, was received from the Police Service.

2.3 Terms of Reference

The terms of reference were developed from the initial scoping and the first meeting of the Overview Panel. These set out the general and the specific questions to be addressed by IMR authors and by the Review. In this case, as there was a child of the household, additional terms of reference were developed to consider the child safeguarding elements of the case. The terms of reference are detailed in Section 5.2.

2.4 Methodology

IMR authors were asked to work in the spirit of the DHR process, presenting an accurate, objective account of what factually happened in the agency's contact with members of the family; to evaluate it fairly; and to identify and explore both missed opportunities and areas for improvement. IMR authors were encouraged to propose specific solutions which are likely to provide a more effective response to a similar situation in the future. Authors were asked to identify where changes have taken place within the agency, as a result of early lessons learned that have been identified, or through other influences such as systems changes; or in a wider socio-political-legal context, that would impact on these events if they were happening now.

2.4.1 Learning lessons.

It is emphasized throughout the DHR process, that the ability of the partnership of agencies to learn lessons from a tragic event is a central principle. The aim of the process is to reduce the risk of future domestic homicides. This is both general, in terms of national, regional and local changes that support potential victims; and specific, in terms of individual agencies developing services, policy and practice. This Review therefore focuses on key factors that will assist learning and change, and takes a developmental approach to resolving any issues that are raised through the Review.

2.4.2 Methodologies:

Each agency IMR evidenced a methodology which included:

- The compilation of an agency chronology;
- A review of the electronic and paper records concerning members of the family held on databases in use by that agency;
- A review of all letters, communications and file attachments.
- Face to face interviews with all practitioners engaged in the case;

- Contact with safeguarding experts within agencies to clarify standards and policy and take advice on best practice.

2.5 Confidentiality

2.5.1 Information sharing:

Information contributed to this Review has been managed in accordance with the information governance arrangements of each agency, and has been kept securely. Participants in discussions have signed a confidentiality agreement. Each IMR is confidential and will be stored securely by the agency. Agencies who have seen other IMRs in order to cross-reference their own Report and to be able to clarify and challenge partners, must not store the IMRs of other agencies.

2.5.2 Individuals:

Identifiers are used for individuals concerned in the Review, including members of the family and staff involved in the case in agencies. Until the Overview Report has been approved by the DHR Panel on behalf of the Community Safety Partnership, it will remain restricted, not for circulation outside authors and Panel. The Overview Report will be examined prior to publication in order that any remaining information that should remain confidential is redacted.

2.5.3 Dissemination:

This report will not be disseminated outside the Panel until clearance has been received from the Home Office Quality Assurance Panel that the Report is at least satisfactory.

Both families will be informed of the date of publication and we will meet with the families, if this is wanted, prior to publication and provide Daisy's family with a copy of the Report upon publication.

SECTION THREE – FAMILY AND COMMUNITY INVOLVEMENT

3.1 Family:

The author met with Daisy's mother, had a telephone conversation with Daisy's father, and met with Alex's mother. The statements of extended family members in the records of the West Yorkshire Police investigation, were made available to the author.

The circumstances of this homicide clearly devastated Daisy's family and continue to have a serious impact on family relationships. During the Review period, Daisy's parents were most concerned about the future care of the baby.

Daisy's mother spoke about her daughter's achievements as a businesswoman and a mother, and praised her strength and assertiveness. During a court case relating to the future care of the baby, she had received papers detailing the perpetrator's allegations against her daughter, of domestic abuse, which he made to the health visiting service, as detailed in this report. It was her view that the control in the relationship was with the perpetrator, although she believed her daughter would have defended herself both verbally and physically, had she needed. She pointed out that Daisy was a small woman, whilst the perpetrator was a large, muscular man, who worked out at the gym regularly. As such, she found any account of her daughter being violent towards Alex, unbelievable, and quoted examples of Alex being controlling, by her daughter's account to her, although Daisy did not disclose abuse to her mother or father. Mother felt her daughter would not have seen herself as a victim of domestic abuse and would have expected herself to sort it out.

Daisy's mother is understandably angry about Alex presenting himself as a victim of domestic abuse, to the health visiting service in 2014 (an event described later in this Report); and was critical of Children's Social Care (CSC) in that she felt CSC should have told her daughter about this. We discussed that CSC's role in this was limited to information received from health visitors and police, who had been involved in the events, both being clear that Alex was a victim at that time, as discussed later in this Report.

Daisy's father felt that staff in agencies could be more alert to signs of living with domestic abuse in very young children. As it has transpired that the parties had been living with domestic abuse for all the baby's life, he felt this must have had an impact on the baby that

might have been missed at the time. This was discussed with the service and Daisy's father can be reassured that the baby was the primary focus of the health visitors during the events described in this Report. This said, Daisy's father had no criticism of the agencies prior to his daughter's death, wishing above all to move on from the tragic events. He did make a criticism of the CSC following the death of his daughter, in that he felt the baby was not offered a service, to which the baby was entitled, as the child of a domestic homicide. This is outside the scope of the Review, however, has been fed back to the CSC representative on the Overview Panel, who undertook to look into it.

One of Daisy's relatives, in a statement to police, said the family was aware of problems, but nothing to give cause for worry or concern. He thought there had been friction when Alex stayed at home after the baby was born because Alex was dependent on Daisy financially. He assumed the matter was solved when Alex got a job as teaching assistant. He was aware that in the summer of 2015 Daisy told Alex to leave the house, but knew no details. The day before the tragic event, Daisy told him she was leaving Alex as he was violent and disrespectful to her including in the presence of the baby. He offered to help and Daisy refused this, telling him her friend was coming to stay with her for a week.

Alex's mother agreed to be involved in the Review, although this was clearly very difficult for her. From her perspective, although she described Alex as a large man and Daisy very small, Alex was not abusive towards Daisy; had he been so, she felt he would have confided in her as they had a very close relationship. Indeed, she related that once he told her he had hit Daisy by accident while defending himself. She felt the homicide was an uncharacteristic loss of control. She did believe Daisy physically and verbally abused Alex, having heard her shouting at him on several occasions; and her son had been upset about their arguments. She attended when he disclosed to health visitors in late 2014, and supported him in those disclosures. She felt he decided not to take the matter further because he was concerned about the impact it would have on his relationship with Daisy, and believed things could improve. She believed he had an ideal of family life, and this was what he wanted to achieve. He returned to her home at intervals, for a day or two, following arguments, and would talk to Daisy and she would agree that he could return. Alex's mother agreed there had been occasions in his past where he had issues with anger management, and thought he had not sought any help in relation to this. She felt she had a good relationship with Daisy and had

discussed with Daisy, the tension between the couple, in relation to her going out to work, his caring for the baby and doing the housework.

One of Alex's relatives said Alex had described Daisy as suffering from depression, taking medication and seeing a counsellor. This account was based on Alex telling this relative that the relationship was 'up and down' and getting worse, that Daisy had attacked him but that he had not hit Daisy; that there were tensions between them over issues such as housework, the fact that Daisy owned the house and earned more money than Alex; and that while Alex cared for the baby, he had to rely on Daisy for money. However, it was thought that once Alex started work in spring 2015, things had improved.

3.2 Others involved in the Review

3.2.1 Friends

The following information is based on a review of the police case summary.

A school friend recalled tension between the couple when Alex failed teacher training, and Daisy wanted him to get any job he could, and he wouldn't; Daisy wanted him to contribute more to the finances as she didn't want to work such long hours after the baby was born.

One friend who had known Daisy for five years said that Daisy became withdrawn and confided that Alex was critical of her appearance and undermined her confidence. This friend understood that whilst Daisy was pregnant, Alex left to live at his mother's and Daisy wasn't sure whether she wanted him to move back in because of his behaviour. In the summer of 2015, Daisy was distressed and wanted to end the relationship but was afraid of how Alex would react and what would happen to the baby. At that time, Daisy denied that any violence had occurred. The last time this friend saw Daisy was four days before the homicide, when he noted how tired she looked and how much weight she had lost. That day, she disclosed she was leaving Alex and that friends were going to give her support.

In the summer, 2015, Daisy contacted a friend for advice: she wanted Alex out of the property as their relationship had broken down; he would finish work on a Friday and go to a friend's where he would smoke weed, returning home on a Sunday; he also owed her money. When asked if Alex was violent towards her she reluctantly disclosed he had hit her and held her up against a wall by the neck. He spoke to Daisy later, when she said she was happy to

give Alex another chance. He spoke to Daisy three to four weeks before the homicide, when she said everything was okay.

In the week leading up to the homicide, Daisy confided in two friends, on the advice of her counsellor. She had previously told one that Alex had been arrested in the past for battery, but did not say their relationship was violent until three days before her death; then, Daisy disclosed that Alex was violent towards her and that this had been going on for some time, giving examples of physical and verbal abuse, because of which she had become anxious and depressed, was on medication and receiving counselling. She planned to leave Alex and over the next few days they were in contact by text. The friend advised Daisy to contact Women's Aid, however, Women's Aid reported to this Review that they had no contact.

The day before her death, Daisy contacted another friend, who had first witnessed arguments between Daisy and her partner a couple of months earlier. Daisy told this friend that because of his abusive behaviour, she was throwing Alex out and needed 'a back-up' as she had put things in place to make sure he went this time.

