**SAFER NORTHUMBERLAND**

**ANONYMISED EXECUTIVE SUMMARY**

**DOMESTIC HOMICIDE REVIEW:**

**INDEPENDENT OVERVIEW REPORT**

**INTO THE DEATH OF**

**‘Julia’**

**PREPARED BY RICHARD CORKHILL**

**FINAL REPORT APRIL 2015**

***(Updated Dec 2015)***

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**1) Purpose of Domestic Homicide Reviews:**

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

**2) Who the report is about:**

This report of a domestic homicide review examines agency responses and support given to **Julia[[1]](#footnote-1)**, a resident of Northumberland prior to her death in 2013. She was in her early 40s at the time of her death.

The review considers agencies’ contacts and involvement with Julia and the perpetrator **Brenda**, who was in her late 50’s and was the paternal grandmother of Julia’s child, **Child E**. Julia had been separated from Child E’s father (**James,** son of perpetrator, Brenda) since around 2005, but had stayed in regular contact with both James and Brenda, as they remained closely involved with Child E.

**3) Outline summary of the homicide incident and surrounding events**

The following is a brief factual summary of events, including the last episode of police involvement with Brenda, which started on the day before the homicide took place.

On a Saturday afternoon in 2013, the police received a call from Julia, stating that after eating meals prepared by Brenda, she felt unwell. She had contacted NHS Direct, who advised that she should inform the police of her suspicion that Brenda may have attempted to poison her. A constable visited Julia, who confirmed that she had been unwell, but did not believe that Brenda would attempt to cause her any harm. She reported that Brenda had cooked her a meal about a week previously. She had noticed a strange taste / texture (explained by Brenda as being an Indian seasoning herb) but had eaten most of the meal, following which she had been violently sick. Brenda had visited again a week later, bringing a pre-prepared meal for Julia. Immediately noticing the same taste / texture, Julia had declined to eat the meal, telling Brenda it was too spicy for her.

Julia did not want the police to approach Brenda directly at this stage. The constable removed the uneaten meal which had been prepared by Brenda, for testing. Julia was advised to seek a medical appointment, but this was not viewed as an emergency, as she had not consumed the meal and did not report symptoms of illness.

On the following day (Sunday) attempts by police to contact Julia (via telephone calls and a visit to her address) were unsuccessful.

On the Monday there were further attempts by the police to contact Julia, but these also were unsuccessful. Enquiries were made with a neighbour, who advised that his wife had seen Julia at lunchtime on the previous day when she appeared safe and well. (It subsequently became clear that this neighbour had been mistaken.) On Monday, contact was also made with Brenda, who stated that Julia was staying with an aunt.

Later on Monday, Brenda crashed her car and suicide notes were found in the vehicle. The subsequent police investigation and criminal trial established that Julia had been murdered by Brenda on the Sunday morning. Brenda’s own account in police statements suggests the following sequence of events took place on that morning:

* Brenda visited Julia at home, at a time when there was intense conflict about James’s contact arrangements with Child E.
* A very heated argument developed, culminating in Julia saying she was going to take Child E abroad and Brenda would never see the child again.
* Following this, Brenda repeatedly stabbed Julia with a filleting knife.
* Child E was in the house when the murder took place and heard the confrontation, but did not see the incident as they were in a different room.
* After the incident, Brenda left the house, taking Child E with her.

The criminal trial was presented with evidence that the knife attack was pre-meditated, but this was denied by Brenda. She was found guilty of murder and sentenced to life imprisonment with a recommended minimum term of 20 years.

**4) Family background / history of domestic violence concerns**

The homicide victim Julia had experienced a traumatic childhood, raised by her mother who had mental health problems and an abusive father. As an adult, she had had 5 children, but only the youngest child (Child E) was in her care at the time of her death. The 4 older children were from previous relationships.

Children’s Services had been involved with the family from the birth of Child E, as a result of a history of child safeguarding concerns in respect of Julia’s older children. A care order was granted in respect of Child E. Child E was cared for by Julia and James with close involvement of James’ parents and ongoing planning and reviews by Children’s Services. Parental care was seen to be successful, resulting in the care order changing to a supervision order, before being fully discharged when Child E was just over 2 years old.

