Bristol Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of Holly in January 2014

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Independent Domestic Homicide Review Chair and Report Author

Report Completed: 14th January 2015

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Tribute from Holly's Mother

Holly was joyful and intelligent.
She bubbled over with energy,
She was funny and at times hilarious.
She was a loving caring mother.

One of her closest friends had this to say;
"Her loyalty and integrity, her kindness and generosity, her dedication to and willful self-sacrifice for her friends, family and her son, made her a uniquely admirable and truly rare person."

There are still no words to describe our pain at the loss of Holly.

But I am grateful to be able to portray some of her loveliness here.

1 Preface

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

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

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

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

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

1.3 The purpose of a DHR is to:

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

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

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

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

2 Domestic Homicide Review Panel

David Warren QPM, Home Office Accredited Independent Chair

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

Detective Chief Inspector Simon Wilstead, Avon and Somerset Constabulary

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

Rhiannon Griffiths, Bristol City Council Crime Reduction

Jackie Beavington, Bristol City Council Public Health

Paulette Nuttall, NHS Bristol Clinical Commissioning Group

Kenny Chapman, Home Office, Immigration Enforcement

Carol De Halle, NHS England

Nicola Bowden-Jones, Next Link Domestic Abuse Support Service

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

Administrator:
Veronica Shorttle, Bristol City Council

3 Introduction

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

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

3.3 **Incident Summary:**

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

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

3.3.3. On the 7th January 2014 Holly went to visit a female friend and told her that she was going to ask Arturo to leave her flat, as their relationship was volatile and she wanted to end it. During the evening she received a number of abusive text messages from Arturo; her friend invited her to stay with her for the night, but she declined. She went home at about 12.30am and her last contact with her friend was at 3.20am, when her friend texted, asking if she was OK.

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

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

3.3.6. The Police attended the flat, Holly was confirmed as dead and a later post-mortem examination established that she had died as a result of "blunt force trauma to the face". She had multiple fractures; there were also signs of strangulation and evidence of sexual assault. It was confirmed that she was in the early stages of pregnancy.

3.3.7. Following his arrest Arturo was interviewed and made no comment, other than to confirm that words written on the headboard of Holly's bed were in his writing and they had not been there the previous day but were present following Holly's death. Translated from Spanish they read "Die Whore". His blood alcohol reading was over 330 micro grammes of alcohol per 100 milliliters of blood (drink drive limit is 80mg). He said he had consumed alcohol after the offence. No drugs were detected, although he later indicated he had taken Ketamine.

3.3.8. He later pleaded guilty to Holly's murder and was sentenced in accordance with Section 5 Schedule 21 of the Criminal Justice Act 2003, murder involving sexual conduct, and received a sentence of life imprisonment with a tariff of 31 years, which was reduced by five years for the early guilty plea. He will be deported upon his release.

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

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

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

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

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

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

- Avon and Somerset Constabulary*
- Avon and Somerset Probation Trust
- Compass Centre*
- Border Force*
- Bristol City Council Safeguarding Adults
- Bristol City Council Children & Young People's Services*
- Bristol City Council Public Health

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

- Bristol MARAC
- Immigration Enforcement Directorate*
- Leicestershire Police
- Leicester Social Care and Safeguarding Service*
- Mexican Ministry for Foreign Affairs*
- NHS Bristol Clinical Commissioning Group*
- NHS England
- Next Link Domestic Abuse Service
- North Bristol Hospital NHS Trust
- Reeds Solicitors*
- University Hospital Bristol NHS Foundation Trust*
- University Hospitals of Leicester NHS Trust

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

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

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

4 Parallel Reviews

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

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

5 Timescales

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

5.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. However consideration about commencing a Review was postponed until the 6th June 2014, after the completion of the criminal proceedings. Due to the Christmas and New Year holiday period it was not possible to arrange a final meeting for the Review until 14th January 2015.