The friend who was present during the homicide, told police she was asked by Daisy to stay with her during the breakup as Daisy was concerned about how Alex would react. This friend had known Daisy for about two years and described her as a 'mother figure' to Alex, who appeared to have difficulty relating to adults. She had observed arguments in which obscenities were exchanged, but was not aware of violence until two days before the homicide, when Daisy talked about her fears and disclosed a violent incident about six months before when Alex had dragged her from her bed and assaulted her.

Daisy had close neighbours who knew her well as she was involved in the local community. One heard the couple arguing, when Daisy referred to this being her house. Another stated that Daisy came to his house a year earlier, distressed, and disclosed that Alex had assaulted her. He spoke to Alex who admitted assaulting her. There was no further disclosure until three days prior to the homicide, when Daisy told him about asking Alex to leave. He advised her to change the locks, which she evidently did, the day before the event.

The Review offered an opportunity to Daisy's counsellor, to be involved in the Review, which was not taken up. In a statement to police, the counsellor stated that their meetings

focused on Daisy's relationship with Alex only in December and January. Daisy expressed concern about Alex's attitude to finances. Daisy felt their relationship suffered when their 'party lifestyle' ended when she became pregnant and then they had the baby to care for, in that Alex didn't want the settled family life. Daisy described Alex as highly sexually driven, and felt pressured particularly after having minor surgery in January 2016. She attended her last appointment with her counsellor four days before her death, when she disclosed that Alex had asked her whether she minded if he went elsewhere for sex while she was ill (post-operative). She disclosed he had been violent towards her and in the past, they had hit one another. This was the first time she had discussed with her counsellor, ending the relationship; previously she had been looking at maintaining it. The counsellor advised Daisy to keep safe by speaking to friends, and not to discuss this with Alex on her own. The counsellor does not believe Daisy saw herself as a victim of domestic violence.

One of Alex's oldest friends described Alex, when feeling down, as being angry and frustrated one minute then crying the next. He was aware of only one occasion when Alex was physically violent, which was an assault on a bus driver (discussed later), and believed this was out of character. He thought Alex changed when he met Daisy, becoming more serious. He was aware they had relationship problems, which he thought started when Alex failed his teaching exams and didn't meet Daisy's standards. He describes their arguments as 50/50. He said Alex described Daisy as having mental health issues, but when his friend advised him to step away Alex wanted to stay with the baby. On the day of the homicide, he received texts from Alex saying he was devastated because Daisy had thrown him out.

3.2.2 Employers:

The Review offered an opportunity for involvement to Daisy's business partner which was not taken up.

The Review consulted the head teacher of the primary school where Alex had been employed as a teaching assistant on a temporary contract through an agency, for eight months. The head teacher confirmed there was no indication of conflict at home, and, so far as school was concerned, Alex's conduct and work did not raise any questions. The head teacher was not aware of Alex's prior convictions and the intelligence concerning violent incidents, as described elsewhere in this Report, and expressed concern that the agency, had they known, had not consulted her before placing Alex in the school. Whilst not directly relevant to the

Review, this is a general safeguarding concern. The Review Team contacted the Leeds Education Department, which is responsible for contracts with agencies supplying temporary staff to schools, and clarified that responsibility for the decision-making process regarding information contained in a DBS check is delegated to the agency and the head teacher would not be made aware of information contained in a disclosure. This case, in which a person with convictions for assault, and intelligence about violence, is employed in a primary school without consultation with the head teacher, suggests either that the system is not working, or that delegation to the agency for these decisions is not safe. The Review does not suggest that Alex was not suitable for that employment, but the head teacher should have been aware and empowered to make the decision about placing him in the school. In discussing these concerns in the Overview Panel, it appears this is just one issue regarding the current DBS system. The outcome is that, separately to this DHR process, the Domestic Abuse Coordinator will request Leeds Safeguarding to investigate the matter.

3.2.3 Nursery:

The manager of the nursery attended by the baby of the family, where staff had daily contact with either mother or father, confirmed there was no indication of conflict in the family, and staff had not observed behaviours in baby that might indicate she was living in an abusive household. Nursery staff receive training in domestic abuse. Based on their observation of relationships, they were completely unaware of any problems at home. The nursery provider is keen to hear of the outcome of this Review and to disseminate any lessons learned and consider whether there is any learning for them.

3.3 Emerging themes - family and community

- There were a number of stressors in this relationship. Daisy was a successful business woman, more aspirational and earning more than Alex, and at times he was financially dependent on her. There were issues about him doing his share of housework when he was at home full time. There is a suggestion of financial tension due to Daisy wanting more time with the baby, and wanting him to get a job.
- The anecdotal information suggests the couple argued and occasionally physically fought, both reporting at times that there was abuse and hitting, and that Daisy found Alex controlling and critical of her.

- Whereas Daisy did not confide in her family, Alex appears to have felt able to disclose to his own family and friends, for example, alleging that Daisy hit him, was unstable and difficult to live with.
- They had previously separated, and it is not known whether Alex returned to the house, on those occasions, because Daisy found this was the best way of dealing with his reaction.
- The abuse in this relationship was visible to only a few friends. Daisy disclosed selectively, for example when she needed advice. Several people in Daisy's social and support network were aware of tension, but did not know about the violence.
- Several people observed that Daisy wanted to end the relationship, and became tired and lost weight, in the months after the summer of 2015, when she unsuccessfully tried to end the relationship. However, no one in Daisy's network of family and friends understood the extent of her experience until the week prior to her death.
- After the final counselling session before her death, Daisy disclosed to selected friends, asking them for back-up as she was concerned about Alex's reaction to being asked to leave. At this point, she disclosed abuse.
- There is therefore anecdotal information from several sources to suggest tension between the two, and that they verbally abused and pushed and hit one another. Daisy is known to have been an assertive, 'feisty' woman who would not have been passive in the relationship. In the final six months, something changed the balance of the relationship and from these accounts we can see an escalation, when Daisy became withdrawn, lost weight, and, as we will hear later, sought medical support because of the relationship problems. It is noted that Daisy is described as tiny, whereas Alex was large and muscular. The tragic, final attack came when she was weakened by surgery.
- Her counsellor said to police, and other information from family and friends supports the view, that Daisy did not perceive herself as a victim of domestic violence. If she failed to disclose to friends, some of whom had known her many years and would have been loyal and supportive of her, it is unlikely she would have disclosed to strangers. However, at the end, Daisy appears to have been sufficiently worried about Alex's violence, to seek and accept the advice of her counsellor, and to put specific steps in place to keep herself safe.

SECTION FOUR – AGENCY INVOLVEMENT

The following summary and analysis is based on the information provided by agencies including the IMRs. The process of preparing IMRs or other information in accordance with the Terms of Reference; the Quality Assurance process; discussions and challenge at draft stage with the Overview Panel; further exploration and the preparation of final reports, is a robust process which, in my view, has highlighted the relevant information, identified missed opportunities, recognized good practice, and been helpful in learning lessons.

4.1 Summary of agency involvement

This narrative chronology is based on the chronology provided by each agency and merged into one chronology.

Prior to the timescale:

The following information from West Yorkshire Police predates the timescale for this Review, but was considered by the Overview Panel to be relevant to understanding later events and is therefore included for context.

In 2004, whilst living at his parents' home, Alex caused damage to a kitchen door after an argument. He was arrested and received an adult caution for criminal damage. This was recorded as a domestic incident. In 2007, a former girlfriend of Alex reported to police that she was receiving abusive texts and emails from him after they broke up from a five-month relationship. He was seen and served with a Harassment Warning. Later in 2007, Alex was found guilty of battery (an unprovoked assault on a bus driver) and at Magistrates' Court received a fine of £80 plus compensation and costs. In police custody, a risk assessment stated that he was taking medication for depression and was receiving treatment. In 2009, an anonymous report of a domestic incident involving Alex, his sister and her husband led police to attend. Both Alex and the other male had been out drinking and argued; his sister became involved in this. Alex drove off, colliding with his sister; it was recorded that he may or may not have been aware of this. The incident was recorded as a non-crime and it is not clear if Alex was spoken to about the incident. A month later, Alex made a complaint to police alleging his sister and her husband had taken out credit cards in his name. He stated that he planned to start working with children and was worried about the implications of a

conviction. It was recorded that the allegations were unfounded and no further police action was taken. In 2011, police attended a fight between Alex and another man, in which they were using bottles and glasses as weapons. Both were arrested for affray and taken to hospital for treatment. Alex suffered a broken right hand; the other man had a cut head and minor injuries. Alex claimed he had fought in self-defence, and was not charged due to insufficient evidence.

Daisy was also known to the police prior to the timescale, in that she reported items that may have been stolen by her ex-partner in 2011, and said that she was being harassed with texts and messages by him.

There was nothing relevant to this Review in relation to the contact between either Daisy or Alex, with GP services prior to the timescale. Neither was previously known to other health or social care services.

Within the timescale:

West Yorkshire Police is the first agency to have had contact with Daisy and Alex as a couple. In July 2012, Daisy reported that following an argument, Alex had left in the car and she was worried because he had been drinking, was depressed and had hinted that he would kill himself. He was recorded as a missing person. A police officer contacted him on his mobile phone and was reassured that he was fit and well and wanted time to himself. He presented himself to a police station the following day, stating he would seek counselling from his GP as he felt low, was out of work, had recently failed his re-sit exams for teacher training; and had experienced deaths of loved ones in recent years. He returned to his mother's address. The police officer recorded a domestic incident between Alex and Daisy and completed a DASH risk assessment as required by Policy, assessing the risk as Standard.

