SAFER BRISTOL

DOMESTIC HOMICIDE REVIEW

Executive Summary Report into the Death of Becky

February 2015

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Associate, Standing Together Against Domestic Violence

Date of Final Version: October 2018

Contents

1. Tributes from Parents

“Rebecca Marie Watts, Becky. As a mother it is impossible to believe that I am having to write a tribute for my daughter. It is a shocking truth that I can’t imagine I will ever accept. I still remember the day I gave birth to Becky as one of the happiest days of my life. Becky would be 21 now, and sometimes I allow myself the luxury of imagining the type of young woman she would be today.

Becky was as beautiful on the inside as she was on the outside. Becky was a peacemaker, a kind and caring friend and a loving daughter. Becky was immensely loyal to those she cared about, she cared more about others than she cared about herself. Becky always wanted her family to be happy and united and she worked hard to bring us all together.

Her happiest times were when we were together as a family watching films and playing games. Becky loved animals and she particularly loved our dog, Jack, she would love to dress him up and for us to go on family walks. She was artistic; she would love to draw us pictures and would always make me beautiful Mother’s Day cards, Christmas cards and Birthday cards which I treasure. She loved to dance and dress up to make us happy and smile.

Even as a baby, Becky lit up the cameras and she lit up all our lives. I called her ‘our little sunbeam’ and she would light up the days with her beautiful smile and her warm heart. She faced her challenges with courage and grace, carrying a heavy weight on her little shoulders. I will miss her forever and always be so proud to call her my daughter.”

Becky’s Mum
January 2020

“Becky. Losing a child is a parent’s worst nightmare; the way in which we lost Becky makes it even harder to bear. We are unable to put into words the level of loss and life will never be the same again. The bond between us was unbreakable and beyond anything I could have ever imagined. I knew I was truly blessed and suddenly life had a totally different meaning.

She grew to be beautiful both inside and out a determined and strong-minded girl and we are gutted that she was denied the opportunity to live a full life and to become a mum. She was caring, loyal and wise beyond her years; her laugh and smile would melt the hardest of hearts. She had a quirky sense of humour and was fun to be with. We never imagined our lives without her and it will take forever for us to adjust to losing her. Becky was the heart and soul of our family and the light at the end of our tunnel without her there is only darkness left and an impatient desire to be reunited with her. The world has lost a very special soul.

Things like this make you realise how fragile and precious life is.”

Becky’s Dad
January 2020

2. Executive Summary

This report is being published using the real name of the victim: Becky. This is explained below.

2.1. The Review Process

2.1.1. This report outlines the process undertaken by the Domestic Homicide Review Panel in reviewing the homicide of Becky who was a resident in Bristol.

2.1.2. In early 2015 Becky was reported as having gone missing by her father. Following a missing persons' inquiry, it was discovered that Becky had been attacked whilst at home on the day she went missing by her step-brother, NM, resulting in her death. After this, NM and his girlfriend SH took steps to conceal the death by removing Becky's body to his home. NM dismembered Becky's body and hid body parts in suitcases and bags at various locations in Bristol. The Pathologist found the cause of Becky's death to be suffocation.

2.1.3. Criminal proceedings were completed in 2015 and the perpetrators were found guilty: NM of homicide, and sentenced to life imprisonment with a minimum term of 33 years; and SH of manslaughter, and sentenced to a minimum of 17 years imprisonment.

2.1.4. A Serious Case Review (SCR) was commissioned by Bristol Safeguarding Board (BSCB) shortly after Becky's death. The criteria contained within Working Together 2015 makes it clear that it is mandatory to carry out an SCR where a child dies and abuse is known: the evidence of abuse in this case was the murder itself. The SCR examined a three-and-a-half-year period in Becky's life when professionals were involved in providing services to Becky and her family.

2.1.5. The SCR identified that Becky's death also fitted the criteria for a DHR and this was subsequently established by Safer Bristol.

2.1.6. The Serious Case Review was published when the Domestic Homicide Review was nearing completion; it used the name 'Becky' which is not a pseudonym. This was at the request of the family and in recognition of the identifiable and high-profile nature of this case which makes anonymity impossible. The DHR has followed this.

2.1.7. Initials have been in used in this Review for the perpetrators.

2.1.8. The Review Panel discussed the sensitivities relating to the nature of the case and agreed that when the Review is submitted to the Home Office, a letter would accompany it requesting approval for only the Executive Summary to be published. As a result, the Executive Summary has been written with more information than would usually be contained in such a report, to ensure that Becky's story is told and the lessons from the case are clear.

2.2. Terms of Reference

2.2.1. *Time period covered*: At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 January 2011 (Becky) and 1 January 2009 (NM and SH) up to the date of Becky's death. These time periods were selected to ensure that relevant agency involvement with all three was captured, as well as any potential information about the relationship(s) between the three, to maximise the opportunities for learning and to understand the journeys of Becky, NM and SH up to the point of the homicide. Agencies were asked to summarise any relevant contact they had had with Becky, NM and/or SH prior to these dates.

2.2.2. *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in 2016 Guidance and identified and considered the following case specific issues:

- Domestic abuse
- Sexual violence and child sexual exploitation
- Mental health issues
- Young carers
- Looked After Children / Leaving Care

2.2.3. As a result, Barnardo's and Young Carers were invited to be part of the Review due to their expertise even though they had not been previously aware of the individuals involved. They reviewed the draft Overview Report and Executive Summary and their comments have been incorporated into those reports.

2.2.4. *Parallel reviews*: The Serious Case Review (SCR) was commissioned by Bristol Safeguarding Board (BSCB) shortly after Becky's death (see above). A link was established between a Review Panel member and the SCR, to ensure that the Reviews ran in parallel as smoothly as possible, in particular in relation to contact with family. The independent chair also spoke with the SCR authors to ensure that learning from each Review was shared.

2.2.5. The SCR was published in March 2018: https://bristolsafeguarding.org/children-home/serious-case-reviews/bristol-scrs/becky-2018/

2.2.6. There were no other parallel reviews conducted. A mental health investigation, either internal by the mental health trust nor an independent investigation, were conducted as none of the individuals were under the mental health trust at the time of the homicide.

2.3. Contributors to the Review

2.3.1. This Review has followed the statutory guidance for Domestic Homicide Reviews (2016) issued following the implementation of Section 9 of the *Domestic Violence Crime and*

Victims Act 2004. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 24 agencies were contacted to check for involvement with the parties concerned with this Review. Eight agencies returned a nil contact and 16 agencies submitted Independent Management Reviews (IMRs) and chronologies. A further six agencies provided information on their services to support the Review, although they had not had contact in the case. The chronologies were combined and a narrative chronology was written by the Overview Report Writer.

2.3.2. The following agencies and their contributions to this Review are:

Agency	Contribution
1625 Independent People	IMR and Chronology
Action for Children (the project delivered was named Bristol Supporting Families)	IMR and Chronology
Avon and Somerset Police	IMR and Chronology
Avon and Wiltshire Mental Health Partnership NHS Trust	IMR and Chronology
Barnardo's BASE (child sexual exploitation support service)	Information
BrisDoc Healthcare Services	IMR and Chronology
Bristol City Council Children's Early Help Services	IMR and Chronology
Bristol City Council Children's Social Care Services: Safeguarding, Looked After Children and Leaving Care	IMR and Chronology
Bristol City Council Education Services (for Bristol Hospital Education Service)	IMR and Chronology
Bristol Clinical Commissioning Group (on behalf of the General Practices)	IMR and Chronology
Bristol Community Health	IMR and Chronology
Child and Adolescent Mental Health Services, Avon and Wiltshire Mental Health Partnership NHS Trust	IMR and Chronology
Creative Youth Network	IMR and Chronology
Department for Work and Pensions	Information
Tutor formerly with Hedley Hall (tutoring service, no longer operating)	Information
Learning Partnership West	Information
North Bristol NHS Trust	IMR and Chronology
Places for People Living+	IMR and Chronology

Solon Housing Association	IMR and Chronology
University Hospitals Bristol NHS Foundation Trust	IMR and Chronology
Young Carers	Information

2.3.3. *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. All IMRs received were comprehensive and enabled the panel to analyse the contact with Becky, NM and/or SH and to produce the learning for this Review. Where necessary further questions were sent to agencies and responses were received.

2.4. The Review Panel

2.4.1. The Review Panel Members were:

Panel Member	Job Title	Organisation
Dawn Taylor	Operations Director	1625 Independent People
David Derbyshire	Director of Practice Improvement	Action for Children
James Wasiak	Quality Assurance	Avon and Somerset Police
Mark Bunker	Quality Director and Inpatient Head of Operations	Avon and Wiltshire Mental Health Partnership NHS Trust
Lisa Jenkins	Child and Adolescent Mental Health Services Consultant	Avon and Wiltshire Mental Health Partnership NHS Trust
Clare-Louise Nicholls	Head of Governance	BrisDoc Healthcare Services
Paulette Nuttall	Designated Safeguarding Adults and MCA lead nurse	Bristol Clinical Commissioning Group
Fiona Tudge	Service Manager Safeguarding Children, Children's Social Care Services	Bristol City Council
Louise Jenner	Consultant Social Worker, Children's Social Care Services	Bristol City Council
Lucy Watkins	City Wide Early Help Social Work Manager, Children's Early Help Services	Bristol City Council
Annette Jones	Education Services	Bristol City Council
Sue Moss	Public Health Principal, Public Health	Bristol City Council
Anne Fry	Named Nurse for Safeguarding Children	Bristol Community Health
Kate Gough	Youth Services Director	Creative Youth Network
Jayde O'Brien	Senior Probation Officer	National Probation Service
Linda Mellows	Safeguarding Officer	Next Link Domestic Abuse Service
Andrew	Quality and Safety Manager	NHS England

Sutherland		
Sophia Swatton	Head of Safeguarding	North Bristol NHS Trust
Judith Tennet & Peter Stafford	Scheme Manager	Places for People Living+
Fiona Jenner	Senior Rehousing Manager	Solon Housing Association
Alison Miflin	Senior Safeguarding Children Nurse	University Hospitals Bristol NHS Foundation Trust

2.4.2. *Independence and expertise*: Agency representatives were appropriate in relation to their independence from the case, their level of seniority within their service or organisation, and their expertise in relation to the issues relevant for the case.

2.4.3. The Review Panel met a total of four times, with the first meeting of the Review Panel in March 2017. There were subsequent meetings in July, September and November 2017. Completion of the Review was done via email and telephone contact.

2.4.4. The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this Review.

2.5. Involvement of Family and Friends

2.5.1. The Safer Bristol Partnership notified the family members of Becky in writing of their decision to undertake a Review in January 2017. The Chair of the Review and the Review Panel acknowledged the important role family and friends could play in the Review. From the outset, the Review Panel decided that it was important to take steps to involve the family and friends.

2.5.2. Throughout contact with the family, the independent chair has been mindful of the fact that Becky and NM were part of the same family household.

2.5.3. The independent chair, through contact with the Serious Case Review leads, ensured that contact with family and friends was distinct from that process, and that people were not being contacted by both Reviews at the same time.

2.5.4. The following individuals were approached to be involved with the Review:

- Becky's mother
- Becky's step-mother and father (Becky's step-mother is also NM's mother)
- Becky's friends (four)
- Becky's brother

2.5.5. These were identified through establishing who had been in contact with the police as part of the missing persons and subsequent murder investigation, and as a result contact details were held for them. The independent chair sought to establish whether any family members were being supported by the Victim Support Homicide Service or Advocacy After Fatal Domestic Abuse (AAFDA), or another support service, prior to making contact.

2.5.6. The independent chair wrote to each of the above, and letters were passed on by the relevant support service working with that individual, or by the police. The Terms of Reference, Home Office leaflet and AAFDA leaflet were included with every letter.

2.5.7. All those contacted were offered the opportunity to participate using the medium they preferred and in as flexible a way as possible. All letters made clear that participation in the Review was voluntary, and that they could contribute in different ways: for example, through a face-to-face meeting with the chair of the Review, making a statement, through a telephone conversation, and Skype (not an exhaustive list). The letter emphasised that their contributions could take place at a time and place of their choosing, and that their involvement in the Review would not be rushed.

2.5.8. The independent chair met with Becky's step-mother (R) and father (K), supported by their Victim Support Homicide Service Worker. K was later referred to AAFDA, and a copy of the Executive Summary was sent in May 2018; a further, updated, version was sent in September 2018, and comments were received on these. K has provided a tribute to Becky via his AAFDA advocate which has been placed at the beginning of the report.

2.5.9. The independent chair engaged with Becky's mother (J) through her AAFDA Advocate. A report was produced from their conversations (prompted by questions provided by the independent chair), and this forms part of the Review. J was provided with a draft of the Executive Summary. She provided her feedback (again through her Advocate) and this has been incorporated into the report. J has provided a tribute to Becky which has been placed at the beginning of the report

2.5.10. The independent chair met with a friend of Becky's (F), and a report was produced from that meeting, which forms part of the Review. F was provided with a draft of the Executive Summary. She provided her feedback in a meeting with the independent chair and this has been incorporated into the report.