6 Confidentiality

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

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

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

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

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

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

7 Dissemination

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

8 The Terms of Reference

8.1. The purpose[2] of the Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

8.2. **Overview and Accountability:**

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

8.2.2. The Home Office Statutory Guidance advises, where practically possible, the DHR should be completed within 6 months of the decision made to proceed with the review. In this case, the Review was adjourned until after the conclusion of the criminal proceedings, so that the views of the perpetrator and witnesses could be sought.

8.2.3. This Domestic Homicide Review, which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

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

8.3.1. Each agency's involvement with the following from 1st December 2012 until the death of Holly on 8th January 2014, as well as events prior to 1st December 2012 which are relevant to violence, domestic abuse or to Holly's life choices .

(a) Holly (pseudonym) 22 years of age at time of her death.

(b) Arturo (pseudonym) 27 years of age at date of incident.

(c) Holly's son Michael (pseudonym) 2 years of age.

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

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

8.3.3. Whether family or friends want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide.

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

8.3.5. Could improvement in any of the following have led to a different outcome for Holly considering:

(a) Communication and information-sharing between services.

(b) Information-sharing between services with regard to the safeguarding of adults and children.

(c) Communication within services.

(d) Communication to the general public and non-specialist services about the role of the police and the availability of specialist support services in Bristol.

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

(a) Professional standards

(b) Domestic Abuse policy, procedures and protocols

8.3.7. The response of the relevant agencies to any referrals relating to Holly concerning domestic abuse or other significant harm from 1st December 2012. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim or perpetrator.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

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

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

8.3.9. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

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

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

8.3.12. Whether decisions made relating to Holly's access to her son were made in an appropriate manner and in accordance with set polices and practice.

8.3.13. Whether decisions made at the time of the perpetrator's entry into the UK, were consistent with the then Border Agency's set procedures and protocols and whether correct procedures were carried out in trying to trace him after he had overstayed his visit to the UK.

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

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

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

10 Methodology

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

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

11 Contributors to the Review

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

11.2 Individual Management Review Authors:

Caroline Howard, Avon and Somerset Constabulary

Lisa Hill, Border Force

Nicola Caldecoat, NHS England

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

David Ingerslev, Compass Centre

Jonathan Watson, Immigration Enforcement Directorate

Jude Atkinson, Leicester Social Care and Safeguarding Service

Michael Clayton, University Hospitals Leicester NHS Trust

Mexican Ministry for Foreign Affairs

James Ferry, Reeds Solicitors

Sarah Windfeld, University Hospitals Bristol NHS Foundation Trust

11.3 Senior Investigating Officer:

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

12 The Facts

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

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

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

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

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

12.6. Prior to the birth of her son, Michael, in April 2012, with the help of Bristol City Council's Children and Young People's Service, Holly secured a two-bedroom flat in the Fishponds area of Bristol. She gave birth at home, without complications. Michael's father stayed for a short time after the birth but the relationship did not last and he left Holly to return to a previous girlfriend in Leicester, Nevertheless he told Holly that he still wanted to share the care of Michael and they arranged for him to return and live with Holly for two weeks out of every month for the first year of the baby's life.

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

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

twenty days, before visiting other countries in Europe. He was able to show that he had sufficient funds to do so and he was allowed entry.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12.28. Holly was confirmed as dead and a postmortem examination established that she had died as a result of blunt force trauma to the face. She had multiple fractures, there were also signs of strangulation and evidence of sexual assault. It was confirmed that she was in the early stages of pregnancy.

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

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

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

13 Overview

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

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

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

13.4 Holly's mother when consulted about the Review stated she wanted to be involved with the Review and would like the Panel to consider two particular issues:

a) When Arturo, a Mexican national, overstayed his 6-month visa period, what attempts were made to trace him and send him back to Mexico?

b) What grounds did "Leicester Social Services" have for stopping Holly having joint custody of Michael. Their decision directly influenced Holly's life choices. That is, Holly's mother believes that if "Leicester Social Services" had allowed Holly to have Michael at home initially under the supervision of a social worker, she would have stopped taking in homeless people and would not have allowed Arturo to stay at her flat.