The first relevant engagement with health services was in 2013, when Daisy was pregnant and was offered smoking cessation advice. She commenced ante natal care with BTHFT. The record shows that routine inquiries regarding domestic abuse and Daisy's emotional wellbeing were completed. There is no record of a safeguarding care plan; the IMR author checked and confirmed that this indicates there was no disclosure of abuse.

In 2013, whilst pregnant, Daisy consulted her GP regarding panic attacks, citing relationship issues and financial stress as two reasons. Her partner, Alex, contacted the GP in between her appointments to say she was self-harming and suicidal. The GP confirmed with Daisy that she had no thoughts of self-harm. The following week, the GP completed a biopsychosocial assessment in relation to the partner issues. Whilst the GP did not document why there was this high concern, extra support was provided during this time, including telephoning Daisy when she did not attend an appointment. She told her doctor she was attending counselling at Relate (the scoping identified no record of contact with Relate and it could be a misunderstanding of Daisy stating that she was working with a counsellor, i.e. her own private therapist, as part of her training to be a counsellor). Daisy was referred to the Primary Mental Health Team. During a telephone consultation with the Primary Mental Health Team, Daisy was asked about "risk to others and from others" and it was documented that there was none. It was recorded that as she was involved with Relate (see above), due to arguments with her partner, it was inappropriate for Daisy to see two different counselling services and she was discharged.

The next contact between Daisy and her GP Practice was in early 2014 when the newborn baby was registered with the Practice. There followed several contacts in relation to attending post-natal, baby massage, and treatment for baby's minor illnesses. The next contact relevant to the domestic situation was in the summer of 2015, detailed below.

During her pregnancy, Daisy attended ante natal appointments with midwives. No concerns were recorded from any of these appointments. The baby was born at home with Alex present, with the support of midwives and without complication. The following day, the baby was admitted to hospital due to low birth weight, which the Review was informed is routine monitoring, and went home the same day.

The health visiting service first became involved with the family following the birth of the baby. In 2013, it was good practice to invite parents for an ante natal contact by letter. There is no recording of parents accepting the offer. No assessment of concern was passed from midwifery colleagues. A home visit took place following the birth of the baby, to introduce and explain the health visiting service and to commence a programme of planned contact. Both parents were present and the health visitor noted good interaction and effective attachment towards the baby. No concerns were identified. As both parents were present,

domestic abuse was discussed with them together, as a public health message. Discussion in the Overview Panel established this is normal practice, as both parents would then know that support was available from the health visitor should they need it in the future; and the health visitor would then find the opportunity for one to one inquiry about domestic abuse in their later contact. It was confirmed that this took place.

Contact between the health visiting service and the family continued in line with expected standards of service. At the 6/8 week review, a maternal mood assessment was carried out by the health visitor, and Daisy indicated she was coping well with support from her partner, mother, mother-in-law and friends. No concerns arose from this assessment. Subsequently, Daisy attended baby clinic and a series of infant massage classes. Her partner, Alex, attended one of these classes. At the 3/4 month visit to the home, the health visitor reviewed the health and development of the baby, and carried out a maternal mood assessment. Daisy reported continued support from her partner and family, and no feelings of low mood. The health visitor recorded no concerns. The next contact was in late summer 2014, when the health visitor called at the home, and met Alex, who said he was unaware of the appointment and preferred to speak to Daisy first. The health visitor left contact details.

The following day, the health visitor received a message from Alex and telephoned him. The records state that on the telephone, Alex was distressed and tearful, and alleged that he was being abused by Daisy, giving details of physical, emotional and financial domestic abuse both historical and current. He said this had been going on prior to the birth of the baby but had escalated since the birth. He alleged Daisy withheld money from him and blackmailed/ bribed him into doing chores; threatened to kick him out of the house, and had belittled and insulted him and had to use physical restraint to defend himself. Maternal mood was discussed briefly and Alex reported that Daisy was denying any depression. He reported not being depressed but feeling stressed due to what was happening. The health visitor offered a home visit for the same day with her colleague. The purpose of this visit was to assess risk to the baby.

Prior to the visit, the health visitor discussed the matter with the Integrated Assessment Team's Health Representative (IATHR) within Children's Social Care (CSC). The IATHR liaised with police who advised that Alex should leave the home with the baby.

The home visit took place the same day, a newly qualified health visitor being accompanied by an experienced colleague. Alex's mother was present during some of the visit. It is recorded that Alex repeated the details of the alleged abuse. The health visitor assessed Alex to be genuinely in fear for the safety of the baby and himself and identified him as a victim. Offers by the health visitors to support Daisy were seen by Alex as potentially increasing risk to the baby and himself. It was noted that throughout the visit, Alex continued to attend to the baby's needs and had a good level of interaction with the baby. The baby's development was observed to be within normal limits. The health visitors, when interviewed for this IMR, indicated they had never seen a man so distressed and continued to feel that Alex was genuine in his disclosures and his concern. It was asked whether concern for Alex was a block to Daisy being offered support and this was not felt to be the case.

The health visitor supported Alex to contact the police while at his home and officers attended. He repeated the allegations, but stated to the officers that he was seeking advice rather than reporting an offence. He then stated he had not been assaulted by Daisy, but she did not give him enough money. He alleged she had anger management issues and may be suffering post-natal depression. He stated he did not need further police assistance and would discuss the matter with Daisy later.

A DASH risk assessment was completed by the attending officers who assessed the risk as medium. The baby had been seen and assessed as safe. Alex's previous conviction for assault and the previous alleged offences regarding assault and damage were not referenced on the DASH form. A domestic violence pack was sent to Alex, and a child protection referral was made to CSC. There was no contact between the police and Daisy, which was discussed in the Review and the IMR author established that as Alex had asked for there to be no contact, and he was the reported victim in this event, the police would not have had the authority to contact Daisy.

The health visitors discussed a safety plan with Alex, informing him of the referral to CSC which he agreed with; and discussed his leaving the house with the baby. His mother who was present said she would support him with this. He was given information about how to contact specialist services including the helpline for male victims of domestic abuse, and legal support.

The health visitor contacted Alex by phone later the same day, when he said he had been visited by the police. He stated he did not want Daisy to be arrested. The following day, the health visitor liaised with the IATHR and was advised to contact Alex to review the situation. It was agreed during that liaison, that the contact would not be progressed to a CSC referral until the update on the situation was known. The health visitor went to the house the following day, when Alex repeated some of his allegations, but said he was fine. He was again given information about local and national male domestic abuse support services, which he said he intended to phone. It was recorded that the baby was observed during this visit and there was no worrying behaviour.

The following day, i.e. on the third day following Alex's initial disclosures, the health visitor carried out a further home visit, focusing on the baby's development and presentation to assess the impact of domestic abuse. Alex reported Daisy was tired due to breast feeding and working. He appeared much calmer in presentation and reported that he intended to find a teaching job. The health visitor recorded indicators of family stressors, but assessed that there was no risk to the baby, and recalled in interview with the IMR author that the situation had quickly de-escalated. The health visitor planned to contact Alex the following week, liaise with IATHR, and invite Daisy and the baby for the 6/9 month review, which would be an opportunity for Daisy to disclose any concerns she had.

The health visitor liaised with IATHR where a Specialist Health Visitor Review was undertaken. The records of both CSC and the health visitor indicate that no child protection concerns had been identified, the case did not reach the threshold for Children's Social Care intervention, and there was a joint decision not to progress the case for further assessment by CSC at this point. In CSC, where this was the first contact with the family, the contact was recorded as information only. In the health visiting service, the information was recorded on the safeguarding template on SystmOne (the electronic record). CSC records indicate that the notification of the incident from the West Yorkshire Police was received regarding the same incident and, in keeping with those discussions, a decision was made by the CSC team manager (in IAT) that no further action was required.

Following this, the health visitor sought advice from the BDCFT safeguarding team, which was expected practice. The team advised that during assessment with the family, the health visitor should consider the pre-MARAC risk indicator checklist with Alex to establish the

level of risk to which he and the baby were exposed. This was not actioned as the health visitors felt the situation had de-escalated and the height of this period of intervention had passed.

Five days later, the health visitor took a telephone call from Alex stating that Daisy had thought about driving into a wall and self-harming following a disagreement. The health visitor gave advice in relation to encouraging Daisy to access her GP and gave him numbers for the crisis mental health team and Accident and Emergency. The health visitor then contacted Daisy, as planned during the earlier visit to Alex, to invite her for the baby's 6/9 month review and undertake a maternal mood assessment. Daisy attended this appointment, which was set two weeks following the original report. No concerns were identified for the baby, who, it was observed, was developing well and exhibited secure attachment to Daisy. The record documents a thorough assessment of Daisy's maternal mood using the Edinburgh Postnatal Depression Score. Daisy's overall score did not indicate a depressive illness. She identified some family stressors including work, running her own business, and family finances. However, Daisy declined any support around her mood reporting that she was fine. Records indicate that the health visitor used probing questions but Daisy made no disclosures and stated she had good support from her partner and friends.

One week later, the health visitor telephoned Alex, who reported that things had improved between himself and Daisy, with no further arguments. Subsequently, contact with the health visiting service returned to core contact, as there had now been three positive maternal mood assessments over a nine-month period, Daisy was not making disclosures, and Alex had no concerns.