2.5.11. The independent chair met with the mother of a friend of Becky's (Q), and a report was produced from that meeting, which forms part of the Review. The chair referred Q to AAFDA and subsequently she engaged with the Review through her Advocate. Q was provided with a draft of the Executive Summary. She provided her feedback (through her Advocate) and this has been incorporated into the report.

2.6. Involvement of the Perpetrators

2.6.1. The family of NM is also the family of Becky (see above).

2.6.2. It was noted by the Review Panel that SH was estranged from her family, and the independent chair discussed this with her.

2.6.3. NM and SH were sent letters from the chair via their probation officers with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back.

2.6.4. SH sent back the signed consent form and the chair met her in prison for interview in July 2017. A report was produced from that meeting, which forms part of the Review.

2.6.5. NM sent back the signed consent form and the chair met him in prison for interview in August 2017. A report was produced from that meeting, which forms part of the Review.

2.7. Chair of the Review and Author of Overview Report

2.7.1. The Chair and Author of the Review is Althea Cribb, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). Althea has received Domestic Homicide Review Chair's training from STADV and has chaired and authored twelve reviews. Althea has ten years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse.

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

2.7.3. STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews.

2.7.4. *Independence:* Althea Cribb has no connection with Safer Bristol nor any of the agencies involved in this case.

3. Overview and Chronology

3.1. Overview of Information about Becky

3.1.1. *Background information relating to Becky*: Becky was aged 16 when she died. She was attending a training college. From a young age she had lived with her father and step-mother, and remained living there until her death. She had regular contact with her mother and grandmother. Substantial agency contact with Becky started in 2011 (she was aged 13).

3.1.2. *Becky's relationship with NM and SH*: Becky was the step-sister of NM and was 12 years younger than him. Becky's father and NM's mother had been in a relationship since Becky

was very young. NM lived with his maternal grandmother, but maintained regular contact with his mother, and as a result was in Becky's life from the time she started living with her father and step-mother. SH and NM started a relationship when SH was aged 15 and NM aged 22 (Becky would have been aged 12 at that time).

3.1.3. *Overview of Becky's contact with services*: Becky's period of contact with services started in mid-2011 when she was aged 13. Her step-mother contacted Children's Social Care due to concerns over Becky's non-attendance at school and behaviour at home. An assessment was completed and Becky and her step-mother and father were allocated to the Family Intervention and Support Service, and they were engaged with the service until the end of the year. This service met with Becky one-to-one and with her step-mother to support her parenting of Becky. The service referred Becky to the Child and Adolescent Mental Health Service (CAMHS, now delivered by Avon and Wiltshire Mental Health Partnership NHS Trust) and Becky was engaged with them from 2011 to 2013, primarily through appointments she attended with her step-mother; her father was able to occasionally attend (appointments were scheduled for during the day, and he was unable to take time off work), and limited contact was made by CAMHS with her mother. Becky declined to have one-to-one sessions with CAMHS. CAMHS referred Becky to the Bristol Hospital Education Service, a specialist education service for children who cannot attend mainstream school for physical/mental health reasons, and she attended that service from the end of 2011 to 2015. In 2012 there were increasing concerns over Becky's weight and diet, and she was diagnosed and then treated for anorexia. She was discharged from CAMHS in early 2013 when she had recovered from this and they had seen improvements in her overall mental health. Bristol Hospital Education Service referred Becky to the Bristol City Council Early Help service in mid-2014 and they referred her on to Creative Youth Network, who met with her one-to-one weekly until the autumn of 2014. Action for Children were in contact with Becky and her family in 2012, but the work done was not recorded well; they were in contact again in 2014 with a one off meeting following concerns expressed by Becky to Bristol Hospital Education Service about her housing situation. At the end of 2014, until her death in 2015, Becky attended KTS, a training college. She had three appointments in 2013 and 2014 with her General Practice.

3.2. Overview of Information about NM and SH

3.2.1. *Background information relating to NM*: NM was aged 28 at the time he killed Becky. He is now believed to have been living with SH, although this was not known at the time and he appeared to spend a lot of time at his mother's (Becky's) home. He was not in work at the time, due to his physical health. From a young age he had been in the care of his

grandmother, with whom he lived until adulthood. He had regular contact with his mother throughout his childhood. From age 11 to 22, there were no agency records for NM.

3.2.2. *Background information relating to SH*: SH was aged 21 when she was involved in the killing of Becky. She was not in work. She had been placed in foster care at a young age, and remained there until she moved back in with her mother at age 13. She moved out at the age of 16. In 2009 (when SH was 15) SH's mother reported to police and Children's Social Care that SH had said she had been raped by a stranger. This was investigated by Avon and Somerset Police, and no further action was taken due to an absence of evidence and because SH declined to make a statement.

3.2.3. *NM and SH's relationship*: SH and NM started a relationship when SH was aged 15 and NM aged 22. This Review understands that they were living together from 2012 but this was not known by agencies at the time.

3.2.4. *Overview of NM's contact with services*: NM had contact with all of the agencies that were engaged with SH, as her partner (see below). In addition from 2009 onwards he attended his General Practice with issues in relation to his physical health (pain) and mental health (depression and anger). In 2011 the GP referred NM to the Community Mental Health Team (Avon and Wiltshire Mental Health Partnership NHS Trust, AWP); he was assessed and discharged back to the GP. The GP then referred NM to the IAPT (Improving Access to Psychological Therapies, now delivered by AWP) service and NM engaged with them sporadically from 2011 to mid-2012. During this time (2010-2012) NM had three appointments with the pain clinic at North Bristol NHS Trust. Following these, he was discharged as he did not attend a further scheduled appointment. NM continued to attend his GP with regard to his mental health in 2014, with the last appointment in autumn 2014.

3.2.5. *Overview of SH's contact with services*: Prior to 2009 SH had ongoing contact with the Bristol City Council Looked After Children and then the Leaving Care services; this continued until the homicide. From 2009 all of her contact with services involved NM: he was present at nearly all appointments and concerns were noted by some agencies about his behaviour towards SH (e.g. appearing to control access to money, heating, food and contact with agencies. In 2011 she moved into supported accommodation managed by 1625 Independent People. In 2012 she moved into non-supported accommodation in a property managed by Solon Housing. In 2012 SH became pregnant and received services from North Bristol Trust and University Hospitals Bristol NHS Foundation Trust midwifery. Following the birth of the child SH had contact with health visiting (Bristol Community Health), who referred the child and SH to Children's Social Care and the Places for People Living+ support service for teenage parents. An assessment was completed in 2013 and Children's Social Care, health visiting and Places for People Living+ worked separately and

together to improve the child's nutrition, SH's finances and access to support groups. This support came to an end towards the end of 2014 because improvements had been seen.

3.3. Information from Becky's Family and Friends

3.3.1. This Review heard from Becky's mother, Becky's step-mother and father, a friend of Becky, and the mother of another of Becky's friends (see 1.5). Additionally Becky's grandmother commented on the Executive Summary.

Becky's mother (J)

3.3.2. J described Becky as a "*typical teenager … she had found her feet and some friends and she was enjoying life*". She was "*headstrong*" and could speak her mind but that she was very forgiving, loyal and would never bear a grudge. J was asked about the time when Becky was accessing support from CAMHS and she fed back that perhaps in hindsight Becky was painting a smile on her face, not wanting to worry anyone about her situation at home. J reported that Becky asked her repeatedly to move to a larger home so that Becky could live with her. J knew that Becky was unhappy living where she was and recalls that NM had "*chased her up the stairs threatening to kill her*". J said that Becky was a "*sweetheart*", very loyal and trusting. Becky wanted all the adults in the family to get on, she was the "*glue that kept them together*".

3.3.3. J asked a number of specific questions and these are included and addressed within the report.

3.3.4. J was sent a draft of the Executive Summary for her to read and comment on. Additionally Becky's grandmother (J's mother) read and commented on the report. They both found it very difficult to read the report, in particular the information about NM and SH; but they understood that this was necessary.

3.3.5. J's feedback on the report is listed below; where appropriate these are also referenced later in the report or the report has been amended:

- J is happy for the report to use Becky's real name.
- J feels that the Family Intervention and Support Service could have involved her too, as she was engaged with Becky. Reading the report, J felt she had been missed out of the loop quite a lot with agencies. This was a theme for other agencies as well, including CAMHS and Hospital Education, who could and should have been more proactive in seeking to involve J.
- J felt that more emphasis could be placed on the services gap for young people 16-21 when you are not quite an adult not quite a child.
- A significant issue that J asked to be flagged prominently, and nationally, was that it would have been really good practice for the GP to link NM and Becky together when

they registered at the same surgery. Particularly as Becky was vulnerable and NM disclosed his feelings of anger and once even punched the wall in the surgery. This was also significant as he has a child and a young mother as a partner who is also vulnerable. This is added to the report (and a recommendation made) at 2.5.6; it is noted there that, had Becky been identified as a Child in Need (section 17) or a Child in Need of Protection (section 47) then this would have been done[1].

- J asked questions about the involvement of Action for Children with Becky: she asked whether a risk assessment had been done, and whether Becky had been offered the opportunity to be seen alone. This is clarified below (see paragraph 3.5.8).
- With regard to Becky's 'aggression at home' when involved with Children's Social Care / Family Intervention and Support Service, J felt this was a missed opportunity as Becky's behaviour could have been explored as being frustration or distress.
- J highlighted the missed opportunity of the KTS tutor not acting on Becky's disclosures shortly before she died.
- A common theme for J was that it was not clear when and how Becky was asked if she wanted to see someone alone. She suggests it could be standard practice to be seen alone even if just at the beginning or end of a meeting; in particular in light of Becky's statement that 'no adults listened to her'. This is added to the report, and a recommendation (1) made, at 3.4.9.
- J felt it was a missed opportunity when Becky attended the hospital intoxicated; she could have been seen then or later by a skilled professional.

Becky's father (K) and step-mother (R)

3.3.6. Becky's step-mother and father described Becky as a "*loving girl*" and that they had the usual sorts of problems that come with a "*typical teenager*" but they always worked them out quickly. Becky loved to dance. She had a small circle of very good friends: she had found it difficult to make friends but had become very close to them. They "*lived in each other's pockets*" and were very supportive. R stated that the support for Becky from services was helpful and had helped Becky recover from anorexia. The family and CAMHS had worked together as a team that really helped Becky. R said that Becky and NM were jealous of each other but she never suspected he could do what he did. K asked for information about SH's and NM's contact with Children's Social Care, and this is included in the report (see 2.5.30).

3.3.7. The draft report was sent to the AAFDA Advocate (a later updated draft was then provided) for K and R to read and comment on. Their comments are included here.

[1] These are defined by the Children Act 1989; for more information see: http://www.proceduresonline.com/swcpp/bristol/p_assessment.html

3.3.8. K and R agreed with J's comments about GPs and other services (above). Their AAFDA Advocate fed back that they "*echo the fact that had there been more communication between agencies and maybe more joined up thinking Becky might still be alive*".

Becky's friend (F)

3.3.9. F had met Becky when they both attended Hospital Education; they got on well and spent a lot of time together, including sleeping at each other's houses. They both liked having another person there to talk to, as they had lost touch with friends from their previous school after joining Hospital Education. F and Becky would stay round each other's houses; they would play games on the x-box, like karaoke games. Becky had loads of pets including a rabbit that stayed in her room even though it shouldn't have been there.

3.3.10. With Hospital Education, they didn't get out much so they enjoyed going to the local shop together. Later, Becky was doing Functional Skills, or English and Maths GCSEs, at KTS. She enjoyed it at first, but then started to feel that she didn't like the way they handled things. She got on with the teachers, but ended up feeling "*what's the point*" of going. Becky's friend thought this might have been because of her time in Hospital Education, that it was difficult to get used to being in the mainstream.

3.3.11. Becky had four boyfriends in the time F knew her. She broke up with one because she felt he had anger issues and she didn't like the way he spoke to her. The fourth boyfriend she was with for the few months before she died. They were all her age or near her age.

3.3.12. Becky got cat-called a lot (shouted or whistled at by men in the street). Sometimes she found it flattering but a lot of the time she found it scary. One time a man took a photo of her through a shop window, and another time a man tried to get her to get into his car. F said "*it was shocking how much it happened*" and that because of it Becky "*wouldn't walk anywhere alone*". This meant she stayed home a lot in her room.

3.3.13. The independent chair asked about Becky's contact with services. F thought that Becky had been in contact with someone like a Social Worker but not one exactly, who had supported her, taken her places; at one point the worker provided F and Becky with tickets to a local youth event. Then Becky was texting her and not getting any response, and she felt let down as she didn't know why they weren't responding. F felt that because Becky had a family, plus her mum, she didn't get into services, even though she needed support and she was desperate to move out. F also felt that services really dropped off once you were 16, and it was difficult because you were a kid but then you also weren't a kid.