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

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

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

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

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

13.6.2. **Mexican Ministry for Foreign Affairs**

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

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

13.7.1 **Avon and Somerset Constabulary.**

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

13.7.2 **Home Office - Border Force**

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

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

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

In November 2012, Holly, who was five months pregnant and homeless, sought help to secure accommodation, after being placed in emergency accommodation she was allocated a two bedroomed flat in Bristol. In accordance with the Bristol City Council Expected Baby Protocol (2011) a social worker carried out an assessment on Holly prior to the birth of Michael. The social worker did not consider that an ongoing service was required to enable Holly to be able to meet the needs of the unborn child once it was born.

In August 2013 Bristol Children and Young People's service were informed by Leicester Social Care and Safeguarding Service that they were making enquiries into concerns that Holly's 16-month-old son Michael was at risk. However as Michael was then living in Leicester with his father, there was no requirement for Bristol Children and Young People's Service to take any action. They asked to be notified if Michael returned to Holly in Bristol.

13.7.4. **Compass Centre**

The Compass Centre is a centre providing help and support for homeless people in the centre of Bristol, managed by St. Mungo's Broadway.

The Centre had no record of any contact with Holly and the only contact with Arturo was on one occasion he visited the Centre to find out if there was any funding available for him to return to Mexico. He had an appointment to return to the Centre the week after the homicide.

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

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

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

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

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

c) Losing weight

d) No childhood vaccinations by Mother (she refused)

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

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

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

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

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

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

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

13.7.6. **NHS Bristol Clinical Commissioning Group**

Arturo had no contacts with any medical service during his time in the UK, up until the time of the homicide. Holly's medical history has been considered in detail within the IMR. Holly favoured going to the Broadmead Walk-in Centre in central Bristol rather than to a GP surgery; however in August 2012 she attended a GP practice near her home for a post-natal eight-week check-up after the birth of Michael. There were no problems reported.

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

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

13.7.7. **Reeds Solicitors**

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

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

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

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

13.7.9. **University Hospitals Leicester NHS Trust**

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

13.8. **General information**

The information from Holly and Arturo's friends which is set out in paragraphs 12.15 to 12.25 shows that Holly was open with her friends that Arturo was violent to her, yet neither she nor their friends or neighbours considered contacting either the police or any of the support agencies available in the Bristol area. The information was only provided to the police during their investigation into Holly's murder.

14 Analysis

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

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

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

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

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

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

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

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

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

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

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

14.6. **Compass Centre**

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

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

14.7. **NHS Bristol Clinical Commissioning Group**

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

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

14.8. **Immigration Enforcement Directorate**

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

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

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

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

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

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

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

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

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

Michael's needs:

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

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

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

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

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

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

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

In terms of parental needs:

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

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

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

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

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

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

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

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

14.10. **Mexican Ministry for Foreign Affairs**

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

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

14.11. **Reeds Solicitors**

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

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

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

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

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

14.13. University Hospitals Leicester NHS Trust

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

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

15. Effective Practice/Lessons to be learnt

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

15.2. **Avon and Somerset Constabulary**

15.2.1. In partnership all agencies and services, there is a need to work together to raise awareness of domestic abuse and to encourage domestic abuse reporting, particularly third party reporting.

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

15.3.1. The response to the initial contact with Holly in 2011 could have been quicker. Nevertheless relevant professionals were communicated with and an assessment of the unborn child's needs was completed culminating in Holly being provided with a two-bedroomed flat. A clear and reasonable decision regarding ceasing Social Work involvement was made after this was achieved.

15.3.2. The outcome of the contact in August 2013 between the Social Work Assessment Team and Leicester Social Care and Safeguarding Service was appropriate given the issues and concerns raised. The situation clearly placed the child within the care of his father, who was residing in Leicester. Therefore it was appropriate that the concerns raised by the father were addressed.

15.4 **Bristol Clinical Commissioning Group**

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

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

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

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

15.5.1. There were aspects of work and assessment undertaken by children's services in Leicester which could have been developed further in order to ensure that Michael's needs were being met.

15.5.2. There were also missed opportunities to identify with Holly, through the process of assessment about her home circumstances, any concerns that she may have had about her relationship with Arturo, although it is questionable whether she would have taken up such opportunities to share any concerns she may have had at this time.