Between 2005 and 2007, there were domestic violence incidents in the relationship between Julia and James, resulting in a number of police contacts and generation of Child Concern Notifications, by the police to Northumberland Children’s Services. One of these incidents resulted in James being convicted for kidnapping, affray and assault, for which he received a 12 month Community Order, in 2007.

Following separation from James, Julia had a short relationship with a subsequent partner. In 2008 there were some reported conflicts and possible domestic violence involving this new partner. Police visits resulted in further Child Concern Notifications to Children’s Services, but there were no criminal charges arising from these incidents

There were no reported incidents of conflicts or domestic abuse affecting Julia (from any source) between October 2008 and the day immediately prior the homicide in 2013, when the police were advised of the suspected poisoning incident. There was no known previous history of domestic violence involving Brenda.

There had been a history of periods of heated conflict between Julia and Brenda, which was focused very much on contact arrangements with Child E. Following a domestic violence incident in 2007(involving James) Brenda had attempted (without success) to persuade Julia to withdraw support for a criminal prosecution. Despite these areas of conflict, Julia has consistently been reported by friends and family to have regarded Brenda as having been a source of support and to have referred to Brenda as being her “*rock”.*

**5) The Domestic Homicide process**

In March 2013 Northumberland Community Safety Partnership agreed that the circumstances of this case met the criteria for a DHR and the Home Office was duly informed of the decision to hold a DHR.

The following tables provide a summary of agency contributions:

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| **DHR Panel Members** |
| **Name** | **Organisation**  |
| Richard Burrows | Independent consultant / **Independent Panel Chair** |
| Richard Corkhill | Independent consultant / **Overview Report Author** |
| Allan Brown  | Domestic Violence & Sexual Abuse Policy Officer,Northumberland County Council / **Panel Administrator** |
| Mark Douglas | Northumberland County Council: Head of Safeguarding & looked After Children |
| John Douglas | Northumbria Police: Acting Chief Inspector, Protecting Vulnerable Persons Unit |
| Dr. Stephen Blades | NHS Northumberland Clinical Commissioning Group (CCG): G.P. Practices |
| Debbie Reape | Northumberland Health Care NHS Foundation Trust: Deputy Director of Nursing |
| Jan Grey | Northumberland Tyne & Wear NHS Foundation Trust: Head of Safeguarding |
| Liz Kelly | Northumbria Probation Trust: Director of Offender Management |
| Anna English | Northumberland County Council Adult Services: Strategic Adults Safeguarding Manager |
| Lesley Thirwell | North East Ambulance Service: Safeguarding Lead |
| Matt Thomas | Northumberland Fire and Rescue Service: Deputy Chief Fire Officer |
| Liz Jarvis | Northumbria Victim Support: Divisional Manager |

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| **IMR Authors** |
| Audrey Johnson | Northumberland County Council: Children’s Services Manager |
| Joan Robson | Northumbria Police: Major Crime Review Advisor |
| Dr. Stephen Blades | NHS Northumberland Clinical Commissioning Group (CCG): G.P. Practices |
| Jan Grey | Northumberland Tyne & Wear NHS Foundation Trust: Head of Safeguarding |
| Pat Amis | Northumbria Healthcare NHS Foundation Trust: Senior Nurse, Safeguarding Adult Lead |
| Liz Kelly | Northumbria Probation Trust: Director of Offender Management |

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| **Other contributions** |
| DC Emily Butler | Detective Constable, Isle of Man Police Service:Family Liaison Officer for Victim’s sister |

**6) Involvement of family members and friends in the DHR:**

This report has been informed by meetings between the Independent Overview Report Author and the following people:

* Brenda (homicide perpetrator)
* Brenda’s husband and her son (James)
* Julia (victim’s) sister
* 3 close friends of Julia

*The DHR Panel and Overview author would like to convey particular gratitude to the victim’s sister and friends for their contributions, which provided valuable additional insight and learning.*

**7) Terms of Reference and Key Learning**

The Terms of Reference included a number of specific questions which the Individual Management Reviews (IMRs) were required to address and have formed the structure for presentation of key learning from the DHR. The following is a summary of the overview analysis and key learning points arising from these questions:

**If there was a low level of contact with your agency why was this so? Were there any barriers to either the victim or the perpetrator accessing your services and seeking support?**

The DHR has highlighted a history which included missed opportunities, when allegations of domestic violence by the perpetrators son were not followed up with sufficient focus on the potential impacts of wider family relationships. However, the last of these occasions was around five years before the homicide took place and at that time there was no indication that Brenda presented any risk of violence, towards Julia, or anybody else. On this basis, the level of response to those past incidents could not be seen to have contributed directly to the eventual tragic outcome. However, the family background and known history leading up to this homicide have highlighted a very important learning point for the future development of MARACs and multi-agency approaches to risk assessment:

**Learning Point 1**

Domestic violence does not always happen in a “relationship vacuum” occupied exclusively by the known perpetrator and victim. The findings of this DHR clearly illustrate that domestic violence risk assessments and multi-agency interventions need to consider the potential impacts (positive or negative) of wider family relationships, in line with “Think Family” principles.

On occasions when she was subjected to violent incidents, Julia did request - and receive - appropriate intervention from the police. It is not possible to know whether or not there were other incidents of violence which went unreported, but there can be significant barriers to mothers reporting domestic violence, if they fear that social services interventions (including possible care proceedings) could follow. Bearing in mind the history with Julia’s older children, this might have been factor in this case, but the evidence seen by the DHR does not confirm this.

This highlights a challenge for Children’s Services which have been criticised for lack of robustness in responding to allegations of domestic violence within a family, when they are rightly required to treat the safety and wellbeing of children as the paramount concern. On the other hand, they may also be criticised for assertive approaches which could leave domestic violence victims feeling reluctant to report future incidents and seek advice and support.

**Learning point 2**

**All** services dealing with reports of domestic violence in families where children could be at risk of harm, are charged with making some very difficult and complex judgments in gauging appropriate levels of response.

They must be as supportive as possible to the adult victim of abuse, whilst recognising that the safety and emotional wellbeing of the child is of paramount importance. This creates a professional challenge not only for statutory Children’s Services, but also for other agencies such as the police, primary health care and voluntary sector advice and support agencies.

There are no simple or “one size fits all” solutions to such complex and potentially high risk situations. However, a key learning point for the future is that multi-agency responses within a MARAC framework must be planned in ways which ensure that adult domestic abuse victims are properly supported and protected, whilst any potential risks to the safety and wellbeing of children in the family receive specific attention. Children’s Services have the primary statutory responsibility for assessing and managing any risks to children. However, in situations of domestic abuse, meeting this responsibility requires high quality communication, planning and joint working from all MARAC partners.

Julia had very limited contact with mental health and psychology services, even though she has appears to have had very considerable needs resulting from childhood experiences of abuse.

Although Brenda has reflected that she was under increasing personal stress in the months leading up to the homicide, she confirms that she did not seek any support or assistance from medical or any other services. The DHR has not seen evidence of any barriers which prevented her from seeking professional support. Her own explanation is that, at the time, she did not recognise a need for such support.

**Was there indication of the victim being isolated by the perpetrator and could this have prevented them from contacting services?**

There was no indication that Julia was socially isolated. She had good social contact with her close friends and was also able to communicate regularly with her sister. However, Julia’s friends report that on occasions Brenda would make repeated phone calls to Julia when she was with her friends.

There is clear evidence that the perpetrator’s behaviour sought to assert control (especially in relation to contact with Child E) through behaviour which was both abusive and manipulative. An obvious example of this was the confirmed poisoning incident, shortly before the homicide. It is not possible to be certain whether or not behaviour of this nature had happened over a longer time period, but the possibility cannot be ruled out.

There is also evidence that, on one occasion at least, Brenda tried to persuade Julia to withdraw a complaint, following domestic violence by James. On this occasion her attempt to assert pressure was unsuccessful and James was convicted for this offence. This suggests that Brenda may have attempted to prevent Julia from contacting services, but the evidence does not show that such attempts were successful.