3.3.14. The independent chair looked at the records provided to the Review and it may be that the 'Social Worker' referred to by F may have been the worker from Creative Youth Network. Their records show that Becky's case was closed after their involvement with her came to an end; this differs from F's recollection from what happened.

3.3.15. After her involvement had ended with CAMHS, F thought that Becky might not have thought she could go back there because it would have had to have been *with* her family. She needed an agency to help her because of problems with family, not get the family involved. F felt that after CAMHS, there was nothing there to support them. If you didn't want to go to the Off The Record service, then there wasn't anywhere to go. There needed to be someone who you could message or call when you were having a problem. They felt left alone.

3.3.16. Housing was difficult for Becky to try to get as she didn't know where to go or what her options were. "*You had to know what to search for online, and what was in your [local authority] area.*"

3.3.17. F asked the Review to address issues in relation to services for children once they turn 16, particularly housing and mental health. This is addressed in the lessons to be learnt.

3.3.18. The independent chair asked about Becky's relationship with NM. Becky had told F she had always had problems with NM. Becky told F she remembered being aged around eight, and NM sitting next to her and rubbing her thigh, or grabbing her. It would stop when he had a girlfriend.

3.3.19. Becky felt that NM was "*weird*" and "*wrong*" but didn't know if she would be believed if she told anyone. In the years before she died NM had threatened to kill her. She didn't believe that he would really do it. She didn't want to tell anyone because it was happening at home in the family. During the trial, NM painted a completely wrong picture of Becky's relationship with her step-mother. Becky really cared for her step-mother, and would talk about her as though she was her mother. She didn't favour her step-mother or her mother; they had different relationships.

3.3.20. F was sent a draft of the Executive Summary for her to read and comment on; the independent chair then met with F to go through the report and got F to feedback and ask questions. F found it hard to read about NM and SH. F's main feedback concerned CAMHS, Hospital Education and Creative Youth Network, and this has been added below (see 2.5.14, 2.5.19 and 2.5.22). She asked for more detail on the contact Becky had with CAMHS to be included, and this has been added below.

Becky's friend's mother (Q)

3.3.21. Q had seen Becky on a regular basis up to when she died, as Becky and Q's child had been very close friends. Q had taken them to Hospital Education and then to college and also to other services including Creative Youth Network.

3.3.22. Q described Becky as "*bubbly*" and "*lively*" and very close to her friends, and they supported each other all the time. She did not have any contact with Becky's family and did not know NM or SH at all. When Becky was at Q's house, she always seemed "*happy*". Becky never talked about any issues she was having but sometimes she would talk about

being hungry, and Q would feed her. Becky attended Hospital Education and then KTS with Q's child, and they didn't enjoy it very much but would go together. Becky wanted to work with animals, and Q tried to help her with this. Shortly before Becky died, Q's child had asked Q if Becky could come and live with them; Q didn't know at the time what was behind this. Q told the Review that on the day Becky was killed she had been "*pleading*" with her friend (Q's child) not to go away on a planned trip that day.

3.3.23. Q had a lot of questions about the investigation when Becky went missing, and the criminal investigation that followed that. The independent chair put her in touch with Advocacy After Fatal Domestic Abuse, and an Advocate is now supporting Q and working with her to address the issues and questions that she has, which unfortunately this Review cannot answer as it does not cover the police investigation.

3.3.24. Q also asked about what services were there to support Becky and how they had worked with her, in particular CAMHS. This is included in the report (see 2.5.12).

3.3.25. Q was sent a draft of the Executive Summary for her to read and comment on. She provided her feedback to the AAFDA Advocate and her comments have been integrated into the above or the report.

3.4. Information from NM and SH

3.4.1. This Review heard from NM and SH through interviews conducted by the independent chair. The content of these interviews contradicted each other significantly, as well as differing from the records of agencies.

3.4.2. NM fed back that he should have been offered more mental health support, particularly from his GP. He felt that no professional fully understood or responded to his physical and mental health.

3.4.3. SH alleged physical domestic abuse as well as controlling and emotional abuse from NM; she stated she would not have sought help at the time, as she did not understand the situation. She fed back that the Local Authority (Looked After Children / Leaving Care Team) support reduced after she moved away from her family and started her relationship with NM, but at the time this wasn't a problem for her because she couldn't see the benefit of them.

3.5. Information Known to Agencies Involved and Learning for Agencies

3.5.1. 16 agencies (covering 17 services) submitted information to this Review about their contact with Becky, NM and/or SH. No agency knew of any connection between them: agencies in contact with Becky were unaware that NM was part of her household, and agencies in contact with NM and/or SH were unaware of Becky being in their lives.

3.5.2. Becky, NM and SH were unknown to: Barnardo's BASE (child sexual exploitation support service); BDP drug and alcohol service; Young Carers; Bristol City Council Adult Social Care.

3.5.3. The following services had contact:

Agency	Becky	NM	SH	Comment
1625 Independent People			Y	
Action for Children	Y			
Avon and Somerset Police		Y	Y	Contact unrelated with each other
Avon and Wiltshire Mental Health Partnership NHS Trust		Y		
BrisDoc Healthcare Services		Y	Y	Attended service together
General Practices	Y	Y	Y	See below
Bristol City Council Children's Social Care: Looked After Children and Leaving Care Team			Y	
Bristol City Council Children's Social Care Services: Safeguarding		Y	Y	See below
Bristol City Council Children's Early Help Services	Y			
Bristol Hospital Education Service	Y			
Bristol Community Health		Y	Y	Contact with NM as a result of contact with SH
Child and Adolescent Mental Health Services, Avon and Wiltshire Mental Health Partnership NHS Trust	Y			
Creative Youth Network	Y			
North Bristol NHS Trust		Y		
Places for People Living+		Y	Y	Contact with NM as a result of contact with SH
Solon Housing Association			Y	
University Hospitals Bristol NHS Foundation Trust	Y		Y	Contact unrelated with each other
Total (17 services)	**7**	**8**	**10**	

3.5.4. Bristol City Council Children's Social Care had contact with Becky and with NM and SH: this contact was at different times and in different parts of the service.

3.5.5. Becky and NM were registered at the same General Practice from 2013. Becky had been registered there from a very young age, and NM registered there in 2013, when he gave his address as the same as Becky's; they were not identified as connected. SH was registered at a different practice.

3.5.6. Becky's mother queries why the GP did not identify that NM and Becky shared an address. The Clinical Commissioning Group stated that there is a system in place that is used when there are safeguarding concerns for vulnerable children, and there is a need to link together those living at the same address; this was not the case for Becky at that time, as

she was not a 'Child in Need' or a 'Child in Need of Protection' as assessed by Children's Social Care with reference to the Children Act 1989. Becky's mother felt strongly that this was an opportunity to identify the connection between Becky and NM, and for this to be understood in light of Becky's potential vulnerability and NM's anger issues as disclosed to and seen by the GP. A national recommendation (2) is made.

Agencies in contact with Becky

3.5.7. This section sets out the contact had by each agency and the learning identified through the IMRs and Review Panel discussions: recommendations made are listed in section 4.1.

3.5.8. *Action for Children*: Action for Children had contact with Becky and her step-mother in 2012 but records were not clear on what that involved; staff met with Becky and her step-mother, but subsequent meetings were with her step-mother only as Becky refused to meet with the service. Due to the absence of clear recording it is not clear why, or what attempts were made. A referral was received from Early Help in autumn 2014 (at the same time Early Help referred to Creative Youth Network, in response to a referral from Hospital Education, see below) and a home visit was done in which the member of staff met with Becky, her step-mother and father. Becky was asked, but declined, to see the worker alone. Becky's housing situation was discussed with her father and step-mother. No formal risk assessment was done; the worker assessed Becky's housing situation and closed the case as they concluded there was no immediate threat of Becky being made homeless.

3.5.9. *Learning*: The key learning was in relation to recording, which was identified as needing significant improvement, and recommendations were made which have already been acted on. Case closure and exit plans were also identified as in need of review and improvement, and this has also been acted upon. Due to the recording issues it is not possible to analyse the contact that was had with Becky during either time.

3.5.10. *Bristol City Council Children's Social Care and Early Help Services*: Becky's step-mother approached Children's Social Care in June 2011 for help because Becky was not attending school, and displaying increasing aggression at home. An assessment was done and the family was allocated to the Family Information and Support Service (FISS) who met with Becky alone and with her step-mother and to a lesser extent her father to support their parenting of Becky. Following improvements seen with Becky, and the referral made to Child and Adolescent Mental Health Services for Becky, the case was closed in December 2011. A referral for Becky was received by Early Help from Bristol Hospital Education Service in mid-2014; this was sent on to Creative Youth Network and Action for Children for support and the case closed.

3.5.11. *Learning*: FISS were able to engage effectively with Becky and her step-mother, albeit less successfully with Becky's father. The case was closed appropriately by FISS as improvements in her situation and behaviour were seen. When Becky was referred in 2014

no assessment was done, and this would have been an effective means of identifying all her needs and her whole situation; in similar circumstances an assessment would now be done. The case was closed without Early Help checking that the referrals had been progressed and that support had been provided as needed; recommendations are made to ensure this does not happen again.

3.5.12. *Bristol Hospital Education Service (Hospital Education)*: Becky was referred in 2011 by Child and Adolescent Mental Health Services because Becky was not attending school and had a troubled family history and mental health issues. Becky started attending in November 2011 and left in 2014. Throughout 2012 regular student reviews were completed in which Becky was recorded as, for example, "*doing fine*" but her attendance was noted to be low. Through 2013 this continued (e.g. "*things going well*" but continued low attendance) but also that Becky was displaying "*oppositional behaviour*" and not following instructions. Becky left to attend Bristol City Academy[2] in September 2013 but returned to Hospital Education in the October as the transfer was "*not a success*". Hospital Education staff made records about Becky being "*argumentative*" in class and "*on her phone a lot*"; actions in response to this perceived behaviour were not clear. In November 2013 Hospital Education referred Becky to Young Carers (this service was contacted for the Review and they had no record of the referral or contact with Becky) and to Early Help for Becky to get additional support. Through 2014 staff continued to record that Becky exhibited 'challenging behaviours' (such as those listed above) and had low attendance. She reported difficulties at home a number of times in 2014 and concerns were noted by staff with regard to her eating and home life. In mid-2014 Becky reported to a member of staff that an ex-boyfriend had private photos of her and was threatening to post them online. This information was passed on to Early Help (as an update on the referral made previously); they advised Hospital Education to refer to BASE (Barnardo's child sexual exploitation service) and support Becky to report to the police. BASE have no record of a referral being received. Becky did not want to report to the police and shortly after was dismissive of the concerns and what had happened. Becky transferred to KTS (a training college) in autumn 2014. She attended inconsistently and was recorded as being absent ("*ill*") frequently. She reported concerns over how her classmates treated her, and unspecific concerns about her home life, shortly before she died; there was no recorded action in response to any of these disclosures. One KTS tutor messaged Becky due to concerns about her as she had not been attending recently; Becky replied that she "was poorly". This was the last contact they had with Becky.

[2] Information was sought by the Review but could not be gained from City Academy on Becky's time there.

3.5.13. *Learning*: Good practice was identified in how the staff at the centre worked to support Becky's complex needs. But, information from the multiple services in contact with Becky was not gathered together and understood as a whole, in the context of what was known about Becky's history and her family situation (being in a 'blended' family, i.e. one in which two families have come together as one[3]). Referrals were not consistently followed up on, e.g. to Young Carers. When CAMHS and FISS closed Becky's cases, Hospital Education was in effect left to try to manage Becky alone, while her psychological and emotional needs remained high. There was a lack of focus or action on Becky's low attendance at Hospital Education and by KTS when she moved there; and tutors at KTS did not act on Becky's disclosures shortly before she died. It is notable that Becky talked about her personal life in a one-to-one with a tutor, when she was alone. Recommendations are made to address the learning.

3.5.14. *Feedback from Becky's friend, F*: F reported that Becky had developed good relationships with staff at the service and felt comfortable talking to them in a way she hadn't with CAMHS staff. This was helped with the frequent contact she had with them, and the more informal nature of that contact, because it wasn't a scheduled appointment but part of the routine of attending the service. F felt that it would be helpful if Hospital Education staff could be trained as part of the Children and Young People's IAPT project (this is described below, see 3.4.21).

3.5.15. *Further information provided by Young Carers*: At the time Hospital Education made the referral there would have been no record kept by the service on why a referral was not acted upon, if the referral was found to not be for a young carer. If the referral was clearly for a young carer there would have been a record of this, and it would have resulted in a needs assessment of the young carer. Young Carers have kept records since 2016 for referrals received when the child/young person is not a young carer; as they now keep a record of all referrals received. It is not uncommon for the service to receive inappropriate referrals and they monitor how regularly this happens, in order to address this with partner agencies. Young Carers have found that professionals can be unclear on the definition of a young carer. Young Carers define a young carer as a child who "*provides care to the level that we would expect of an adult: the care can manifest in a variety of ways from practical tasks, personal care, emotional care and household management*". A child or young person is not a young carer just because they live with someone who has a long-term illness, mental ill health, disability or misuses substances: they may be impacted by this situation but it does not necessarily make them a young carer.