15.6.3. Social work case notes do indicate that Holly was clearly and understandably troubled and upset that Michael was not returning to her care and planned to challenge this through independent legal advice. Again, however, it is difficult to determine what impact Michael's remaining in Leicester or the involvement of children's services in both Leicester and Bristol had on Arturo, or on Holly's relationship with Arturo - for example, whether this

resulted in increased stress for either or both of them, thereby increasing tensions in their relationship or acted as a catalyst for abusive behaviour by Arturo.

15.7 **University Hospitals Bristol NHS Foundation Trust**

15.7.1. The Community Midwife demonstrated good practice in relation to domestic abuse by discussing this with Holly at booking and documenting this in notes. Appropriate referrals were made in pregnancy, and when Holly did not attend appointments these were all followed up.

15.7.2. In the Accident and Emergency Department (A & E) of the Bristol Royal Infirmary there is no documentary evidence that when Holly was admitted pregnant and with a head injury that she was asked about domestic abuse or whether this was considered, as would be expected practice. The Accident and Emergency Department did not formally inform the Maternity service of Holly's admission, despite her being 37 weeks pregnant.

15.7.3. The drug liaison midwife assumed Holly had changed Community Midwifery team when she moved house and when sharing the information about her A & E admission just left a message on an answerphone.

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

15.8 **All Bristol-based Organisations**

15.8.1. There is a general lack of awareness amongst the general public on what they can do if they become aware of incidents of domestic abuse involving other people.

15.8.2. There is a reluctance to contact the police about domestic abuse/violence involving friends or neighbours, this was particularly apparent in this review by people living in rented accommodation, by homeless people and by people in other "hard to reach/hear" groups.

15.8.3. There is widespread fear of being considered to be interfering in someone's private life if they, as a third party, contact the authorities, support agencies or even by asking the suspected victim if she/he needs help about domestic abuse.

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

16. Conclusions

16.1. In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Holly, her son, and Arturo in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of domestic abuse victims in Bristol in the future?
- Was Holly's death predictable?
- Could Holly's homicide have been prevented?

16.2. The IMRs have been open, honest and thorough. The organisations have used their participation in the Review, to consider their policies and practices and where appropriate identify and address lessons learnt from their contacts with Holly in line with the Terms of Reference (ToR).

16.3. The Panel however has recognised that there were very few agency contacts with either Holly or Arturo and none relevant to the homicide. The fact that neither Holly nor any of their friends and neighbours, who were aware of the ongoing abuse, contacted any statutory body or voluntary support agency for help, is highlighted as the key lesson to be addressed by the organisations contributing to this Review.

16.4. The Review Panel is satisfied that the agreed recommendations address the needs identified from the lessons learnt. Provided those recommendations are fully and promptly implemented, they will improve the safety of victims of domestic abuse, but particularly those living in rented accommodation or who are homeless in Bristol in the future.

16.5. The Review Panel, in considering all of the information provided, believes that Holly's death was not predictable. None of her friends or neighbours appeared to consider the dangers and no agency had been informed about Holly's situation.

16.6. Could Holly's death have been prevented? The Review Panel believes that if Holly, or any of the people who knew of Arturo's violence to Holly, had informed the Police, Housing or one of the many support agencies of their concerns, then positive action may have been taken to stop the abuse. As Arturo was an "overstayer" in this country, he could have been detained prior to removal to his country of origin, Mexico.

17. Recommendations

17.1. **National Recommendations**

17.1.1. That the Home Secretary completes the introduction of the exit checks programme in relation to people leaving the UK and that intelligence gathered as a result is passed to Immigration Enforcement to tackle those who overstay their leave.

17.2. **Cross-Agency Recommendations**

17.2.1 That the Bristol Domestic and Sexual Abuse Strategy Group organizes a domestic abuse awareness campaign focused on third-party reporting from all communities, but particularly from people less able to easily access mainstream services.

17.2.2 All partner agencies of the Bristol Domestic and Sexual Abuse Strategy Group and the DHR Panel will take action to pro-actively raise awareness of domestic and sexual abuse amongst their staff and service users and promote a third party reporting campaign.