Three months later, an appointment letter was sent to parents for the baby's 2-year developmental review. This was the last contact with the health visiting service.

Eight months after these events, in the spring of 2015, Alex telephoned the Police and reported that Daisy had driven off, stating she wanted to kill herself and was thinking of driving off a cliff. He stated she had cut herself before. The baby was with Alex. An officer telephoned Daisy who stated she was fine. Police attended her, parked in a car park, and she explained she had driven off after a verbal argument regarding paternity leave. It was established she had no intention of carrying out her threats which were made in anger to

upset her partner. Officers attended the family home and observed that the baby was safe and well.

A DASH risk assessment was completed though it was unspecified to whom the risk factors applied. The incident was assessed as standard risk.

Police made the standard notification of a domestic incident in which a child was present, to CSC. CSC received this as information only as there was no indication of risk to the child and it was graded by the police as a verbal dispute; it was not felt that there was any intent by Daisy to act upon the threat made. This contact was recorded by CSC as the first contact regarding domestic abuse.

West Yorkshire Police had no further involvement with the family until the homicide investigation.

In the summer of 2015, Daisy consulted her GP about pre-menstrual tension symptoms which were 'putting a strain on the relationship' and was given advice. Domestic abuse was not discussed.

Several weeks later, Alex registered at this Practice, transferring from a Practice in Leeds. The IMR author has reviewed the visible records for Alex prior to this date, and advised that there is nothing relevant to the Review.

In the autumn of 2015, Daisy consulted her GP about 'family issues' and was prescribed anti-depressant medication. There is no documentation of a discussion in relation to these issues and no indication that a question was asked about domestic abuse. However, two weeks later, in a follow up consultation, the GP records that 'safety advice' was given to Daisy.

During the same month, both Daisy and Alex took the baby to the Accident and Emergency Department (AED) with a raised temperature. The initial diagnosis was tonsillitis and the baby returned home the same day. The Safeguarding Children section of the AED document was completed and all questions were answered 'no' indicating there were no concerns in relation to the baby.

Daisy next attended the GP at the beginning of 2016, when she was referred to private hospital for a minor surgical procedure. She had a telephone consultation in the week following the procedures, concerning post-operative pain, and was given advice. This was the final contact between Daisy and any of the agencies.

4.2 Analysis of agency involvement

4.2.1 Police Service

Analysis of involvement

West Yorkshire Police Service had the most substantial involvement with the couple, with three domestic incidents dating back to 2012. There was prior information about Alex as a single man, which concerned a caution for damage (2004), a conviction for battery (2007), the report of a former girlfriend about abusive texts (2007), and two other violent incidents involving police attendance (2009) which had not resulted in a charge.

Both Alex and Daisy are recorded as suspects in the incident of July 2012, Daisy is recorded as the suspect in the incident of 2014, and both are recorded as suspects in the incident of 2015. In the two incidents where one or other of the parties drove off after arguments, it is notable that officers took steps to locate the parties urgently, and ensured there was face to face contact and that they were reassured about their welfare.

In the incident in 2014, when Alex alleged he was a victim of abuse, Daisy was not spoken to by police officers. The IMR author notes this was contrary to Policy which is to locate and check on the welfare of the suspect. In both the reported domestic abuse incidents, it is not recorded if any consideration was given to referring Alex's mental health concerns about Daisy, to health professionals. Force Domestic Abuse Policy sets out the actions that officers should take if it is apparent that the victim or suspect has mental health issues. This includes consultation with the designated mental health triage nurse and obtaining details of services involved with the person, irrespective of the wishes of the individual. The officers were asked by Alex not to contact Daisy following this incident, so there would be a professional reason for this; however, it could have been considered in the spring of 2015 when Daisy was seen.

During the Review, there was discussion with the police about whether prior information about Alex's history of anger management issues ought to have been cross-referenced with the domestic incidents. With the benefit of hindsight, the question was raised whether, when he was disclosing being the victim of domestic abuse, this was genuine, or whether – a question raised by the Terms of Reference – this was an example of controlling behaviour; and taking account of his previous aggressive behaviours in domestic settings might have clarified this. Also, had Daisy been seen by officers and informed of his allegations, might

she have had the opportunity to respond and report her own experience of domestic abuse, which may in turn have initiated a different response to this, and to the later incident in 2015? As referenced elsewhere, there is no evidence that Daisy would have disclosed, however the Review process raised the question of whether this had been a missed opportunity. As such, the Overview Panel discussed whether Alex's previous behaviour should have been probed further by police attending the domestic incidents. In several discussions with the IMR author and the police representative on the Panel, it was clarified that the officers were following common practice. Alex presented as a victim, and as a victim, it was not appropriate to consider his previous convictions. The officers attending did not doubt his disclosures. He asked police not to contact Daisy, and he did retract the seriousness of his concerns, stating that he had not been hit and that he could discuss the problems with Daisy; and the officers would have been reassured by this. As this happens often – for informing a perpetrator could raise the risk to the victim – police are minded to follow the victim's wishes. Whilst police attended, no offence was disclosed, and therefore the risk assessment was based on the victim, i.e. Alex's, information. Whilst it would be policy to speak to the perpetrator, the Review established that the officer's judgment would be an acceptable reason not to do so.

It was noted by police during the Review that Daisy had an opportunity for disclosure in the incident of 2015 when she was one-to-one with a police officer concerned for her welfare. Anecdotal information suggests this could have been the beginning of the fatal escalation, referenced later in this report, yet Daisy did not disclose.

In terms of safeguarding children, the West Yorkshire Police decisions and actions in dealing with the incidents of 2014 and 2015 complied with the Force's Domestic Abuse Policy and the local Safeguarding Board procedures. The baby was seen by police officers and the details of this observation included on the DASH risk assessment; notifications of a child being present during a domestic incident were promptly made to Children's Social Care.

Lessons learned

Previous domestic homicide reviews in West Yorkshire have identified that awareness and understanding of coercion and control has been limited amongst police officers and staff and a programme of training has been implemented to address the new legislation (s76 of the Serious Crime Act was introduced in December 2015). The events described in this Review

predate the new legislation and, were it to occur now, WYP has expressed confidence that officers attending would be aware and alert to issues of coercion and control.

This Review has identified two areas of improvement for West Yorkshire Police:

- That officers must complete comprehensive DASH risk assessments for both parties when the victim is unclear.
- In cases where mental health issues are known or suspected consideration needs to be made to refer these concerns to the appropriate health professionals as provided for by the Force Domestic Abuse Policy.

4.2.2 Midwifery Service

Analysis of involvement

There was good evidence of practice that met the expected standards throughout this Review. Specifically, there was a record of the question relating to concerns regarding domestic abuse having been asked. The record does not indicate the outcome of the question, however the IMR author established that if there had been a disclosure then a Safeguarding Care Plan would have been devised and kept separate from the pregnancy document. This is because the pregnancy record is a patient held record, and a more detailed record might place a woman at risk.

Similarly, there is evidence that questions relating to emotional wellbeing were asked and that there was no disclosure to indicate maternal low mood.

There was no evidence in BTHFT records that Daisy experienced domestic abuse. It does not appear there were any missed opportunities for staff to enquire further about domestic abuse.

Lessons learned:

Since these events, a new electronic system (Medway) has been implemented. This system has a function within it that prompts the midwife to ask the question about domestic abuse, and continues to prompt until a response is recorded.

4.2.3 Health Visiting Service

Analysis of involvement

The maternal mood assessments were in line with the Well Child Quality Standard (2011) and NICE Guidance (2006). However, when Daisy became engaged with the health visiting service, it was not known that she had been referred to the Primary Mental Health team. In current practice, BDCFT has an antenatal standard (2015) which states all women are offered a face to face contact, part of which will focus on mental health.

There was a discussion in the Overview Panel as to whether the service could have been more proactive in engaging Daisy, after Alex made the disclosure in September 2014. This was relevant because it could have provided Daisy with an opportunity to make her own disclosure of domestic abuse, had she known that Alex had made the allegations against her. The family raised this as a concern. When Alex made the disclosure, he was presenting himself as the victim, and Daisy as the perpetrator. Alex's presentation as a victim appeared to the health visitors to have been completely genuine and there was no reason to question the truth of his account. The health visitors interviewed for this Review continued to reflect on Alex's mood and the depth of detail of his disclosures and his distress. The role of the service in domestic abuse is to recognise and respond. Practice focuses on understanding risk and impact for a child living within domestic abuse whilst signposting victims to access specialist services. Health visitors work most closely with mothers and therefore it is mothers who present more often as victims. During this Review, the Service has clarified that their role with perpetrators, should there be a disclosure, would be to signpost to services. In this case, they responded by ensuring Daisy was seen, when invited for the baby's next review, by the health visitors who had met Alex, and undertaking a maternal mood assessment along with probing questions to provide an opportunity for her to disclose.

Therefore, the health visiting service evidenced that the response to Alex's disclosure was the same as it would be for any victim of domestic abuse, irrespective of gender. The health visitors scrutinized their practice to consider the dilemma of working with a male victim and of understanding the truth of a disclosure. They demonstrated that overall, their concern was to ensure protective factors were in place for the baby.