[3] https://www.helpguide.org/articles/parenting-family/step-parenting-blended-families.htm. Blended or step families have become prevalent over the past decades.

3.5.16. *Child and Adolescent Mental Health Services (CAMHS), Avon and Wiltshire Mental Health Partnership NHS Trust*: The Bristol Family Intervention and Support Service (FISS) referred Becky to CAMHS in 2011 due to her high anxiety and fear of being outside, suicide threat and being low in mood. CAMHS referred Becky to Hospital Education as she had not been attending school. CAMHS had meetings with Becky and her step-mother together, and at the end of 2011 concerns increased over Becky's eating, diet and weight. Through this time contact was attempted with Becky's mother and father; her step-mother attended nearly all meetings (Becky's father was unable to take time off work) as it was recorded that Becky did not like to be seen alone. Her mother also attended some meetings. Becky was offered individual sessions with the therapist, which she declined. Becky stated she didn't want to attend any sessions at all, alone or with family, but she did attend. The contact continued through 2012 with an increasing focus on Becky's anorexia. Becky was to be admitted as an inpatient but there were no spaces and so she was managed in the community by the specialist team, with the support of the GP. Becky's weight improved as the year ended, and her mental health was seen to improve in the family therapy sessions. CAMHS recorded that Becky's anxiety was improved and she did not want to work any further on it with CAMHS. She was discharged in March 2013.

3.5.17. *Learning*: The support and treatment for Becky in relation to her anorexia was effective and she was able to recover fully. The service worked with Becky and her family but this contact was not balanced between the adults in her life. In particular there should have been more emphasis on supporting Becky's father and mother to attend meetings. Becky was offered one-to-one meetings which is good practice. There was learning in relation to record keeping and risk assessment and recording, which has been acted upon. Further learning was identified in that a standardised way of asking about domestic abuse should be introduced for assessments, and that joined up working between CAMHS and other agencies needs to be reviewed and improved.

3.5.18. *Feedback from Becky's mother, J*: J asked about the fact that Becky had declined one-to-one sessions with CAMHS and queried whether Becky had been asked when she was alone. If she hadn't, then J felt this may have impacted on Becky's response. CAMHS fed back to the Review on this point (generally, not specifically in relation to Becky) that it wouldn't be normal practice to see a child alone in order to ask them if they would like one-to-one sessions, as they live within a family unit and it is important to work with that. It would be considered if there were concerns, or if the child were an older teenager. This would be approached as something routine in a consultation with a family. This is further addressed in 3.4.9.

3.5.19. *Feedback from Becky's friend, F*: F felt Becky should not have been discharged while Becky was still attending Hospital Education (this feedback was also given by Becky's

friend's mother, Q). She also questioned whether, for someone in Becky's situation (having accessed the service with her family), it would be enough for a service to say 'come back if you need to' – Becky may not have had the confidence to do this. Additionally, the service was located far from Becky's home and she had no means of getting there alone (as her anxiety meant she felt unable to travel by bus alone). F also questioned whether the contact CAMHS has with families is always through the adults involved, or whether (for older children like Becky) they make direct contact with children as well to involve them in the service and inform them of, e.g. outcomes, actions and discharge information. The independent chair put this question to CAMHS; writing directly to the young person would be something they considered depending on the circumstances, and would be in place as the young person moved towards being 18.

3.5.20. *Creative Youth Network*: A referral was received from Early Help in mid-2014. The service met with Becky alone and an action plan was created. The worker met with Becky weekly until the autumn. The worker recorded that at this time Becky "*had lots of friends*", was "*very sociable*" and was "*a lot happier*". Her case was closed. Becky then contacted the worker again for help with her CV, which was provided, following which her case was closed again.

3.5.21. *Learning*: The service was able to engage with Becky and the worker developed a positive relationship with her. The worker did not contact the referrer to fully understand Becky's situation, and the service came to a close without a face to face meeting between the worker and Becky. Recommendations have been made to address this learning, and these have been acted on.

3.5.22. *Feedback from Becky's friend F*: F is aware of Creative Youth Network and reported that the agency has its own Facebook page, with members of staff having professional pages linked to it, which F feels has made it easier for young people to know about and keep in contact with the service.

3.5.23. *General Practice (GP)*: Throughout 2011 the GP had contact with Becky and her step-mother with regard to their contact with Child and Adolescent Mental Health Services. This focused on Becky's anorexia. Becky attended in 2013 and twice in 2014. In one of the three appointments Becky was assessed for Gillick Competency using Fraser Guidelines[4].

3.5.24. *Learning*: Good practice was noted in the regular contact between the GP and CAMHS in relation to Becky's anorexia and general mental health, with additional support being

[4] The NHS states "*children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment.*" (https://www.nhs.uk/Conditions/Consent-to-treatment/Pages/Children-under-16.aspx accessed 22 October 2017.) This is assessed using Fraser Guidelines referring to guidelines set out by Lord Fraser (1985). https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/ [accessed 22 October 2017]

offered by the GP. Becky was assessed once for Gillick Competency; she should have been assessed at every appointment and a recommendation (3) is made (see 4.4).

3.5.25. *University Hospitals Bristol NHS Foundation Trust (UHB)*: In mid-2014 Becky was brought to the Bristol Royal Infirmary Emergency Department of UHB "*intoxicated*" from drinking with friends at a house party. Her father collected her and she was discharged.

3.5.26. *Learning*: In cases such as this, because Becky was aged under-18, a 'Cause for Concern' form should have been completed to alert Children's Social Care, and this was not done, and was a missed opportunity for Becky to be offered further support. An IMR recommendation is made to address this.

Agencies in contact with NM and/or SH

3.5.27. *1625 Independent People (1625ip)*: SH was referred to this service by the Looked After Children service (Bristol City Council) and she moved into supported housing provided by them in 2010. NM was mentioned in the records from the start of SH's contact with this service. In 2011 they referred SH to Hedley Hall tutoring service. Support continued until 2012 when SH moved out to a Solon Housing property. Throughout her time with 1625ip they recorded issues in relation to accessing her room and about NM always being present. They engaged with the Looked After Children service who were supportive of the relationship between SH and NM. At the end of 2011 and early in 2012 1625ip had difficulty contacting and engaging with SH and this continued until she moved out in mid-2012.

3.5.28. *Learning*: The worker demonstrated good practice in acting on their concerns over NM's behaviour towards SH in their relationship, through contact with the Leaving Care service. Recording was identified as an issue in relation to the contact that was had with SH and the support that was offered. Staff are trained on domestic abuse, child protection and dealing with difficult behaviour, and many improvements have been made in the years since their contact with SH, including strategic multi-agency working, increased quality assurance tools, systems and the gathering of feedback on the service.

3.5.29. *Avon and Somerset Police*: In 2009 SH's mother reported that SH had said she had been raped by a stranger. Police investigated the allegation and no further action was taken due to the absence of evidence and because SH declined to provide a statement.

3.5.30. *Learning*: The report of the alleged rape was not recorded as a crime; this has since changed, and even in cases where no further action is possible, reports such as this are recorded as crimes.

3.5.31. *Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)*: In 2011 NM was referred by his GP and engaged with IAPT (Improving Access to Psychological Therapies[5]). He did not attend, and then re-engaged later in the year. IAPT assessed NM and offered a group session on stress control. Also in 2011 his GP referred NM to the Community Mental Health Team at AWP and he was assessed by a consultant psychiatrist. The outcome of the assessment was that NM was discharged back to his GP with a recommendation for him to be referred for anger management. NM continued to engage sporadically with IAPT, who also discussed NM with the pain clinic at North Bristol NHS Trust. In early 2012 NM attended an IAPT group and then said he was unable to continue with that provision due to the constant pain he was in, as he couldn't sit in the room for that long. In mid-2012 IAPT received a letter from the pain clinic at North Bristol NHS Trust about NM's care pathway. IAPT attempted to contact the pain clinic and left two messages but were unable to speak to the clinic. NM continued to be on the waiting list for IAPT intervention. At the end of 2012, when AWP took over the service, they wrote to NM to ask him to make contact; when he did not, he was discharged from the service.

3.5.32. *Learning*: The assessment and response to NM by the Community Mental Health Team was appropriate, with advice given to NM's GP. The IAPT service tried to be flexible to meet NM's needs, offering different options for support. The recording could have been better and this has been addressed by AWP since they took on the service in 2012.

3.5.33. *BrisDoc Healthcare Services*: NM made use of the GP out of hours service in 2009 and 2013 due to back pain. NM and SH attended a Walk in Centre together (and were seen separately) in early 2014 and were treated.

3.5.34. *Learning*: Procedures were followed and no concerns were noted. On each occasion, SH's and NM's GPs were notified of attendances and treatment.

3.5.35. *Bristol City Council Children's Looked After Children and Leaving Care Team*: The Looked After Children service had contact with SH from an early age due to her being in the care of the Local Authority. There were regular meetings and reviews. In 2009 SH moved back in with her mother but contact with the service continued under 'Placement with Parent' regulations. The service noted concerns with regard to SH's school attendance and being socially isolated. SH informed the service of her relationship with NM when she was 15 and he was 22 (2009). In 2011 SH disclosed to the service that she had nightmares related to her childhood experiences and the alleged rape; she was offered a referral to CAMHS which she declined. Regular reviews with the service continued through 2012, and NM was

[5] Improving Access to Psychological Therapies, a national programme delivered in each local area. https://www.england.nhs.uk/mental-health/adults/iapt/ [accessed 22 October 2017]. In the information submitted to this Review, the service was called 'Right Steps', 'First Steps' and 'LIFT Psychology' and was delivered by another provider; it is now called Bristol Wellbeing Therapies, delivered by Avon and Wiltshire Mental Health Partnership Trust since the end of 2012.

noted to always be present, and often spoke for SH. In 2012 SH turned 18 and was transferred to the Leaving Care service. In mid-2012 a tutor from SH's college made contact with the service as they felt NM was a "*bad influence*" on SH[6]. SH informed the service she no was longer attending college because she was pregnant (SH's child was born towards the end of 2012). In early 2013 the Leaving Care worker noted that NM "*would not let*" SH speak but that there was "*no evidence [of] physical control*" in the relationship. At the same time, SH's Leaving Care worker completed an initial assessment on SH's and NM's child, following referral from North Bristol NHS Trust (NBT) and University Hospitals Bristol NHS Foundation Trust (UHB) (all children born to a parent who is a former Looked After Child are assessed, see below). There was no reference to SH's and NM's relationship in the assessment and the child's case was closed. Through 2013 contact continued with SH; she was recorded as being unhappy with the worker because she thought she had been entitled to more of a grant than she had received. Routine contact continued in 2013 and 2014, although contact was difficult to establish at times. The Leaving Care pathway plan completed for SH at this time noted that NM was "*holding SH back*"; there is little detail and no recommendations or actions except for the need for SH to "*trust support workers*". At the end of 2014 a new worker was allocated, who was unable to reach SH.

3.5.36. *Learning*: This is covered in the learning section for Children's Social Care (2.5.38).

3.5.37. *Bristol City Council Children's Social Care Services Safeguarding*: In 2009 SH's mother contacted the service as SH reported having been raped on her way to school by an unknown male; this was investigated by Avon and Somerset Police (see above). In mid-2012 a referral was received from NBT midwifery for SH's child due to SH being a former Looked After Child. The assessment was allocated to SH's Leaving Care worker and completed in 2013 some months after the child had been born. A referral was received for the child from the health visiting service (Bristol Community Health) in spring 2013. An assessment was done and the child identified as a 'child in need' as a result of which a plan of support was drawn up. This included: SH to engage with work around domestic abuse; NM to engage with support around his mental and physical health. A joint meeting with SH, the child's social worker, and SH's leaving care worker was held in which they discussed the service's concerns with regard to SH's relationship with NM. She was recorded as stating she was happy in the relationship and declined referrals or support. Actions were made for Places for People Living+ to work with SH around her finances. Information was requested from NM's GP (with NM's consent) to understand his self-reported mental and physical health. The GP responded with a letter containing information

[6] The tutor who made this contact has since left the college, who had no records relating to concerns for SH.

on NM's history and the statement that NM posed no risk of violence or being a threat to children. The letter was not shared with Leaving Care worker. At the end of 2013 Children's Social Care noted that they could only contact SH through NM's phone: that she did not appear to have a phone of her own. Work continued with health visiting and Places for People Living+, and the case was closed early in 2015 due to improvements in the child.