17.2.3 The Bristol Domestic and Sexual Abuse Strategy Group will remind agencies of the importance of domestic and sexual abuse training for staff and to offer help in designing training to those organisations.

17.3 **Individual Agency Recommendations**

17.3.1. **Avon and Somerset Constabulary**

- Force processes need to be examined to ensure that front-line officers are able to accurately identify foreign nationals and conduct relevant checks, and that any intelligence gathered is routinely shared with the Immigration Enforcement Department and other relevant agencies

- That Avon and Somerset Constabulary continues to raise the profile of domestic abuse and encourages all victims, friends, family and neighbours to seek advice and support. Methods of anonymous reporting to be publicised to increase intelligence where members of the public do not wish to come forward directly when they are aware of domestic abuse. This, in turn, will provide more opportunities for third-party reporting of incidents and intelligence from a wide range of agencies and organisations, including, as an example in this case, abortion clinics and midwifery services

- That where third-party intelligence is captured in respect of potential domestic abuse, that it is disseminated to neighbourhood policing teams and to the Safeguarding Co-ordination Units who will assess and develop a safety plan. Where appropriate, as part of a considered safety plan the relevant information is shared sensitively with immediate neighbours to establish a ‘cocoon watch’ to look out for the welfare of the victim and immediately report any signs of disturbance. This ‘cocoon watch’ must be fully briefed and supported by the local policing team to ensure they are familiar with how and whom to report concerns to.

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

- IMR findings to be cascaded where relevant with Child in Need Service heads of service and service managers, via senior management meetings.

- IMR findings to be cascaded where relevant to Child in Need team managers and social workers, via team meetings or briefing session

- Within this process, the need to seek and evidence decision-making, inter-agency discussion, and third-party or triangulating information (e.g. health information which corroborates or reduces concern about a child) should be reinforced to social work staff. Relevant procedures e.g. Leicester Safeguarding Children's Board (LSCB) procedures should also be highlighted. The need to ensure that an inter-agency perspective is maintained throughout an assessment or intervention should be highlighted.

- Within this process, the importance of completing timely, thorough and holistic social work assessments which take fully into account the overall needs of each child, the overall circumstances of each carer or parent, and any relevant environmental issues or issues for the wider family should be reinforced. In particular, reminders should be offered about promoting and ensuring effective cross-boundary working. Again, relevant procedures e.g. LSCB procedures should be highlighted. Dissemination of IMR findings should comment on the need to ensure that contact or residence issues or disputes do not falsely obscure or hinder focus on children's day-to-day and safeguarding needs.

- Within this process, reminders should be offered about the importance of ensuring that families are given appropriate information about social work processes, expected timescales for assessment, appropriate contact information and complaints and appeals information.

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

- Emergency Department (ED) Bristol Royal Infirmary (BRI) Staff to consider domestic violence and safeguarding when patients attend the unit, and take the appropriate action.

- Adult Services to inform Maternity Services of any attendance of a pregnant woman to A and E or any admission to an Adult ward.

- Staff should not leave messages about patients and clinical information on answer phones but speak directly to colleagues or send written information if time allows.

17.2.4 **Bristol Clinical Commissioning Group/NHS England**

- Bristol NHS Provider services staff should consider asking people attending the service with symptoms or injuries which could indicate domestic or sexual abuse, whether they have been the victim of abuse

Note: Bristol Sexual Health HIT (Health Integration Team) is in the process of considering how to update primary care and specialist sexual health service providers training, to include identifying repeat requests for emergency contraception as a risk indicator for domestic/sexual abuse.

18. Postscript

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

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

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

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

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

Appendix A: Glossary

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

Appendix B: Bibliography

CAADA Responding to Domestic Abuse: Guidance for General Practice.

Care Act 2014

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

Department of Health Care and Support Statutory Guidance

Domestic Homicide Review Toolkit.

Domestic Violence, Crime and Victims Act 2004.

Equalities Act 2010

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

HM Government Information Sharing: Guidance for practitioners and managers.