At the point of the 2014 disclosures, Alex told health visitors that both he and Daisy used cannabis and small amounts of alcohol occasionally; the health visitors found no evidence of substance misuse or mental ill health during any contact with either parent, therefore they had

no observable concerns. Records suggest lifestyle advice around substances and alcohol was discussed with them, as with all parents, at the birth visit.

The health visitors demonstrated that they were alert to family stressors, and identified Daisy's return to work, family finances and Alex's desire to return to work as factors present.

The health visitors were able to demonstrate that they understood the effects and impact of domestic abuse on children by increasing contact, in order to create opportunities to observe the baby's behaviour, and to assess any risks to the baby. The records evidence that they actively observed the baby's behaviour during these visits. They shared information appropriately with CSC. They also facilitated three maternal mood assessments with Daisy and liaised with the wider health visiting team to do so. All contacts were in line with BDCFT Safeguarding Policy. Daisy's family had raised a question about whether staff were sufficiently trained in being able to observe behaviours indicating that very young children might be affected by domestic abuse in the household. This was therefore addressed in the IMR, and discussed in the Overview Panel. The service was able to evidence, through records, that the health visitors had in mind on each occasion, when they observed the baby, possible impact of domestic abuse in the household, and the family can therefore be reassured on this point.

The health visiting service, alongside the police service, had the most significant contact with the family. The Review saw evidence that the health visitors were responsive to the disclosure of domestic abuse, acted accordingly to signpost, share information, support Alex to contact the police, and maintained an overall view of the safety of the baby. The theme of family stress was also evidenced and this was later discussed with Daisy, who told health visitors she had a network of support. The health visitors raised their contact significantly during the time of concern, returning to core service standards when they were informed by Alex that the situation had been resolved, having first visited to observe the baby and assess that there were no observable risks. The maternal mood assessment at the baby's review visit to clinic would have been an opportunity for Daisy to disclose, had she wished to do so.

The health visitor took the advice of a specialist practitioner in safeguarding who advised that the MARAC checklist should be completed. This was not done. In discussion in the Overview Panel, it was established that Alex may not have consented as he refused to allow

the police to take the matter further, and, had it been completed, the concerns would not have met the threshold for referral to MARAC. Nonetheless, best practice would have been to follow the advice of the specialist practitioner.

Lessons learned

The health visiting team demonstrated awareness of coercion and control in domestic abuse through this Review. The law has changed since, and the team reported being more aware of the impact of coercive and controlling behaviours now it has been given the weight of the law. BDCFT safeguarding team has been trained around coercive and controlling behaviour and the safeguarding team has developed a new domestic abuse course which has been piloted and is to be included in the training on offer in 2017. To support this, BDCFT safeguarding team publishes a quarterly newsletter which is available to all staff and will ensure that domestic abuse is a standing item within this.

The IMR Author noted that in interviews, staff reflected on the level and complexity of domestic abuse, and concluded there is a need for one overarching policy for BDCFT to provide staff with best practice guidance and a robust framework.

The Review has underlined the importance of following the advice of specialist safeguarding practitioners. Whilst subsequent events indicate that this was not a missed opportunity, best practice is to follow the advice of specialist practitioners. In discussion in the Overview Panel, it was considered that health visitors are much clearer and familiar with MARAC processes today than they were in 2014.

4.2.4 General Practice

Analysis of involvement

There were 57 contacts with professionals at the Practice within the timeframe and all were in line with usual or good practice. Most contacts were for medical advice and treatment. This appears to have been given in a timely and effective manner.

The first relevant contact with GPs concerned panic attacks and stress when Daisy disclosed relationship and financial issues, in 2013. Records imply that at least one of these contacts

was prompted by the partner, Alex, saying she was suicidal and self-harming. She was contacted by the GP promptly and referred to Primary Care Mental Health Team for support but there appears to be some confusion and she was referred again. The GP record indicates she did not attend the appointment, however, the BDCT IMR explains this was because she was already engaged in counselling and it was agreed that she should not attend two counselling services. Daisy did have a telephone conversation with the Primary Mental Health Team in which it was documented that she stated there was no risk to others or from others.

During the Review, it was mooted that the disclosures from Alex, in 2014, might have been visible to Daisy's doctor when she was seeking support for family issues, and it was clarified that this was visible on Alex's record, but not Daisy's. As such, her GP would have been unaware of this background.

In the second half of 2015, Daisy consulted her GP seven times, four times in relation to a medical issue and three times in relation to issues related to mood disturbance, which she described as arising from strain in the relationship, and family issues. She was prescribed anti-depressants (fluoxetine) from this time.

The IMR Author analysed the service against contemporary practice standards and found no instance of serious or significant clinical or systematic errors. The Practice evidenced good continuity of care, good access and appropriate length of appointments. The delivery of care was generally flexible and responsive to clinical need.

Routine inquiry about domestic abuse, is not expected by GPs at every contact. The post-natal check is one opportunity where it could be considered good practice, however, post-natal checks are undertaken infrequently by GPs; routine inquiry is built in to Health Visiting and Midwifery pathways. However, the IMR Author concluded that a potential opportunity to ask about domestic abuse was missed at Daisy's postnatal appointment and there were two further potential opportunities to ask about domestic abuse, i.e. the consultations in 2015 in which Daisy disclosed strain in the relationship. It is recorded that the GP offered 'safety advice' but this was not further explained.

With hindsight, it is possible to identify that Daisy had escalating wellbeing and safety issues during the second half of 2015, the significance of which could not have been appreciated at the time. Daisy was accessing private counselling during this time.

Lessons learned

GPs had received safeguarding training and had a good awareness of domestic violence, however the IMR Author noted a lack of confidence amongst practitioners around how and when to enquire about domestic abuse and how to respond if someone makes a disclosure.

The Post-natal check undertaken by the GP is an example of good practice, but is also a missed opportunity to inquire about domestic abuse. NICE guidance is ambiguous as to whether GPs are specifically required to enquire about domestic abuse at this consultation. However, the IMR Author believes that it would be beneficial to raise awareness amongst GPs that inquiry at post-natal checks would be good practice.

There are well-established systems for targeted enquiry within pre- and post-natal pathways, with direct questions around domestic abuse being asked by both health visitors and midwives. In addition, a maternal mental health pathway is in place. The IMR author believes that a specific question about domestic violence within in the maternal mental health pathway template~~,~~ may have helped the GP to ask the question of Daisy. In discussion in the Overview Panel, it was noted that a recommendation from a previous DHR is already being actioned, relating to domestic violence inquiry and prompts being added to relevant SystmOne templates.

When Daisy disclosed relationship issues and mood disturbance, this may represent another missed opportunity to ask about domestic violence. However, the GP clearly recollected during the IMR interview that Daisy had been reserved and not forthcoming about her relationship and a direct inquiry may not have changed the outcome.

The IMR Author recognized the need for continued training and awareness for GPs, particularly in risk factors such as post-natal mood disturbance and disclosure of relationship issues.

One development – not a result of the present case – is the appointment of a Domestic Violence Manager within the CCG since September 2015, to promote good practice, raise awareness and advise practitioners in relation to domestic violence situations across primary care.

4.2.5 Children's Social Care

Analysis of involvement

The first contact with CSC was following the incident of 2014 when there was a discussion between the health visitor and the specialist health visitor within the Integrated Assessment Team (IAT). The outcome was that no child protection concerns had been identified, and the health visitor and CSC team manager in the IAT agreed that as it had not reached the threshold for Children's Social Care intervention, the contact would be recorded as information only.

The second contact, in 2015, was recorded as the first contact regarding Domestic Abuse. It was not cross referenced with the previous incident. It was the internal report author's view that, had it been cross referenced, a short assessment by IAT should have been considered at this stage. An outcome could have been signposting to Early Help. Other information available to this Review raises the question of whether the parties would have accepted an offer of help.

Lessons learned

Since this time Children Social Care has changed the way the service deals with all Domestic Abuse notifications. There is now a bespoke partnership team which deals with domestic abuse notifications received from the Police; all these notifications have a duty social worker review and are allocated for assessment or directed to universal or targeted services. As such, there are no notifications which now would not result in an action.

SECTION FIVE – CONCLUSIONS AND LEARNING LESSONS

This section reflects on the findings of the IMR Authors, discussions and further information received, and the views of the Overview Author following independent scrutiny of the information provided.

5.1 Critical Path

From the broad range of information provided by chronologies, police case summary, and information from family friends and members of the local community, as discussed in this Report, the events that stand out as having been significant in leading to the tragic death of Daisy in early 2016, appear to be:

Summer 2012

Daisy reported to police that Alex went off after a row and she was concerned. He was located and the matter resolved.

Autumn 2013

Daisy was referred by her GP for counselling for family issues. The GP made a referral to Primary Mental Health. It was recorded that Daisy was already in counselling and agreed with her that it was not appropriate to work with two counsellors.

Late summer 2014

The baby was nine months old when Alex disclosed to the health visitor that he was being abused by Daisy. He was supported to contact the police. HV and CSC make a joint decision not to proceed. Police gave Alex advice and completed DASH relating to Alex only as he told police he did not wish Daisy to be contacted and retracted allegations of physical abuse. Alex later told HV the issues had settled down. Subsequently, HV met Daisy at baby's review and undertook a maternal mood assessment; there were no contra-indications.

Around the same time, Alex told a friend he had concerns about Daisy harming herself.