3.5.38. *Learning*: The service identified that SH's care from the Leaving Care Team was not up to the expected standard that should be delivered; changes made since that time have seen significant improvements in ensuring regular contact, reviews and plans with young people leaving care. Supervision of staff has also improved to ensure staff are properly supported in their work with young people. Concerns would now be raised over a relationship such as the one SH started with NM, given the age gap and her potential vulnerability. Significant work has been undertaken across services to improve awareness and understanding of, and responses to, situations in which child sexual exploitation may be a risk or a feature. SH's child should have been assessed prior to birth, and when this was done greater account should have been taken in relation to the concerns over SH's and NM's relationship and the controlling behaviours seen from NM towards SH, and to ensure that he was more included in the assessment and support. Recommendations are made and these have been acted on or are in progress.

3.5.39. *Bristol Community Health*: The health visiting service started working with SH when she and the child were discharged from NBT community midwifery towards the end of 2012. Routine checks were carried out with the child and SH; the service discussed heating and finances with SH and NM, and made contact with the Leaving Care team. In early 2013 they referred SH to the Places for People Living+ support service for teenage parents for help with budgeting, managing her tenancy, daily living skills and accessing teenage parent groups. The health visitor recorded concerns over the low temperature of the home and the child not being fed properly. Joint visits were made with Places for People Living+, and single visits by the service in which improvements were noted with the child's clothing but the home was still noted to be cold. NM was recorded as always being present, "*very vocal*" and "*very little was known about his history*". The health visiting service referred the child to Children's Social Care in spring 2013 due to their concerns for the child and what were seen as elements of "*control*" by NM over SH. In late summer 2013 further concerns were noted in relation to the child's diet and nutrition. NM rejected the health visiting service's advice, and SH tried to change worker which she was encouraged not to do. NM informed the service he could prove what was said at appointments because he tape-recorded all meetings with professionals, following which health visiting and Places for People Living+ agreed there would be no further lone professional meetings with the family. In autumn 2013 improvements were noted for the child. The health visiting service

continued to see the family, with visits decreasing as the situation improved. In autumn 2014 the routine two-year check was completed and the family moved to universal provision (no contact to be made by health visiting unless the family requested it).

3.5.40. *Learning*: There was good practice identified by this service in the multi-agency working with other agencies (Places for People Living+ and Children's Social Care) and the proactive support offered to the family, including attempts to see SH alone to discuss concerns over NM's behaviour and the relationship. The service identified that at the time the service was engaged with the family, it was not routine to ask about domestic abuse; this is now done as part of the Family Health Assessment, which is the health visiting tool for identifying the needs of the child and/or parent, and is used to inform multi-agency referrals.

3.5.41. *General Practice (GP) for NM*: In 2009 and 2010 NM attended with musculoskeletal problems and pain. In 2010 the GP recorded NM's psychological problems linked to the physical pain, and referred him to the IAPT service (now delivered by Avon and Wiltshire Mental Health Partnership NHS Trust, AWP). In 2011 the GP recorded that NM had seen IAPT and attended the North Bristol NHS Trust (NBT) pain clinic. The GP then referred him to the AWP Community Mental Health Team, from which he was discharged following an assessment (see above). Later in 2011 the GP re-referred NM to IAPT after he had not engaged. NM attended again in relation to pain and his mental health. He was recorded as being angry about not being given help. NM registered with a new GP towards the end of 2013. (This was the same GP as Becky, but the relationship was not known by the practice at the time.) The GP recorded a history for NM of "*long term problems [for] many years*" including pain. NM told the GP he had been referred for therapy with IAPT but after it had "*felt worse – too stressful*". The GP noted that NM had a girlfriend and child who did not live with him and that NM stated SH "*couldn't manage both him and baby*" and as a result he lived with his mother. The GP recorded an action to get NM's previous notes to understand his medical history; it is not clear if this was achieved. NM attended at the end of the year (2013) and was noted to have "*very low self-image problems, very anxious, irritable*"; he did not want to return to Cognitive Behavioural Therapy (IAPT) as "*he was too angry with a specialist*". NM had "*lots of emotional and mental health issues underlying. Has self-harmed and overdosed in the past. No suicidal thoughts at this stage*". The GP noted they would discuss NM with another GP and consider a referral to mental health services; there is no record of this being done / the outcome. NM attended two weeks later and it was noted he had "*difficulty managing anger … reacts inappropriately to situations and often ends up in a conflict situation with others*". NM's physical pain and poor sleep were noted, that he was "*not keen*" on medication and had a "*bad experience*" of Cognitive Behavioural Therapy (IAPT). NM was prescribed anti-depressants and given the details for IAPT, and a

review appointment booked for 4-6 weeks. In early 2014 he attended for that review. The GP recorded their own view that the consultation with NM was challenging because "*much of NM's problem is a personality rather than mental illness*". It was noted that NM continued to take an anti-depressant, but was feeling "*no benefit*" from it, and he was advised again to contact IAPT. In summer 2014 SH attended NM's GP alone and without NM's knowledge and was recorded as saying "*he gets angry and doesn't deal with people well – gets angry and frustrated*". SH was worried for NM's mood, that he did not want to go out and was struggling to interact with their child. The GP noted that SH stated NM was "*never physically violent but had aggressive and angry outbursts*". The GP encouraged SH to get NM to attend himself, and to see his usual GP who knew his history. NM attended in the autumn of 2014 to discuss managing his anger. The GP recorded that NM "*stormed out of the room*" part way through the appointment in a sudden escalation as NM was apparently "*unable to control his frustration and perception that health care professionals do not understand him*". The GP noted that NM "*again presents in a manner which is very much like a personality disorder*". IAPT was again discussed. Having suddenly left the GP appointment, NM then punched a wall in the practice as a result of which he had to attend Bristol Royal Infirmary Emergency Department (University Hospitals Bristol NHS Foundation Trust, UHB) for treatment. He telephoned the GP to apologise. This was the last contact NM had with his GP.

3.5.42. *Learning*: The GPs attempted to support NM with his physical and mental health issues, including referrals to appropriate services according to NM's level of need. The Review learned that support for GPs in relation to mental health has increased, with a link Consultant Psychiatrist in place for support and advice, and all General Practices having a Mental Health Lead GP. The GP could have acted in relation to NM's child when they noted concerns over NM's mental health and aggression, through a referral to Children's Social Care. In particular in light of the other information the GP had about NM and in response to NM's aggression in the surgery when he punched a wall.

3.5.43. *General Practice (GP) for SH*: In 2010 SH's mother called with concerns for SH at school, and her physical health following the alleged rape in 2009. In 2012 SH attended as she was pregnant, and the GP referred her to the midwifery service (NBT). In early 2013 SH attended her GP who recorded that SH's "*life is crappy at the moment with an under heated house and lots of stresses*". NM was noted to be present and "*chipped in frequently*". The GP felt there were some "*underlying concerns perhaps festering due to financial problems*" and contacted the Health Visitor (Bristol Community Health, above) for support to be given to SH.

3.5.44. *Learning*: The GP maintained contact with the Leaving Care service and the health visiting service that were in contact with SH. The GP responded appropriately to SH alleging she

had been raped, by referring her to a specialist support service (which she declined). There were opportunities for the GP (and NM's GP) to see SH alone and ask her about her relationship with NM, in response to issues she disclosed and the behaviour of NM that the GP witnessed. The Review was informed that Bristol has rolled out the IRIS initiative (Identification and Referral for Improved Safety[7]) with 46 General Practices; work is ongoing with a further eight practices to engage them in IRIS. IRIS is a nationally recognised general practice based programme for the improved enquiry with and identification of victims of domestic abuse. An Advocate-Educator is employed, who trains doctors and practice staff and is then the point of contact for support and referrals for victims of domestic abuse. In addition a lead clinician is identified as the IRIS champion, and they are responsible for co-delivering training, and being a peer supporter for clinical colleagues in each practice. All of the practices involved in this Review are now part of the IRIS initiative in Bristol.

3.5.45. *Hedley Hall*: 1625ip referred SH to this tutoring service in 2011 and the tutor worked with SH for the year. SH was a "*conscientious*" student who always did her homework. Support for students always took place in their home, and so the tutor would visit SH on a weekly basis. The tutor remembered that NM was always present but it did not impact on SH's learning. Despite the age difference the tutor had no significant concerns over the relationship; looking back they can remember feeling that NM "*was controlling*" of SH but did not have strong concerns.

3.5.46. *Learning*: The service is no longer in place. The issue of recognition of and response to concerns with regard to SH's relationship with NM is addressed in the broader learning for the Review.

3.5.47. *North Bristol NHS Trust (NBT) for NM*: At the end of 2011 NM saw the pain clinic consultant who referred him to the psychologist for further assessment, which took place in April 2012 (a standard waiting time). The psychologist wrote to IAPT following that assessment. The letter noted that NM struggled with daily activities and mood changes, and concluded that IAPT was the best pathway for NM to address his emotional difficulties, as well as referring NM to the pain clinic physiotherapist. NM was recorded as attending one physiotherapy appointment. He then missed one and the clinic then wrote to NM saying he would need a new referral from his GP for further appointments. This was the end of the contact (late summer 2012).

3.5.48. *Learning*: The NBT Review Panel member had difficulties accessing records at the Pain Management Clinic, and the learning in relation to the different places in which records are held is being taken forward by NBT.

[7] http://www.irisdomesticviolence.org.uk/iris/ [accessed 22 October 2017]

3.5.49. *North Bristol NHS Trust (NBT) for SH*: SH received routine midwifery services from NBT throughout 2012. The service referred SH's unborn child to Children's Social Care in spring 2012 due to SH being a former Looked After Child, as per procedure. A further notification was made (by a new team which SH was allocated to following her house move) to Children's Social Care in autumn 2012. The child was born at a University Hospitals Bristol NHS Foundation Trust (UHB) hospital (see below) Following discharge from hospital SH and the child were seen by the NBT community midwifery at home, then transferred to health visiting (Bristol Community Health).

3.5.50. *Learning*: The midwifery service acted appropriately in making referrals to Children's Social Care in relation to the child. The service informed the Review that all women are routinely asked about domestic abuse throughout their pregnancies.

3.5.51. *Places for People Living+*: The health visiting service (Bristol Community Health) referred SH in early 2013 to the Places for People Living+ support service for teenage parents. This was in relation to SH's budgeting, managing her tenancy, daily living skills and accessing teenage parent groups. Home visits, telephone calls and joint visits with health visiting and Leaving Care services were made throughout 2013 to support SH in these areas including referrals and signposting to support groups. Towards the end of the year contact decreased and SH was difficult to reach. Due to staff absence SH was not contacted for four months, after which (early 2014) the service was unable to reach her and her case was closed.

3.5.52. *Learning*: Record keeping was identified as an issue for this service as well as a lack of support being offered when the main worker for SH was absent for a period of time. Although the service did not identify concerns over SH's relationship with NM at the time, they have, through this Review, identified a need for staff to be trained in relation to awareness and understanding of and responses to coercive and controlling behaviour. Recommendations have been made and are in progress.

3.5.53. *Solon Housing Association*: SH applied for and was granted a property in mid-2012. NM was recorded as being present at the allocation meeting, and was listed as next of kin. No concerns were noted in routine contact by the service.

3.5.54. *Learning*: Solon had no direct contact with SH due to the nature of her tenancy, which was 'general needs' (no additional needs identified). The only contact related to maintenance and building works carried out by contractors. Nevertheless, through this Review they have identified some best practice improvements to the system of New Tenancy Visits and Tenancy Audits. Recommendations have been made and are in progress.

3.5.55. *University Hospitals Bristol NHS Foundation Trust (UHB)*: SH's child was delivered in a UHB hospital; the midwifery service (in hospital) made a referral to Children's Social Care. Children's Social Care stated that they would follow up with SH at home (see also NBT

above). NM attended in autumn 2014 for treatment on the injury to his hand after he punched the wall at his General Practice (see above); he was treated and discharged and the GP was notified of the attendance.

3.5.56. *Learning*: The UHB hospital midwifery team acted appropriately in contacting Children's Social Care prior to discharging SH, in case any concerns needed to be shared. UHB now has a dedicated person within the safeguarding team who is responsible for contacting allocated social workers to ensure social reports are in place when a baby is delivered. The service informed the Review that all women are routinely asked about domestic abuse at different stages of their pregnancies.

4. Conclusions and Lessons to be Learnt

Domestic Abuse/Violence

4.1.1. Becky was killed by her step-brother NM and his girlfriend SH. This was the only act of domestic abuse/violence from NM towards Becky that had been documented by agencies within this Review.

4.1.2. In the months before she was killed, Becky told her mother and her friend that NM had threatened to kill her; but she did not give the impression of believing this, or of feeling threatened by NM or SH. She also reported to a friend that when Becky was aged around eight NM had "*grabbed her*" or rubbed her thigh when they sat together on the sofa. Neither Becky nor her friend had reported this to anyone else.

4.1.3. Some agency records suggest that NM may have been abusive to SH in their relationship, which SH also alleged to the independent chair. This is addressed below.