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

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

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

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

Appendix C: Action Plan

Recommendation	Scope of recommendation ie local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
That the Home Secretary considers the introduction of an exit-checks programme in relation to people leaving the UK	National	The UK Government is committed to introducing exit checks. - The Government defines an "exit check" as a check that satisfies the Government to a reasonable degree that an individual has left the United Kingdom. - By April 2015 the UK will have exit checks on scheduled commercial international air, sea and rail routes. - Introducing exit checks will improve our ability to identify those who have left and, more importantly, those who have failed to leave the UK when they should have done so, and will bolster border security	Home Office	April 2015 - exit checks on scheduled commercial, international air, sea and rail routes Staff briefing has been issued across the Home Office immigration commands confirming exit checks will go live from 8 April.	April 2015	
That the Bristol Domestic and Sexual Abuse Strategy Group organises a domestic abuse awareness campaign focused on third-party	Cross-Agency	Campaign to be developed alongside partner agencies and disseminated across the city.	Bristol Domestic and Sexual Abuse		Ongoing June 2015	

reporting from all communities, but particularly from people less able to easily access mainstream services.			Strategy Group			
All partner agencies of the Bristol Domestic and Sexual Abuse Strategy Group and the DHR Panel will take action to pro-actively raise awareness of domestic and sexual abuse amongst their staff and service users and promote a third party reporting campaign.	Cross-Agency	Campaign messages and resources to be shared with partner agencies for use with their own staff and service users.	Bristol Domestic and Sexual Abuse Strategy Group		Ongoing June 2015	
The Bristol Domestic and Sexual Abuse Strategy Group will remind agencies of the importance of domestic and sexual abuse training for staff and to offer help in designing training to those organisations.	Cross-Agency	Bristol Domestic and Sexual abuse Strategy Group to develop offer for agencies to support development and improvement of training.	Bristol Domestic and Sexual Abuse Strategy Group		Ongoing June 2015	
Emergency Department (ED) Bristol Royal Infirmary (BRI) Staff to consider domestic violence and safeguarding when patients attend the unit.	Local	BRI ED staff to be reminded and it to be highlighted in training the importance of completing documentation and assessing any safeguarding/domestic abuse issues on a patient's admission	University Hospitals Bristol NHS Foundation Trust		February 2015	
Adult Services to inform Maternity Services of any attendance of a pregnant woman to A and E or any admission to an Adult ward.	Local	ED staff to be reminded and it to be highlighted in training	University Hospitals Bristol NHS Foundation Trust		February 15	
Staff should not leave messages	Local	Information and good practice to	University		February	

about patients and clinical information on answer phones but speak directly to colleagues or send written information if time allows.		be re iterated via training.	Hospitals Bristol NHS Foundation Trust		2015	
Force processes to be examined to ensure that front-line officers are able to accurately identify foreign nationals and conduct relevant checks, and that any intelligence gathered is routinely shared with HO Immigration and other relevant agencies	Local	ASC to liaise with HO Immigration and Enforcement to establish current or new protocols for information sharing of intelligence relating to foreign nationals New force crime recording system (NICHE) to ensure opportunities to capture nationalities and intelligence relating to foreign nationals	Avon and Somerset Constabulary		November 2014 April 2015	
That Avon and Somerset Constabulary continues to raise the profile of domestic abuse and encourages all victims, friends, family and neighbours to seek advice and support. Methods of anonymous reporting to be publicised to increase intelligence where members of the public do not wish to come forward directly when they are aware of domestic abuse. This, in turn, will provide more opportunities for third party reporting of incidents and intelligence from a wide	Local	The DA lead for the Constabulary considers all possible methods of raising awareness and encouraging third party reporting including through media opportunities Local policing teams establish good partnership working with their communities and encourage third party reporting including through Crimestoppers	Avon and Somerset Constabulary		Ongoing Ongoing	