Early 2015

Daisy disclosed to a neighbour friend that Alex was violent. The neighbour spoke to Alex who admitted this.

Spring 2015
Alex started work as a teaching assistant at Primary School.

Summer 2015
Alex reported to police that Daisy had driven off after an argument and he was worried as she had threatened to harm herself. She was located and reassured police she had no intent to harm herself; she subsequently returned home. DASH assessment was completed by police.

Daisy disclosed to a friend that Alex was violent.

Daisy described strained relationship and family issues to GP.

Late 2015
Daisy was prescribed anti-depressants by GP.

January 2016
Daisy underwent a minor operation.

Two weeks later, she attended the final private therapy appointment and discussed exit strategy from relationship. She was advised to speak to 2 friends.

The next day, Daisy disclosed to 2 friends as advised, and asked for their support when she asked Alex to leave. A friend arranged to stay, the following day.

The following day, Daisy asked Alex to leave and changed the locks.

The following day was the date of the tragic event.

5.2 Emerging themes in relation to the Terms of Reference

This section considers missed opportunities, good practice, and lessons learned that have been identified during this process, in relation to the terms of reference. It follows the headings in the terms of reference. This is the analysis of the Independent Author, based on information within the IMRs, discussion with IMR authors and the Overview Panel, and information from family and community involvement.

General Questions concerning domestic homicides:

1 *Was the incident a 'one off' or were there any warning signs and were opportunities missed?*

The relationship became increasingly abusive; with the benefit of hindsight, there were warning signs and a clear escalation in the final six months, especially in the final month. However, anecdotal and recorded information and evidence indicates the victim disclosed selectively and to friends who were not connected and could not have shared this information sufficiently to see it as a pattern, more than a one-off, or a side effect of having two strong characters clashing. Daisy did not disclose to professionals at any time, though she referenced relationship issues in conversation with her GP. The cumulative events were not visible to any one person or agency, and the Review suggests that because there was no composite picture, no one could have predicted the outcome or taken action in that final period of escalation.

The analyses by IMR authors highlighted several opportunities in which more could have been learned about the dynamics in this relationship. A lack of guidance and systems to enable GPs to make a routine inquiry, in the way that is established on the midwifery and health visiting pathways, could have helped GPs to ask questions when Daisy presented with mood disturbance in the second half of 2015. However, one GP clearly recalled that Daisy had been guarded when asked about the issues causing her problems, and she did not take the opportunity to disclose.

The police on two occasions omitted to include Daisy in the DASH risk assessment. Had they done so, it could have offered an opportunity for Daisy to give her perspective. The most significant event was in 2014, when Alex presented her as the perpetrator, unchallenged. It

has been clarified that Alex, as the victim on this occasion, asked police not to contact Daisy, a decision that professional practice supports as it is victim-focused and appropriate. Whilst the Review knew about Alex's previous convictions/ intelligence about his behaviour, which gave us cause for scepticism about his presentation as victim, it was established that it would not have been appropriate for the police to take this into consideration when he presented as a victim. Neither the police nor the health visitors had cause to doubt that his disclosures were genuine.

Had Daisy been included in a DASH assessment, and become aware of his disclosure, it is possible that – from what is now known of her personality – she may have been driven to disclose her own experience of abuse. In that case, she may have decided to end the relationship then. This is a perspective based on hindsight; we established that, without Alex's agreement, Daisy could not have been included in the risk assessment.

It is completely understandable that Daisy's family believed either the health visiting service or Social Care missed an opportunity by not speaking to Daisy about what Alex had said, in 2014. During this Review, we have established that it is not part of the health visitor's role to discuss domestic abuse with alleged perpetrators (which is unfortunately how Daisy was being presented by Alex at that time), and therefore this was not a missed opportunity. As there was no case in Social Care, this could not have happened.

2 *Did Daisy have any contact with a specialist domestic violence organisation or helpline?*
There is no evidence that Daisy had contact with these services at any time.

3 *Did agencies have an opportunity to refer Daisy to a domestic violence organisation and if so did they? If not, why not?*
There is no evidence of any agency having an opportunity to refer Daisy for support. There is evidence that Daisy herself sought support, by using her private counselling to discuss exit strategies for her relationship. We have not been able to discuss with the therapist, whether this practice has training in, and strategies for advising, in domestic abuse.

4 *Were any barriers experienced by Daisy or her family / friends / colleagues in reporting any abuse in Bradford or elsewhere, including whether they knew how to report domestic abuse should s/he have wanted to?*

The Review heard that Daisy did not see herself as a victim of domestic abuse, and disclosed selectively and in such a way that no one person or agency had a picture of her as a victim of domestic abuse and the opportunity to refer her for support. In the final days, when she was clearly worried about Alex's potential for violence, one friend advised her to contact Women's Aid, and she did not.

5 *Is it known whether Daisy experienced abuse in previous relationships, and whether this experience impacted on her likelihood of seeking support in the months before s/he died?*

There was anecdotal evidence from a friend that Daisy experienced abuse in her first marriage, and some information to suggest a previous relationship had been conflicted, which was not confirmed in any other information received in the Review. The greatest barrier to seeking support appears to have been Daisy's own reluctance to disclose or perceive herself as a victim. She did ask for help from friends over the last weekend, when she was intending to ask Alex to leave, which is a very clear indication that she was concerned for her safety.

6 *Were there opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Daisy, were such inquiries were undertaken or were any opportunities were missed?*

The Review evidenced that routine inquiries were made by midwives and health visitors according to practice standards. When Alex attended ante natal with Daisy, the health visitor gave domestic abuse information and advice as a public health message to both parties, which is standard practice.

There is no routine inquiry expectation for GPs and this could have helped in 2014 when Daisy attended her post-natal check with the GP, and in 2015 when she presented with stress arising from relationship issues.

7 *Did Alex have any previous history of abusive behaviour to an intimate partner and was this known to any agencies?*

Alex had previous history (2007) of sending abusive texts and emails to a former girlfriend who said Alex could not handle the fact that their relationship had finished. He was seen by Police and served with a Harassment Warning. This information would have been directly relevant and supportive had Daisy disclosed. When he presented himself as a victim of domestic abuse perpetrated by Daisy, police followed their professional practice standard in being victim-focussed; therefore, his previous history was not cross referenced. Had he not

retracted his report of physical abuse, and asked police not to contact Daisy, this may have led to her disclosing her own experience of domestic abuse.

8 *Were there opportunities for agency intervention in relation to domestic abuse regarding Daisy, Alex or the child that were missed?*

The Review concluded that there were no opportunities for intervention because there was no disclosure. However, as described above, opportunities which could have led to Daisy disclosing, were missed.

9 *Could more be done to raise awareness of services available to victims of domestic violence?*

The missed opportunities do not appear to be a result of lack of awareness of services available. Both police and health visitors, when responding to Alex's disclosures in 2014, demonstrated awareness of services.

Arguably, Daisy's counselling service could have directed her more proactively towards services when she disclosed in the period just prior to her death. However, in interview with police, the counsellor noted that Daisy did not see herself as a victim of domestic abuse, a view supported by the evidence that she did not disclose, and she would therefore have been unlikely to take up services. Considering Daisy's reluctance to disclose, the counsellor's advice about keeping herself safe, and including friends in a safety plan, was good practice.

It may be that information more widely available in the community could have helped friends to advise Daisy when she spoke about domestic abuse. It would be difficult to assess how best to do this, since poster campaigns which include helpline numbers are widespread. One friend did suggest Daisy should contact Women's Aid, and there is no evidence she did so. Daisy would have been able to access information on the internet; by using her professional resources in occupational health; or through her therapy, and it is known she only used the latter resource when she became afraid of Alex's reaction to their separation. This victim was independent and private, and did not disclose her personal issues easily.

Alex's mother had no awareness of services that could help a male victim (as she believed her son to be), and there could be a need to inform the public of support services for males. It

was clear that health visitors were aware of relevant services, and gave the information to Alex.

10 *Are any training or awareness raising requirements necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the City?*

The IMRs reflect a wide knowledge and awareness of domestic abuse processes and services in the agencies. The Review also identified that widespread training is underway in relation to the new legislation on coercion and control in domestic abuse.

11 *Were any equality and diversity issues pertinent in relation to the victim, perpetrator and dependent children?*

The health visiting service considered whether the response to Alex had been different given that he was presenting as a male victim. This was found to have made no difference to the response. The police service found no evidence of a differential response by police officers. The Review questioned whether Daisy had been considered differently, when she was believed to be a perpetrator because she was a woman, and could find no evidence to support this.

The Review considered whether Daisy's heritage – her family originated from Portugal – was a diversity issue. Daisy's parents own a successful family business; she was a well-educated, aspirational business woman, who was well established in her local community with a wide network of friends. There was no evidence to suggest that culture related to nationality influenced Daisy in not disclosing her experience of abuse.

12 *Did the victim's or perpetrator's immigration status have an impact on how agencies responded to their needs?*

This was not relevant in this Review.

13 *Was the victim threatened with or subjected to 'honour based violence'. If so, did this affect how agencies responded to the victim?*

This was found to be not relevant to this Review.

Specific Questions in relation to this Review:

Q1 *Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Specifically, were practitioners alert to indicators of power, control and coercion in domestic abuse? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?*

Only health visitors and police officers became aware of domestic abuse in the household, and these professionals believed, following the incident of 2014, that Daisy was the perpetrator. Following Alex's disclosures, health visitors had contact with Daisy and at this point she had the opportunity to disclose her own experience as a victim of abuse. There was evidence in the IMRs that professionals were alert to issues of power, control and coercion (although these events predated the legislation).