4.2. Conclusions

4.2.1. This Review has shown that none of the agencies involved with Becky and NM/SH knew of the connection between them. In their contact with agencies, none of them mentioned the others in the context of wider family networks. It is important to note here that many agencies have recognised, through this Review, that they were not proactively asking or recording family networks at the time (see more below in Lessons to be Learnt).

4.2.2. Had agencies asked Becky about her wider family, and had she given information about NM and SH, it seems unlikely (from the information submitted to this Review from agencies, family and friends) that NM and SH would have been seen as posing a threat to Becky to the extent that they would murder her. The information provided to this Review suggests that Becky and NM did not get on, and that Becky did not like being around NM; but it is not clear whether she felt fear, or at risk from him.

4.2.3. Agencies did not have any information that NM posed a risk to Becky, or to any other known person. Agencies documented NM's issues in relation to anger management, and his mental health issues, but these were never seen as leading to a risk to SH, their child, Becky or any other person.

4.2.4. The information provided to this Review presents a picture of Becky as a vulnerable young woman with a troubled past and complicated family picture; who was nevertheless attempting to move forward and find a future for herself. She had very close friends, and cared a great deal for her family.

4.2.5. NM and SH also appear as potentially vulnerable people with troubled and complicated backgrounds including and leading to significant amounts of agency intervention (actual and attempted). The pictures of them individually and as a couple can be contradictory; and as family and friends fed back to the Review, whatever their backgrounds nothing can excuse what they did.

4.2.6. Becky's friend asked the Review to address issues in relation to services for children once they turn 16, particularly housing and mental health. This is addressed below.

4.2.7. Becky's step-mother and father asked about what was known by Children's Social Care in relation to NM and any risk he may have posed. Children's Social Care, while involved with NM and SH and their child, did not record categorically that NM was a risk to his child; there was evidence that he may have posed a risk to SH, through his controlling behaviours, but this was not seen as impacting on the child. This issue is addressed below.

4.2.8. Becky's mother asked about Becky being in fear of NM, and whether this was known by anyone. This came from the court case, in which the prosecuting barrister appeared to state that Becky had told someone she was afraid of NM. Police records indicate that the prosecuting barrister referred to a statement from CAMHS in which Becky had stated she was afraid of NM. On behalf of the Review, the police Review Panel representative looked at the documents that had been submitted, and found that they do not state that Becky shared any fears, anxieties or incidents involving NM with the CAMHS consultant. It is therefore assumed that this was an unfortunate accidental misrepresentation of the statement from CAMHS.

4.2.9. Becky's mother asked whether Becky had been alone when asked by CAMHS whether she wanted to be seen on her own; this is addressed above (see 2.5.18). She also asked why the General Practice had not identified that NM shared Becky's address when he registered at the same GP (this was responded to, see 2.5.6 above).

4.3. Equality and Diversity

4.3.1. The Review Panel identified the following protected characteristics as requiring specific consideration for this case:

- Becky: age; sex; mental health; child sexual exploitation; young carer; poverty/deprivation.
- NM: sex; mental health.
- SH: pregnancy/maternity; sex; age; looked after child.

4.3.2. Sex is a relevant characteristic for all Domestic Homicide Reviews because women are overwhelmingly the victims of homicide from their male partners and ex-partners. In this case Becky was killed by her male family member and his girlfriend. There is little research into family homicides as opposed to intimate (ex)partner homicides; and to have a female perpetrator as well is unusual. It has been suggested that the coercive control NM appeared to display towards SH played a part in her role in Becky's murder. This Review cannot establish the facts of this, and can only observe from research on relationships in which a man is coercively controlling his female partner, that abusers can sufficiently establish both control and fear in their victim as to have significant impacts on them[8].

4.3.3. Gender is also relevant in relation to Becky's mental health issues, for which she was referred to Hospital Education and CAMHS. A 2017 NCB research report into young people's mental health concluded: "*Gender plays out in many ways important to children and young people's emotional and mental health and well-being. Gender-blind approaches to protecting and promoting children and young people's emotional and mental well-being miss important aspects of their needs and experiences; therefore, gender-informed policy-making, commissioning and service provision are required. Forthcoming developments in data collection and an evolving evidence base on the effectiveness of specific interventions can be drawn upon to achieve this.*"[9]

4.3.4. The issues of age, mental health, young carers, pregnancy/maternity, looked after children are addressed below in section 3.4.

4.3.5. Poverty and deprivation were identified by those agencies that had been in contact with Becky, NM and SH and noticed a common theme in relation to concerns over money. NM was recorded as having concerns over finances and appearing to control this in his relationship with SH. The issues for Becky related to concerns that she would be made homeless. According to the mother of one of Becky's friends (Q), Becky was 'always hungry', an issue also identified by a member of staff at Hospital Education who noted that a staff member was bringing in food for Becky. The aspect of money was not explored with

[8] *Controlling or Coercive Behaviour in an Intimate or Family Relationship: Statutory Guidance Framework* (2015) Home Office

[9] 'Gender and Children and Young People's Emotional and Mental Health: Evidence Review' (2017) NCB https://www.ncb.org.uk/genderandcypmentalhealth [accessed 7 December 2017]

Becky in the context of her other presenting issues, including the potential threat of homelessness, her anorexia, and attendance at Hospital Education. This is explored further below in section 3.4.

4.3.6. Disability was an issue in this review related Becky's experiences in her family. This is addressed below in section 3.4.

4.3.7. Race/nationality; religion and belief; sexual orientation; gender reassignment; marriage/civil partnership: the panel concluded these had no impact on this case.

4.4. Lessons to be learnt

4.4.1. The lessons and recommendations are made in the context that many years have passed since much of the agency contact with Becky, NM and SH.

Seeing the whole family, hearing the voice of the child and understanding the historical context

4.4.2. Becky, NM and SH accessed a large number of services between them across the timeline for this Review. The Review Panel agreed that for some of these services, inadequate account was taken of their histories. All three had complex and traumatic experiences in their lives. Agencies at times did not view the whole of these experiences alongside the presenting issue, e.g. potential homelessness (Becky) or depression (SH). All three could have been seen (and at times were seen) as vulnerable young people due to their previous experiences, regardless of their current life situation.

4.4.3. There was good practice related to recognition of SH's status as a 'Looked After Child' and subsequently as a 'Care Leaver'. Children's Social Care, 1625 Independent People, midwifery, health visiting and Places for People Living+ took into account SH's background in the services they attempted to provide to her.

4.4.4. The Bristol Hospital Education IMR acknowledges that insufficient research was carried out into Becky's background when she was first referred. Notes record how she had presented that day or at that meeting, with no interrogation of how this may have changed. She was alternately described as vulnerable and in need of services, and then as (e.g.) "*doing fine*". Her very low attendance over time did not appear to have been addressed. Becky's GP could have interrogated Becky's background more when responding to her in relation to anorexia, and during her later appointments. Similarly Early Help, when Becky was referred in 2014, could have assessed her history (including previous contact with services) to inform their response.

4.4.5. There was a lack of enquiry as to who comprised Becky's 'family', while taking into account her history and what was known about her life. In light of the fact that Becky was known to live in a 'blended' family (one in which two families have come together as one) with her

father and step-mother, it is surprising that there was not more professional curiosity about who else was in and around the household. This could have revealed the presence of NM (and SH) in Becky's life and any issues or vulnerabilities in relation to this, and the large age gap between them. In addition, because in the main Becky presented with her step-mother, some services did not pursue with Becky what her relationship with her mother was like, and proactively seek to include her mother in the delivery of services to Becky. Becky's GP recorded Becky as attending with her "*mother*" when in fact this was her step-mother. Had agencies asked more, they may have discovered NM's (and SH's) presence in the household; although we cannot know whether it would have led to any more than that. This lesson is also found in the Serious Case Review (findings two and four). Finding one of the Serious Case Review also stated there was "*no understanding of the nature of the overall family difficulties or bringing together of all the available information to make sense of what were the underlying issues and develop a holistic plan for addressing them.*"

4.4.6. Children's Social Care, CAMHS and Hospital Education IMRs note the absence of Becky's father from records and from agency interactions with Becky (this was also finding five of the Serious Case Review). He is referred to but not often seen. This is also highlighted in relation to the lack of challenge to NM when he is identified as exhibiting controlling behaviours towards SH and the child. The ways in which services for children and young people do not always facilitate the involvement of fathers has been well documented[10], and (while not conclusively a factor for NM and SH) this has been shown to have particularly negative affects when that father is abusive to the mother[11].

4.4.7. For a young person, their wider networks in relation to friends and intimate partners can be as important and influential as family, and this comes through for Becky from family and friends. Becky's friends were a significant source of support for her.

4.4.8. *Recommendation (4)*: agencies (through Safer Bristol Partnership and Bristol Safeguarding Children's Board) to report on how they now ensure that full account is taken of a child/young person's history, household and wider family/friend networks, including practitioners' use of professional curiosity, and how identified issues and needs are addressed. With specific reference to the recognition and inclusion of fathers, step-siblings and wider family and friend networks in work with children and young people.

4.4.9. While it is necessary and important for agencies to engage with a child or young person's whole family, the feedback from Becky's friend to this Review suggested that this might have also been a barrier for Becky to access services. Records from CAMHS suggest

[10] http://www.fatherhoodinstitute.org/2013/a-review-of-research-on-engaging-with-fathers-in-child-welfare-services/ [accessed 30 October 2017]

[11] *The Multi-Agency Response to Children Living with Domestic Abuse: Prevent, Protect and Repair* (2017) Joint Targeted Area Inspection Programme (HMIP, HMICFRS, CQC, Ofsted)

there was at times an emphasis on the voices of the adults around Becky, rather than taking on board what Becky was trying to say or communicate: for example at one point she stated she felt "*no adults listen to her*". This was a missed opportunity: CAMHS, or another service working with Becky at the time, could have explored this statement with her, ensuring that she was alone when this was done. If Becky did not want to speak with that agency or professional, they could have identified who Becky did trust and talk to, and ensure that Becky was supported through that route. Becky's mother also had concerns that Becky was not seen alone by agencies (see 2.3.4), and a recommendation (1) is made.

4.4.10. All Safeguarding Children's Boards ensure that key organisations carry out 'Section 11 Safeguarding Audits' (Children Act 2004). This places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. The audit covers a number of areas of work, including accountability, training and supervision, safer recruitment and ensuring that, where appropriate, the views of children and families are taken account of in service development and provision. This means that key agencies (local authorities, health agencies, police and probation) already report on how they seek and respond to the view of children and young people and families.

4.4.11. *Recommendation (5)*: agencies not already reporting on this through section 11 audits (through Safer Bristol Partnership and Bristol Safeguarding Children's Board) to report on how they integrate and prioritise the views of the children and young people they are working with, within a 'whole family' approach.

Record keeping

4.4.12. Action for Children, CAMHS, Early Help, Hospital Education, Places for People Living+, and 1625 Independent People outlined issues with recording. This meant that some of the interactions staff had in this case were difficult to identify or analyse in order to identify learning. It is possible that this also impacted on their ability to deliver effective, coordinated services at the time. Where necessary, agencies have taken prompt action in relation to this, as outlined in section four.

4.4.13. Record keeping is essential to track the needs being responded to by a service, and to understand the impact the service has on an individual. They can be time consuming for staff to complete and this was recognised by the Review Panel as a challenge. Nevertheless, without accurate, comprehensive and clear record keeping there are risks of needs not being met (because they haven't been recorded), of people dropping out of services (because a member of staff is absent and those trying to pick up cases cannot understand what contact they have had), and of multi-agency working not happening

(because records are not made and then shared). This lesson was also a finding in the Serious Case Review (finding two).

4.4.14. *Recommendation (6)*: agencies (through Safer Bristol Partnership and Bristol Safeguarding Children's Board) to report on how they monitor record keeping by staff to ensure it is consistently and robustly done.

Multi-agency working and information sharing

4.4.15. The issues with record keeping impacted on the Review Panel's and independent chair's ability to understand of how agencies worked together. There was good practice in relation to working together: CAMHS regularly kept Becky's GP and Hospital Education up to date on Becky. SH's Health Visitor communicated frequently with Children's Social Care and Places for People Living+, and joint meetings were held.

4.4.16. There were also examples of mismatches in understanding as to the purpose of a particular intervention, and a lack of follow up of referrals made to partner agencies. In 2014 Early Help and Action for Children understood each other's roles with Becky very differently. Early Help acknowledge that they should have checked on the referrals made for Becky before closing the case in 2014; and Hospital Education did not ensure that Becky had been referred to Young Carers. (Further information was provided by Young Carers, at 2.5.12 above.) The Review Panel discussed that agencies responded to Becky's presenting issues, rather than understanding the context and background to those issues and responding to her holistically.