range of agencies and organisations, including as an example in this case, abortion clinics and midwifery services						
That where third party intelligence is captured in respect of potential domestic abuse, that it is disseminated to neighbourhood policing teams and to the Safeguarding Coordination Units who will assess and develop a safety plan. Where appropriate, as part of a considered safety plan the relevant information is shared sensitively with immediate neighbours to establish a 'cocoon watch' to look out for the welfare of the victim and immediately report any signs of disturbance. This 'cocoon watch' must be fully briefed and supported by the local policing team to ensure they are familiar with how and who to report concerns to.	Local	Intelligence, SCUs and Integrated Victim Care assess and disseminate relevant safeguarding information to ensure the safety of known victims or potential victims where information is received via third party reporting. This can be achieved through the tasking process under the new force operating model. Intelligence should be shared with the Safeguarding Champions on the local policing teams as soon as possible for awareness and appropriate action including Cocoon watch if relevant Both actions to be implemented and driven by the force DA lead through the Gold Group	Avon and Somerset Constabulary		July 2015	
IMR findings to be cascaded where relevant with Child in Need Service heads of service and service managers, via senior management meetings.	Leicester		Leicester Social Care and Safeguarding Service			

IMR findings to be cascaded where relevant to Child in Need team managers and social workers, via team meetings or briefing session.	Leicester		Leicester Social Care and Safe-guarding Service			
Within this process, the need to seek and evidence decision-making, inter-agency discussion, and third-party or triangulating in-formation (e.g. health information which corroborates or reduces concern about a child) should be reinforced to social work staff. Rel-evant procedures e.g. Leicester Safeguarding Children's Board (LSCB) procedures should also be highlighted. The need to ensure that an inter-agency perspective is maintained throughout an assess-ment or intervention should be highlighted.	Leicester		Leicester Social Care and Safe-guarding Service			
Within this process, the importance of completing timely, thorough and holistic social work assessments which take fully into account the overall needs of each child, the overall circumstances of each carer or parent, and any relevant envi-ronmental issues or issues for the wider family should be reinforced. In particular, reminders should be	Leicester		Leicester Social Care and Safe-guarding Service			

offered about promoting and ensuring effective cross-boundary working. Again, relevant procedures e.g. LSCB procedures should be highlighted. Dissemination of IMR findings should comment on the need to ensure that contact or residence issues or disputes do not falsely obscure or hinder focus on children's day-to-day and safeguarding needs.						
Within this process, reminders should be offered about the importance of ensuring that families are given appropriate information about social work processes, expected timescales for assessment, appropriate contact information and complaints and appeals information.	Leicester		Leicester Social Care and Safeguarding Service			
Bristol NHS Provider services staff should consider asking people attending the service with symptoms or injuries which could indicate domestic or sexual abuse, whether they have been the victim of abuse	Local	DHR Report to be taken and presented to the Bristol Safeguarding Adult Board (SAB); Safeguarding Board asked to add this recommendation to their work plan;	Health – BNSSSG AT NHSE SAB Board Member	DHR on Bristol SAB Agenda; Recommendation contained on SAB Work Plan	March 2015	

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

Family of victim

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

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

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

Chair gave her contact details for AAFDA service.

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

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

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

Solicitors,

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

Perpetrator

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

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

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

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

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

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

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

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

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

Friends and neighbours

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

Appendix F: Home Office Quality Assurance Panel correspondence

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2 Marsham Street
London
SW1P 4DF

T 020 7035 4848
F 020 7035 4745

www.homeoffice.gov.uk

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

22 May 2015

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

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

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

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

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

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

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

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

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

Yours sincerely,

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

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

Tel: 0117 914 2222

26th May 2015

Re: DOMESTIC HOMICIDE REVIEW QA PANEL RESPONSE

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

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

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

This has been actioned as appropriate.

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

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

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

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

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

This has been actioned.

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

We have considered this feedback and the wording of the report has been amended to read 'The Review is therefore satisfied that, although there are lessons to be learnt, the actions of Leicester Social Care and Safeguarding Service are unlikely to have influenced Holly's decision to let Arturo live at her flat'. We trust this addresses any concerns you may have had.

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

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

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

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

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

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

Yours sincerely,

Chair of Safer Bristol Partnership

Appendix G: Family Statement (20th May 2016)

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

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

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

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

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

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

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

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