It appears not to have been considered by any of the practitioners that Alex could be using disclosure as a form of control over Daisy. For example, he stated to health visitors and officers that he wanted to work, and that if he did, Daisy would have to sort out child care herself; I would suggest that, if he were not working, it was reasonable for Daisy to expect him to care for the child while she worked; however, he presented her expectation that he would do cleaning and childcare as unreasonable, and evidence of her control of him. His account was compelling, and the health visitors had no doubt that he was telling the truth. With the benefit of hindsight, I believe that either he was not telling the truth, or, he held inflexible views about gender roles and was genuinely upset by tension in the relationship around finances and Daisy's concern that he was not taking his fair share of the household duties while she worked long hours. There is anecdotal evidence of mutual verbal and physical fighting, but it appears that the balance shifted from the middle of 2015, and Daisy was undoubtedly a victim of domestic abuse by later in 2015 when she consulted her GP.

Q2 *Where practitioners were working with children in this case, are they confident of observing unusual behaviour that could signal domestic abuse? Particularly with very young children?*

The role of the health visitors in domestic abuse is to understand risk and impact for a child living in the household whilst signposting victims to access specialist services.

There is evidence that the health visitors increased contact at the time Alex disclosed domestic abuse, with the specific intention of observing the baby's behaviour to form an opinion about whether there had been an impact. They concluded through continued health visiting assessment that there was no observable impact on the baby's behaviour from the disclosed domestic abuse.

Police also have a duty of care for children in households where there is domestic abuse, and observed the baby, recording no concerns.

Q3 *Did the agency have policies and procedures for risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Does the agency guidance, and tools, for practitioners include risk assessment to identify control and coercion in domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?*

The IMR for West Yorkshire Police demonstrated that on two occasions, a DASH assessment was not completed with Daisy, contrary to Force Domestic Abuse Policy. The discussion in the Overview Panel established that the officers' response was appropriate given that Alex, who was presenting as the victim in this incident, asked them not to contact Daisy.

The timeframe of the Review predates the law concerning coercion and control. However, IMRs evidenced that staff were aware of coercion and control issues when they responded to Alex's allegations of domestic abuse.

The case was not subject to MARAC. The threshold for MARAC is a high risk DASH assessment. The DASH assessments completed indicate one Standard and one Medium risk event. The health visitor was advised to complete a MARAC checklist and did not do so; however, it is clear the case would not have reached the threshold for referral to MARAC.

There was evidence that all agencies engaged in this Review had in place policies, guidance, procedures and tools for practitioners and that these were effective, where they were implemented.

Q4 *Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols and referring cases to other agencies? How does the agency process domestic abuse referrals? Is this process effective?*

There was effective information sharing between health visitors and police and CSC during the events of 2014. A standard notification about a child in a household with domestic abuse was sent by police to Children's Social Care on two occasions and there was a decision not to forward this for assessment. The health visiting service stressed that the decision not to proceed with a CSC assessment was taken jointly. CSC has critically analysed these decisions and recognizes that, whilst the decision may have been correct, the way the information was processed could be improved, and had this been so, the second notification might have led to a referral for a short assessment.

Q5 *What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way? Specifically, is there any evidence that the agency is able to recognise, in its assessment practice, a case in which parties may be both a victim and a perpetrator of domestic abuse, and cases in which people may present as victims in order to further their control of another person?*

- The DASH risk assessments by police: on two occasions, had Daisy been included in the risk assessment, there may have been a disclosure.
- The prior information about Alex's aggressive behaviour in domestic situations, which is undoubtedly relevant to his behaviour in the final, tragic event, could not be taken into account in decision making, as discussed.
- The health visitors' assessment, following Alex's presentation of himself as a victim, was thorough and professional, and focused appropriately on the risks to the baby. In hindsight, it is known that Daisy was a victim, and that the health visitors could not have established this. They liaised with colleagues to carry out a maternal mood assessment at the next opportunity, and, had Daisy disclosed domestic abuse at that point, could have offered support and signposting; however, she did not.

- Information was passed by health visitors and police to CSC during the events of 2014, and a decision was taken with CSC management overview, considering the wishes and feelings of Alex, not to proceed to assessment. The process of decision-making has been improved by recent developments in Children's Social Care.

Q6 *Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?*

This is covered above.

Q7 *Had the victim disclosed to anyone and if so, was the response appropriate? Was this information recorded and shared, where appropriate? Include in this any response where the perpetrator presented as a victim.*

Daisy disclosed to some friends, and specifically to her counsellor and the two friends she asked to help when she asked Alex to leave the house the day before her death. She had not disclosed to any agency. In the autumn of 2015, she told her GP she was experiencing mood disturbance because of relationship issues, but was guarded and did not disclose further.

Conversely, the perpetrator presented as a victim and gave a detailed description of physical, emotional and financial abuse which was compelling.

Q8 *Was anything known about the perpetrator that could have affected the response by practitioners?*

The perpetrator had a prior history of anger management issues, who had responded badly to a previous relationship breakup, assaulted someone without provocation and received two police callouts for violent arguments with family members. This could have affected the response had it been taken into account by police officers attending the incident of 2014; however, as discussed earlier, officers were required to respond to Alex as a victim and this information was therefore not taken into account.

Q9 *Are there examples of working effectively, including good practice that could be passed on to other organisations or individuals?*

There was good liaison and exchange of information and assessment between health visitors, police, and Children's Social Care, during the incident of 2014. The outcome was flawed in that all believed that Alex was the victim, however, the information sharing process itself was effective.

Q10 *Thinking specifically about recognising and responding to control and coercion, are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?*

The law has changed since these events, and IMRs highlighted that there has been training of practitioners to reflect that change. This case raises the need for practitioners in all services to be alert to ways in which coercion and control may operate in domestic abuse. Were the events of September 2014 to happen now, most practitioners would be trained and aware of ways in which perpetrators may exert control, examples of which are discussed in this report. Understanding the complexities and subtleties of coercion and control is an ongoing development need for all professional staff. It is unusual for perpetrators to present as victims and this may not be detected by professional staff; however, it is by no means certain that this was the perpetrator's intention in this case, as discussed below.

Q11 *To what degree could this homicide have been accurately predicted and prevented?*

There is no evidence that this homicide could have been predicted or prevented. There is evidence that different actions could have led to different responses at various points during the timeframe under Review. There is evidence of missed opportunities. However, we do believe that Daisy would not have taken those opportunities to disclose. There is anecdotal evidence from friends and family that Daisy was an independent, private woman who would not have disclosed and would have expected to sort the matter out herself. There is anecdotal information to suggest that both parties argued noisily and during this they would shout and hit; and there is information to suggest that controlling behaviours may have been expressed by both, during their relationship. To this extent, there appears to have been a balance, albeit fragile. However, it is very clear that the balance in the relationship changed over the last six

months of Daisy's life, and she undoubtedly became a victim of domestic violence during this time. Daisy appears not to have seen herself as a victim of domestic abuse and to the end, even though she was evidently afraid of his reaction to the end of the relationship, believed she could resolve it herself.

SAFEGUARDING CHILDREN ELEMENT OF THE DOMESTIC HOMICIDE REVIEW

3.1 In delivering services to the family were all agencies ensured that decisions and actions taken in the case complied with the policy and procedures of Bradford Safeguarding Children Board (BSCB)?

Yes, agencies demonstrated compliance.

3.2 Did professionals from the agencies involved with the family ensure that appropriate consideration was given to potential risks specific to the children and to the children's needs, and did this consideration lead to the delivery of services that were focused specifically on the children?

Children's Social Care raised that there could be more robust review of safeguarding information received from other agencies when children are resident in households where domestic abuse is occurring. The structure and systems for managing safeguarding in Bradford has changed since the events described here, and if a contact was received from a health visitor or police officer now, this would be reviewed by social workers and managers in a structured decision-making process, and may lead to a short assessment.

3.3 Is there any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in the case?

Prior to this Review, there have been developments within the multi-agency safeguarding agencies which reflect lessons learned in other Reviews, and general multi-agency developments. Improvements include the MASH, which I am informed has led to improvements in communication, information-sharing and risk assessment. There is no learning from this Review to add to those developments.

3.4 Was appropriate consideration given to multi-agency actions to assess the needs of the children and to agree actions to provide necessary help, including early help and the provision of child protection services?

Children's Social Care recognizes that, had the recent improvements and developments been in place at the time of the events described here, there may have been a short assessment and the family might have been referred to early help services. It is not known whether the family would have accepted that help, however, it does present another missed opportunity.

An issue about DBS in employment was raised during the Review, which, whilst not pertaining to the Domestic Homicide, is a concern in relation to safeguarding children generally. The perpetrator's previous convictions and other intelligence about domestic-related violence, were not disclosed to the head teacher of the school employing him as a teaching assistant. We were informed that in agency appointments, DBS checks and decision making is delegated to the agency providing the staff. The Review has recorded concerns that the DBS checking system may not be effective and has asked for this to be investigated by Leeds Safeguarding.

5.3 Overall conclusions:

The key question for this Review has been whether action could have been taken to prevent the tragic death of Daisy. In relation to that question, taking account of all the evidence and information from agencies, family and friends, the following themes have emerged.