4.4.17. The records do not suggest a 'team' of agencies around Becky, but a number of agencies all of whom were potentially doing good work but were not collectively discussing Becky and her needs. The Review Panel agreed that part of this problem stemmed from the lack of an assessment of Becky and her needs when she was referred to Early Help in 2014. Early Help have confirmed that an assessment would now be done for a case such as Becky's where multiple concerns and risk factors were identified by the referrer, including worries about youth homelessness, young caring, child sexual exploitation and poor attendance at Hospital Education. Processes are in place for the service to deliver support directly, alongside other services such as Creative Youth Network.

4.4.18. A Single Assessment Framework is now in place and assessments identify the level of need and the appropriate response required, whether this is advice and no further action, allocation to an internal team of Family Support Workers or external allocation to a commissioned service. A 'Team around the Family' (TAF) is now formed for those cases that require it, aiming to ensure a more holistic response to children taking account of their environment, relationships and the wider family needs. This includes the identification of a Lead Professional, and TAF meetings to ensure a multi-agency response.

4.4.19. In 2011 Becky did receive an initial assessment and was appropriately referred to services (FISS and CAMHS). When these services closed Becky's case (or discharged her) she was still potentially vulnerable, evidenced through her background and continued placement at Hospital Education. The Hospital Education IMR author felt that the service was left to manage Becky and her continuing needs alone and that this was not appropriate. A recommendation has been made to ensure that staff escalate these situations to senior managers when required.

4.4.20. The Serious Case Review found that there should have been planned multi-agency working through a Child in Need plan, but this did not happen (finding two).

4.4.21. Becky's friend and her mother told the Review that she felt after CAMHS that there wasn't a service in place that met Becky's needs. She felt that Becky may have perceived CAMHS and others as places she could only access with her family, which she did not want to do. She was not aware at that time of other services that could have helped her (e.g. Off the Record), in particular in relation to her wish to move out of home. If a single professional had been identified and able to establish a trusting relationship with Becky, this could have facilitated her accessing the services and support she needed.

4.4.22. A partnership is now in place in Bristol under the name 'Children and Young People's Improving Access to Psychological Therapies' or CYP-IAPT. Adult IAPT is a specific service provision for adults to access therapy; the IAPT offer for children and young people, funded currently in Bristol by NHS England, involves the upskilling of staff who already work with children, young people and families, to enable an enhanced response to their mental health needs. Staff in Bristol City Council Early Help service, CAMHS, Creative Youth Network, Off the Record and 1625 Independent People have achieved (or are working towards) qualifications in areas relevant to their service provision (e.g. parenting work, work with children, work with young people) that adhere to NICE (National Institute for Clinical Excellence) and BACP (British Association of Counselling and Psychotherapy) guidelines and following four key principles:

- Evidence-based interventions
- (Clinical) supervision of staff
- Using routine outcome monitoring
- Service user participation

4.4.23. Practitioners work in partnership with clients to identify their needs and the best pathway of support, utilising their enhanced skills from the training and qualifications. Had this been available at the time Becky was in contact with services, it would have added to the support she received from CAMHS and Creative Youth Network. This was particularly important for Becky once she turned 16, in light of her friend's and mother's comments to the Review

that it felt like a time when they were 'between' services – no longer feeling they are 'children' but not yet adults.

Use of language

4.4.24. Becky was described by family members as a 'typical teenager', and the Review Panel discussed how this phrase can be understood in different ways, and could limit the way professionals understand the needs of a young person, particularly, as in this case, a young person who has experienced early trauma and has ongoing mental health issues. Hospital Education staff commented on Becky's use of inappropriate language, that she was answering back and being argumentative: records do not suggest that this was explored with her, and it could be suggested that because many young people behave in this way it is accepted as 'normal' behaviour in a way that shuts down exploration with them of their situation and needs. CAMHS records described Becky demonstrating "*oppositional*" behaviour in using her mobile phone during a session. This may have been one of the many impressions for professionals in relating with Becky, but it was the one that was noted down and communicated to Becky's GP and Hospital Education. In hindsight there are many other explanations for Becky's use of her phone during work with an agency, such as distraction from a painful or uncomfortable experience, a means of communicating that she did not wish to be there, or a need to maintain contact with her friends who were central to her life.

4.4.25. Rather than using these labels, it could have been more productive to explore with Becky what these behaviours meant to her, and open a space in which she could discuss this. We cannot know whether this would have worked with Becky, but it could have been attempted.

4.4.26. The Serious Case Review about Becky also made a finding about the use of language about Becky (finding one). In addition the Review Panel were alerted to a similar finding in a recent serious Case Review, on the case of ZBM. The finding was that "*common terms used professionally to describe a service user's health may have different connotations depending on the professional setting. If they are taken at face value by other professionals this will have a direct impact on practice and decision making*". The Serious Case Review asks the Bristol Safeguarding Children Board "*How can the Board encourage professionals to use precise language to explain their concerns to other agencies in order to ensure common understanding?*" The learning from this Review should be added to that question.

Child sexual exploitation / Violence against women and girls

4.4.27. At one point Becky was perceived by the Hospital Education service as at risk of sexual exploitation, and they acted appropriately in seeking the support of Early Help. One staff member had concerns about Becky: the way they worded this placed the responsibility onto Becky, a potentially vulnerable child. It would have been more constructive to look at,

and discuss with her, her environment and influencing factors, to understand where the behaviours came from and what they meant to her.

4.4.28. Research and reviews into child sexual exploitation have aimed to move away from a viewpoint that positions the child/young person as 'a problem' towards one that tries to understand their situation, vulnerabilities, background and the risks they face from their environment and networks[12].

4.4.29. Becky's friend told the Review that Becky was "*cat-called*" a lot: shouted at in the street by men, and one instance when a man tried to get her into his car. Becky was very unhappy about the attention she received and it impacted directly on her not wishing to go out alone, or sometimes at all. This sexual harassment of women, particularly young women, is more widely recognised now and seen on the same spectrum of violence against women and girls as sexual abuse and violence and domestic abuse. This was the environment Becky lived in: where her appearance was a significant factor and she was possibly very aware of how others saw her. Her anorexia and social anxiety were possibly part of that.

4.4.30. This needs to be understood in the context of Becky's disclosure to her friend that NM had rubbed her leg when she was a younger child.

4.4.31. The issue of child sexual exploitation was also relevant in relation to SH and NM's relationship, which started when she was 15 and NM was 22: the Review Panel agreed that this would now trigger a proactive response from professionals who have been trained to identify and response to potential sexual exploitation. There was a consistent lack of enquiry and professional curiosity about their relationship from Children's Social Care: NM was seen as a positive influence (this was stated in response to concerns from 1625ip). We cannot know what would have been discovered had this relationship been explored further, but an age gap such as this for any child entering a relationship should be queried, and is particular important when the child is under the care of the local authority and has a complex history.

4.4.32. The Brooke Serious Case Review into Child Sexual Exploitation (CSE) was carried out on behalf of the Bristol Safeguarding Children's Board in 2014. The Review found (amongst other conclusions) that "*the multi-agency system was not set up to provide an effective response for adolescents (including those at risk of CSE) with a complexity of needs at the time and pace they need it, leaving children with a fragmented and reactive response to different aspects of their behaviour.*" This chimes with the learning from this Domestic Homicide Review.

[12] See for example Barnardo's Model of Practice http://www.barnardos.org.uk/cse_barnardo_s_model_of_practice.pdf [accessed 30 October 2017]

4.4.33. The Review received information on action that has been taken by the Bristol Safeguarding Children's Board in response to the Brooke Serious Case Review covering prevention, disruption and prosecution, support for victims and workforce development.

4.4.34. The Bristol Domestic and Sexual Abuse Strategy Group informed the Review that there was an ongoing Bristol Zero Tolerance project; at that time (October 2017) it was running a campaign focussed on street harassment, including information for victims on how to report and get support and for bystanders on how they can challenge what they see[13].

4.4.35. The Strategy Group also informed the Review about the Bristol Ideal Award for schools, which supports them in their education to children and young people around healthy relationships, abuse and violence. Eight schools have so far passed and the work is ongoing[14].

4.4.36. The Review was informed that in Hospital Education the Personal, Social, Health and Economic (PSHE) education curriculum and provision are the same as mainstream schools. Hospital Education staff delivering PHSE in classes attend regular city wide PHSE subject meetings and Hospital Education staff have had additional support from Bristol City Council to develop the PHSE curriculum. Staff have had dedicated time to keep the curriculum in line with current practice.

Identification of and response to coercive and controlling behaviours

4.4.37. Health Visiting, Children's Social Care, Places for People Living+ and 1625 Independent People identified NM as using "*controlling*" behaviours towards SH. Her GP recorded concerns over the relationship and that there was something more going on than was disclosed. SH alleged to the Review that NM was abusive towards her; he denied this.

4.4.38. The behaviours were named as domestic abuse on one occasion, by Children's Social Care in the assessment of SH's and NM's child. No other agency named the controlling behaviours as domestic abuse, or for some behaviours more specifically as economic abuse, and it was not responded to as such. The alleged behaviours included: speaking for SH; not allowing the heating to be put on; not allowing SH to have a phone of her own.

4.4.39. NM's behaviours were not understood within a framework of domestic abuse and economic abuse: this could have enabled professionals to identify risk factors such as SH's isolation, young age and risk factors relating to pregnancy/post-natal. Pathways would also then have been in place to attempt to support SH. It should also have been recognised that any domestic abuse from NM to SH would have impacted on their child, leading to action to support and protect them.

[13] https://www.bristolzerotolerance.com/get-involved/bristol-street-harassment-project/ [accessed 30 October 2017].

[14] http://www.bristolideal.org.uk [accessed 30 October 2017]

4.4.40. We cannot know whether SH would have taken up the domestic abuse services offered: she informed the Review she would not have done as she did not understand the situation she was in and felt "*trapped*". She should have been offered them, and the issue of NM's controlling behaviours should also have been discussed with him by Children's Social Care, and relevant support offered for him to choose to behave differently.

4.4.41. This Review recognises that awareness of coercive and controlling behaviours has increased since the time in question, and that this now forms part of domestic abuse training that is accessed by professionals in many agencies. The legislation introduced in 2015 of the Coercive and Controlling Behaviours Offence has raised the status of and understanding about the behaviours used by perpetrators and the impact had on victims. One learning in relation to the offence is that accurate and well documented record keeping by all agencies is essential, to reflect the experience of the victim in their own words. This record keeping has the potential to enable police to build cases around a victim of their experiences of being controlled and coerced by the perpetrator.

4.4.42. The Review Panel questioned whether knowledge and understanding of coercive control extended to situations in which the abuser and victim were family members, rather than in an intimate relationship. It is essential that training, policies and procedures recognise all forms of relationships in which someone may be abusive; and that training is accessed by managers as well as front line practitioners.

4.4.43. The Review heard that the Bristol Domestic and Sexual Abuse Strategy Group has previously delivered multi-agency domestic abuse training and is hoping to again when resources allow for this. The Strategy Group has links with commissioning and with the Avon and Somerset Police Violence Against Women and Girls Strategy Group, as well as sub-groups addressing specific issues such as sexual violence. A Prevention Network is in place as an informal means for any agency to link with the work of the Strategy Group.

4.4.44. *Recommendation (7)*: The Strategy Group to address how the widest possible network of agencies can access up to date information on domestic abuse, pathways for referral, best practice and any training available.

4.4.45. *Recommendation (8)*: agencies (through Safer Bristol Partnership and Bristol Safeguarding Children's Board) to report on the domestic abuse training they deliver internally, or access externally, and how this addresses the identification of and response to coercive and controlling behaviours, and economic abuse, and where this is not adequately addressed, changes to be made to those training programmes.

4.4.46. *Recommendation (9)*: Safer Bristol Partnership and Bristol Safeguarding Children's Board to review domestic abuse training currently delivered through the partnerships to ensure that it adequately covers the identification of and response to coercive and controlling behaviours, both in relation to support for victims and appropriate and safe challenge to

perpetrators (for those agencies for which this is within their remit). Also to ensure that any domestic abuse training that is developed in the future covers this.

Journeys through services dictated by single issue

4.4.47. Becky was referred to Young Carers for her experience in her family; to Barnardo's because she was seen as at risk of sexual exploitation; and to Early Help for her other needs. There wasn't a single coordinating service at the heart of this. Had those referrals gone through, and had Becky accepted their help, she would have been asked to compartmentalise the different experiences of her past and present into the specific areas those services are commissioned to provide; and this may have impacted on her willingness to engage. Children (and adults) are rarely dealing with a single issue in their lives – and their experience of those issues interlink and impact on each other.

4.4.48. Could those services have come together to address her needs? Does the expertise exist in one agency to support a child like Becky who has multiple needs and issues? How can services address these needs, taking into account a child's history and how that impacts on their vulnerability and ability to manage? The information received on the Team around the Family should address this.

4.4.49. Once CAMHS felt that Becky's mental health had improved to the point that she could be discharged, was there another service that could act as a 'step-down' so that she didn't go from intensive support to nothing? Services have developed so Becky could have supported beyond CAMHS: see the information on CYP IAPT (see 3.4.22).

Responses to individuals with 'low level' mental health issues who are not accessing specialist support

4.4.50. NM's GP repeatedly referred him to IAPT, but NM did not take it up, and his mental health remained a concern. The contact IAPT made to the NBT Pain Clinic was an opportunity to coordinate NM's support but it is not possible to establish what happened, as the Pain Clinic notes were not available and it does not appear that IAPT persisted with their attempts at contacting the clinic.

4.4.51. As an adult NM had responsibility for accessing and engaging with the services that he had been referred to by his GP to meet his physical and psychological needs. Recognising that GPs sometimes have to manage complex patients with low level mental health issues who are not engaging with specialist support, each practice now has a GP Mental Health Lead. In addition, GPs have access to a Link Consultant Psychiatrist to contact for advice and guidance in relation to patients with mental health needs.

GP's role in coordinating care

4.4.52. A person's GP is understood to be at the centre of their healthcare: receiving information from other health services being accessed and making referrals to specialist and secondary services. This assumes that GPs are provided with all of the information, and

that this information transfers when a patient moves practice; the latter was not always evident in NM's case, but notifications were made from IAPT and the hospital. The Review Panel discussed these notifications, and the fact that the GP is unlikely to take action in response to them, unless this is requested specifically.

4.4.53. NM was a complex individual who presented repeatedly with longstanding and hard to explain symptoms and issues across his physical and mental health. The GP's role was to try to understand what NM's needs may have been; but the responsibility for acting on those needs rested largely with NM. Given his history, the complexity of his inter-linking issues, could he have benefited from an independent person to support him in navigating the physical and mental health services that could have helped him?

4.4.54. The Review Panel agreed that central to this point is how GPs are supported to engage with more complex individuals, and in ensuring that other agencies provide GPs with information about their patients to ensure the GP can make informed decisions. The developments in relation to mental health provision and links in General Practices, outlined above, should support this. In addition the Review heard that there is a Bristol City Council Community Support Team, accessed through the Adult Social Care front door Bristol Care Direct, that can support individuals to access community services and navigate their way through applying for benefits. Social Prescribing services are also in place in Bristol to support individuals in accessing support within their own communities through working with a coordinator to identify the individual's needs and opportunities.

4.4.55. Becky could also have benefited from a central person coordinating the services she was in contact with: because she was a child, there were more opportunities for a professional to take on this role and this would now be identified as the 'lead professional' with a clear role and responsibility.

5. Recommendations

5.1. Recommendations from Agency IMRs

5.1.1. These recommendations were made by agencies when they completed their IMRs mid-2017. All agencies have provided updates to the Review on how these recommendations have been, or are in the process of being, implemented.

5.1.2. Action for Children:

- The Operational Director of Children's Services, Children's Services Manager and a member of the Practice Improvement service should review a number of current case files to be satisfied about standards of safeguarding and recording.

- The Children's Services Manager should ensure that further case files are selected for review on a quarterly basis in 2015-16 from this service in order to ensure that any improvements noted have been made and sustained.
- In light of the above and other information, the Operational Director of Children's Services and Children's Services Manager should investigate the workload levels for practitioner staff and report on this and any action needed to the UK Director for Children's services (West) and ensure that the Head of Safeguarding is made aware of the finding in case this might have wider relevance to other similar services elsewhere.
- Training should be provided to all practitioners and supervisors on the implications of safeguarding vulnerable teenagers. This should be based on case materials or case studies so we can check whether there is an over-concentration on adults and/or over-optimism/de-sensitisation in the service and should also review expectations and judgments about required levels of hygiene and cleanliness in households.

5.1.3. Bristol City Council Children's Social Care Services:

- Ensure that fathers are actively involved in social care assessments and ongoing work.
- Ensure all family members living with children or having significant levels of contact are identified at an early stage of assessment.
- Improve standards of practice for Care Leavers.
- Consideration to be given to specific training for Leaving Care Personal Advisers around some the complexities of working with Care Leavers, including a focus on how past experiences of trauma and abuse can impact on their choices as they move into adulthood, and how best they can support them with this.
- Pre-birth assessments of the expected babies of Care Leavers should be carried out in a timely way and should be holistic.

5.1.4. Bristol City Council Children's Early Help Services:

a. Early Help should challenge case closure by commissioned services or external Lead Professionals when a full assessment of all the risk factors included in the referral have not been explored. There are systems in place whereby this could be actioned from immediate effect.
b. Early Help should contact agencies that have been referred to provide support to children and families to ensure that the referral has been accepted and to provide information about the timescales involved for the support being provided.
c. Early Help should ensure that agencies are aware that should concerns re-emerge that a new referral can and should be made.

5.1.5. Bristol Hospital Education Service:

- Review its referral form to ensure that it reflects the Assessment of Need for Children and their Families triangle namely: the child's developmental needs; parenting capacity to meet their needs and environmental factors that impact on the child and their family (which includes family history and functioning).
- Staff supporting children and young people should have access to relevant information, a pen picture of issues which staff should be aware of and monitor. How information is shared within the service should be reviewed, if staff are not aware of risk factors or specific issues then they are not able to respond effectively.
- Adopt a team around the child or family approach to ensure that all professionals, disciplines and agencies involved with the child and their family share relevant information and are part of the support package via a formal referral meeting involving relevant agencies.
- All agencies, including mainstream schools, should submit a written report at the first review and updates of their involvement between reviews and most importantly attend reviews. If agencies do not attend there should be a requirement that they submit a report and if they regularly miss reviews this should be challenged and escalated where necessary by Hospital Education within their organisation.
- Student reviews should be conducted against a standard agenda format that includes updates, progress in relation to education and social/emotional targets, next steps and importantly address any safeguarding issues.
- Put in place recording standards that ensures staff record antecedents, behaviour and consequences when reporting incidents and that all recording is contextual and informative.
- Maintain chronologies that are reviewed regularly by management and before any student review.
- Records held electronically should be audited to ensure compliance with the agreed recording standards.
- Staff to be aware of the BSCB escalation procedure it they are unhappy with the outcome of referrals made to either First Response or Early Help. In respect of other agencies there are similar processes in place to raise concerns.
- In relation to safeguarding CPD this should be reviewed to ensure that staff receive an annual update in relation to safeguarding, access training in relation to attachment, blended families, the importance of effective information sharing, the significance of historical information, working within the CAF framework, the BSCB threshold document, disguised compliance and adopting professional curiosity.
- There should be regular 1:1 supervision of all staff working with children and young people to ensure that the welfare of the child is paramount and their voice heard. In

addition, the 1:1's should have a set agenda whereby staff reflect on their involvement with parents, children and young people and other professionals, the fundamental question being are we being effective? Are we meeting the needs of the child or young person? If not what do we need to do?

- The management committee should consider how it ensures safeguarding governance is embedded and delivered as required under Working Together to Safeguard Children and Keeping Children Safe in Education.
- Education training providers have the same statutory responsibilities under Working Together to Safeguard Children and Keeping Children Safe in Education. As such recommendations made in respect of Hospital Education also apply to training providers and commissioners should ensure that they meet statutory requirements.

5.1.6. Child and Adolescent Mental Health Services (CAMHS), Avon and Wiltshire Mental Health Partnership NHS Trust outlined the following learning and recommendations:

- Clear risk assessment documentation should be recorded and easily accessible in the CAMHS records – this is already in place after the introduction of electronic records.
- Consider whether there should be a standardised way of asking about domestic violence and recording this is in CAMHS records and risk assessments. This needs to be done in a meaningful way with families at an appropriate time and not as a simple 'tick box exercise'. The Review Panel member will take this forward with the safeguarding leads.
- Following an episode of specialist work within CAMHS such as family therapy, a written summary should be produced and disseminated appropriately.
- This case highlights the interface between CAMHS and other agencies. Multi agency meetings should have a clear remit, with goals and action points for each agency. Minutes of meetings should be produced and disseminated with a review date. within the appropriate framework such as SAF, Child in Need, a lead professional should be identified.
- CAMHS records should have a clear and up to date risk assessment outlining risk in a holistic manner, not just focusing on mental health and risk of harm to self. I will take this forward with my safeguarding colleagues so we can produce a service wide approach to assessing and documenting risk.

5.1.7. Creative Youth Network:

- Make contact with the agency /service you have referred the young person to see how they are progressing in their new offer.
- All staff trained in signs of danger and coercive control.
- Ensure that going forward that staff meet face to face with a young person to finish a one-to-one intervention rather than finishing via a text.

5.1.8. University Hospitals Bristol NHS Foundation Trust:

- The IMR has highlighted that staff in the Emergency Department at the BRI did not complete a 'Cause for Concern' form when Becky attended intoxicated. Although not directly related to this Review, Nursing and Medical staff will be reminded that when any young person aged 16 and 17 year olds attends the department intoxicated a 'Cause for Concern' form needs to be completed. This action will be addressed through the existing fortnightly 'Cause for Concern' meeting. Oversight of this action will be through the existing Trust governance process, including through the Child Protection Operational Group.
- When SH delivered her baby at St. Michael's Hospital there was not a social report available for staff to follow. UHB now has a dedicated person within the safeguarding team who is responsible for contacting allocated social workers to ensure social reports are in place when a baby is delivered.

5.1.9. Places for People Living+:

- Amendment to Assessment and Support Planning Procedure to ensure Managers take responsibility for appropriate case management.
- Training to be delivered to all front-line staff on record keeping.
- Review Safeguarding Training.
- Amendment to Assessment and Support Planning procedure. To specify all cases must be closed on ecco (case management system) and good practice to inform in writing/email key stakeholders (Social Workers, Health Visitors etc). Report developed to identify cases with no recorded action for 30 days.
- Amendment to Assessment and Support Planning Procedure. To cover increasing disengagement – how this should be identified, actions and tools available to use to address concerns (Support Philosophy tools, Retention Plans etc).
- Current Safeguarding Training covers coercive control/abuse. Coercive Control is also included in Domestic Abuse Training. Recommend Domestic Abuse Training for all Managers covering customers and staff.

5.2. Overview Report Recommendations

5.3. The recommendations below should be acted on through the development of an action plan, with progress reported on to the Safer Bristol Partnership within six months of the Review being approved by the partnership.

5.4. *Recommendation 1 (ref 2.3.5 & 3.4.9)*: Relevant agencies within this Review to report to Safer Bristol and Bristol Safeguarding Children Board on how they ask children and young people about being seen alone; what policies, procedures, training and considerations

there are in relation to this; and if any improvements are identified, for these to be acted upon and the learning shared.

5.5. *Recommendation 2 (ref 2.5.6)*: Department of Health to draw on the learning from this Review to support General Practices nationally on identifying as early as possible when new patients registering with the practice are connected with existing patients.

5.6. *Recommendation 3 (ref 2.5.24)*: Clinical Commissioning Group to communicate with all health agencies in Bristol the expectation that children up to the age of 16 will be assessed for Gillick Competency using Fraser Guidelines at every appropriate interaction, and that this will be recorded in their notes. With particular emphasis on appointments with children concerning contraception and sexual health.

5.7. *Recommendation 4 (ref 3.4.8)*: All agencies (through Safer Bristol Partnership and Bristol Safeguarding Children's Board) to report on how they now ensure that full account is taken of a child/young person's history, household and wider family/friend networks, including practitioners' use of professional curiosity, and how identified issues and needs are addressed. With specific reference to the recognition and inclusion of fathers and wider family and friend networks in work with children and young people.

5.8. *Recommendation 5 (ref 3.4.11)*: All agencies not already reporting on this through section 11 audits to report (through Safer Bristol Partnership and Bristol Safeguarding Children's Board) on how they integrate and prioritise the views of the children and young people they are working with, within a 'whole family' approach.

5.9. *Recommendation 6 (ref 3.4.14)*: All agencies to report (through Safer Bristol Partnership and Bristol Safeguarding Children's Board) on how they monitor record keeping by staff to ensure it is consistently and robustly done.

5.10. *Recommendation 7 (ref 3.4.43)*: The Domestic Abuse and Sexual Violence Strategy Group to address how the widest possible network of agencies can access up to date information on domestic abuse, pathways for referral, best practice and any training available. To report on this to the Safer Bristol Partnership.

5.11. *Recommendation 8 (ref 3.4.44)*: All agencies to report (through Safer Bristol Partnership and Bristol Safeguarding Children's Board) on the domestic abuse training they deliver internally, or access externally, and how this addresses the identification of and response to coercive and controlling behaviours, and where this is not adequately done, for changes to be made to those training programmes.

5.12. *Recommendation 9 (ref 3.4.45)*: Safer Bristol Partnership and Bristol Safeguarding Children's Board to review domestic abuse training currently delivered through the partnerships to ensure that it adequately covers the identification of and response to coercive and controlling behaviours, both in relation to support for victims and appropriate

and safe challenge to perpetrators (for those agencies for which this is within their remit). Also to ensure that any domestic abuse training that is developed in the future covers this.