The perpetrator had a predisposition to violence, evidenced by his previous convictions and other relevant matters that did not lead to court proceedings, between 2007 and 2011. The first police involvement in the domestic situation in this household was in 2012 (when he went missing having made threats against himself), and there were further incidents in 2014 (his disclosures to health visitors) and 2015 (when he reported that Daisy drove away, making threats to harm herself). With the benefit of hindsight, this raises the question of whether these events, considered together, should have raised police concern about the domestic situation, and led to a more proactive follow up, for example, completing DASH risk assessments with both parties.

However, we do know that Daisy was reluctant to disclose, and proactive engagement by police may not have been effective. Alex's past behaviours, whilst being in a domestic setting, were not related specifically to domestic abuse. No person or agency had the opportunity to form a composite picture of someone who was abusing, or of someone who

was being abused. Even at the point that violence was escalating, Daisy sought to resolve this herself, was reserved with her GP, and depended on private counselling. Daisy did recognize that the point she told Alex to leave would raise the risk to herself, and at this point, worried about Alex's reaction to being asked to leave, she confided to friends the true extent of the abuse. As such, the Review finds it was unlikely that an intervention by any agency, had those opportunities not been missed, would have led to Daisy accepting support services.

There were stressors in this relationship: Daisy working, Alex not working, expectations around childcare and housework and money; Daisy's business worries; there were inequalities in the financial power, the intellectual abilities and aspirations and achievements between a successful business woman and a man who had failed in his ambitions and for a time was unemployed, creating difficult dynamics between the couple.

There are complex themes of coercion and control in this case. The Review has considered whether by presenting himself as a victim, Alex was furthering his control of Daisy. Whilst experienced health visitors found his disclosures credible, there is only anecdotal information from friends and family to support his contention that Daisy was controlling and abusive towards him. Whereas Alex had a history of violence, Daisy had no known predisposition to violence. Physically, she would have been unable to defend herself against physical abuse by Alex.

Health visitors followed current best practice in identifying Alex as a victim and responding appropriately. Since this Review was completed, further guidance has been issued for health professionals and reinforces that male victims must be taken seriously as prevalence studies show financial and emotional abuse of men in a domestic setting is by no means rare (*Responding to Domestic Abuse: a resource for Health Professionals,* DHSC, March 2017). There is nothing in this guidance to alert professionals to the possibility of an untrue disclosure.

A key element of control is where one party expresses concern for the other in a way that builds a narrative of one being rational and caring, and the other as being unstable or unreliable (see below). In this way, perpetrators engage others in controlling the victim, at the same time as drawing praise to themselves as they are seen to be considerate and caring. This is suggested as a pattern of Alex's behaviour, by the way he spoke of Daisy to family,

friends, police, and once contacting her GP to express concern about her mental health. Anderson and Umberson, (2001) describe the diverse strategies by which men retain power and control in relationships. It is suggested here, that presenting himself as the caring partner, to police and Daisy's GP, in expressing concern for her, could be such a diverse strategy, by which Alex furthered his control.

If this perpetrator did present himself as a victim in order to further his control of the victim, this would be unusual, but this was the a hypothesis discussed by Review Panel. There was certainly a financial power change while Alex was unemployed, and anecdotal information from family that Daisy expected him to do more around the house. But we have been unable to find evidence in the Review to conclusively support either the view that he was genuinely a victim, or that he presented himself as a victim to manipulate his position. We could find no directly relevant research. It is clear that Alex was genuinely anxious when he disclosed to the health visitors, and this could have reflected the violence that he was perpetrating, as well as the financial control that he reported experiencing from his partner, as described in the findings of Hester *et al* (2015). Further, Anderson and Umberson (2001) describe how male perpetrators of domestic abuse use diverse strategies to present themselves as rational and capable, while presenting the female partner as responsible for the violence of the relationship. Presenting himself as a victim may have been one such diverse strategy.

There is a significant link between controlling behaviour and domestic violence. In BMJ (2002), few women recalled being asked about domestic violence by their GP, whilst most favoured routine questioning by GPs about controlling behaviour. There is a strong correlation between women presenting to primary care with depression, and controlling behaviour (Chang, Kahle, Jameson, 2015). Whilst the IMR in this Review described NICE guidelines as ambiguous, local and/ or national clarity could usefully be developed.

This Review concludes that there was a pattern of controlling behaviour by the perpetrator prior to the final, tragic event. This Review also assesses that whilst the process has highlighted missed opportunities, as outlined in this Report, this homicide could not have been prevented by any actions of the agencies. The following recommendations aim to address both the gaps in service identified in the Review, and the need for continuous development of the services in relation to their domestic abuse practice.

References:

"*Understanding how domestic abuse is associated with greater depressive symptoms, in a community sample of female prmary care patients",* Chang, Kahle, Jameson, in *Violence Against Women* Research Paper, Sage Journals, Vol 21, Issue 6, 2015.

"*Reported frequency of domestic violence: cross sectional survey of women attending general practice",* BMJ, 2002.

"*Occurrence and impact of negative behaviour, including domestic violence and abuse, in women attending UK primary care*", Hester *et al,* BMJ, Vol 5, Issue 5, 2015.

"*Gendering Violence: Masculinity and Power in Men's Accounts of Domestic Violence",* Anderson and Umberson, 2001.

Responding to Domestic Abuse: a resource for Health Professionals, DHSC, March 2017.

SECTION SIX – RECOMMENDATIONS

6.1 Agency Recommendations

The following recommendations are from the agencies concerned in this Review. All agencies have identified lessons to be learned, some of which are developmental, as a result of closely examining an area of the service, and not remedial in relation to this homicide. Therefore, where agencies are not listed below, this is because there are no recommendations relative to this Review, for that service.

POLICE

1. West Yorkshire Police will remind Police Officers and Staff that when the victim of domestic abuse is not easily identifiable, there is a requirement to complete a DASH risk assessment with both parties independently of one another.

2. West Yorkshire Police will ensure Police Officers and Staff are compliant with the Force Domestic Abuse Policy in making referrals to Health Service Professionals when Mental Health issues are suspected or identified.

GENERAL PRACTICE

1. The CCG will request that the template for the maternal mental health pathway includes an explicit enquiry in relation to domestic violence.

2. The CCG will raise awareness as to the importance of GPs making explicit enquiry into domestic violence where

- the post-natal check is performed by the GP
- potential risk factors such as mood disorder and relationship problems are disclosed.

BDCFT

1. The Trust will recommend that all Level 3 staff working predominantly with children attend domestic abuse training to update on coercion/ control, either via the BDCFT domestic abuse course or multi agency domestic abuse training.

2. The BDCFT safeguarding team will ensure that domestic abuse is a standing item within the safeguarding quarterly newsletter.

3. The Trust will develop and produce a domestic abuse policy for the organization, led by the BDCFT safeguarding team.

6.2 Chair's Recommendations

This Review has been a process of inquiry, information, discussion and challenge, further investigation and clarification, which in the view of the Independent Chair has been an open and transparent examination, challenge, and further exploration of all that we know of the events leading to the death of Daisy, and the lessons to be learned from the agencies. As such, at the end of this process, the Independent Chair takes the view that lessons have been learned and actions taken to improve services where appropriate, and unusually, finds no outstanding gaps or queries to be addressed by a Chair's recommendation. The issue of DBS vetting which is outside the scope of this Review, has been referred for further examination.

However, this case raised issues of mutual abuse, and coercive and controlling behaviour which were often subtle and complex, and explored the difficulty of identifying the victim in such cases. Our knowledge and understanding of control and coercion in domestic abuse is relatively new and developing, and agencies have a responsibility to help staff update their knowledge and practice as new information emerges, and to enable staff learning about domestic abuse as a continuing development process and not as a training event. Debriefing the staff involved, and briefing all staff in agencies, to promulgate the lessons learned in this and other cases, should therefore be a priority for the Partnership.

In feeding back on the first draft of this Report, the Home Office Panel made the following suggestions which will be reflected in the Action Plan:

- Clarify NICE guidance in relation to GPs asking questions about domestic abuse during and after pregnancy;
- Police to interrogate their databases for prior contact with both alleged perpetrators and victims in domestic abuse cases, to help assess the risk and identify repeat victims.

Kate Mitchell
27th January 2017 Amended: 12th January 2018

GLOSSARY

BDCFT	Bradford District Community NHS Foundation Trust
BDTHFT	Bradford District Teaching Hospitals NHS Foundation Trust
CCG	District Commissioning Group
CSC	Children's Social Care
CSE	Child Sexual Exploitation
CSP	Community Safety Partnership
DASH	Domestic Abuse, Stalking, Harassment and Honour Based Abuse , the risk assessment in use by West Yorkshire Police
DBS	Disclosure and Barring Service – a criminal records check on staff working with children and vulnerable adults (previously Criminal Records Bureau)
DHR	Domestic Homicide Review
GP	General Practitioner/ Doctor
HV	Health Visitor
IAT	Integrated Assessment Team, a CSC team co-located with the MASH
IATHR	Integrated Assessment Team Health Representative
MARAC	Multi Agency Risk Assessment Conference: meeting to discuss risk assessments and safety plans in relation to domestic abuse
MASH	Multi-Agency Safeguarding Hub, a partnership of agencies with statutory responsibility for safeguarding children