**Were there any other issues relating to this case such as drug or alcohol abuse and if so what support was provided:**

It is understood that alcohol use was often a factor in conflict and violent incidents between Julia and James. Alcohol was also a reported factor in incidents involving Julia’s subsequent partner.

During the period of the relationship James was a cannabis user, but it is not known to what extent (if any) this contributed to domestic conflicts and violence.

The DHR has not seen evidence to indicate that any of the parties had an ongoing problem of drug or alcohol addiction, or of involvement of specialist substance misuse services.

There is no evidence to indicate that Brenda had any problems related to substance misuse, or that she was under the influence of drugs or alcohol when the homicide occurred.

A key factor in this case was Julia’s unhappy childhood with an abusive father and a mother with mental health problems. It is highly probable that such childhood experiences added very significantly to Julia’s vulnerability to abusive relationships as an adult. There were some very limited attempts to offer Julia psychological support with issues relating to her childhood, but these attempts appear to have been largely unsuccessful.

**Learning Point 3**

As Julia’s experiences clearly illustrate, people who have experienced childhood abuse are at greater risk of entering abusive relationships as adults. This highlights the importance of ensuring that appropriate treatment and support services are offered, to help adults such as Julia overcome the emotional and psychological effects of childhood abuse.

**Whether the perpetrator had a history of any violent behaviour and if any referrals were made to services in light of this:**

Until less than 24 hours prior to the homicide, none of the agencies involved had any information to indicate that the perpetrator presented any risk of harm, either to Julia or to any other individual. The day before the homicide, Northumbria Police were alerted by Julia to her suspicion that Brenda may have attempted to poison her, though Julia had expressed considerable doubt as to whether her own suspicion had any factual foundation. On this basis, a police investigation into the possible poisoning allegation was ongoing, but Brenda had not been detained by the police or questioned about this, when she murdered Julia on the following day. Subsequent to the homicide, it was established that Brenda had in fact attempted to poison Julia, with a substance which could have caused illness but would not have been life threatening.

The DHR Panel has closely examined police actions in response to the poisoning incident, with reference to the Police IMR, an IMR addendum requested by the Panel and an internal Professional Standards investigation[[2]](#footnote-2), which Northumbria Police had already conducted following the homicide. Taking all of these factors into account, the Overview Author has concluded that police actions following the poisoning allegation appropriately followed procedure and were proportionate, based on the information available. Following extensive professional debate, it has to be reported that this conclusion does not have unanimous support from all Panel members.

**Whether any risk assessments had been undertaken previously on the perpetrator and whether these had judged risk appropriately:**

As outlined above, the only incident which could possibly have led to a formal risk assessment specifically focusing on Brenda as a potential perpetrator, was the suspected (later confirmed as actual) attempt to poison Julia. The fact that this did not result in a formal assessment of domestic violence risks has been robustly questioned and examined by the DHR Panel.

The conclusion reached is that, whilst a domestic violence risk assessment could have been completed on the evening prior to the homicide, it was a reasonable professional judgment that a decision on the need for such an assessment would not be taken until it was known (primarily through testing of the suspected food) whether an offence had taken place. Perhaps more importantly, it seems unlikely that an assessment based on the available information could have realistically identified a requirement for immediate protective actions, which might then have prevented the murder from taking place on the following day.

**Learning point 4**

Even though there is no indication at all that a risk assessment or a Child Concern Notification on the evening prior to the homicide would have prevented the tragic events on the following day, Northumbria Police have identified important learning relating to the use of domestic abuse risk assessments and Child Concern Notifications when attending such an unusual incident of an alleged poisoning by a family member. As a result, they will be circulating updated guidance for all officers on completion of risk assessments and CCNs.

**Whether the victim was experiencing coercive control on the part of the alleged perpetrator:**

The report of repeated telephone calls from both Brenda and James when Julia visited friends is a possible indication that Julia was experiencing coercive control, over a significant period of time.

Brenda’s behaviour in poisoning Julia’s food can undoubtedly be described as attempts at coercive control. This is supported by Brenda’s statement that the intention was to make Julia ill and therefore dependent upon Brenda for assistance and less inclined to carry out her threat of moving to the Isle of Man and severing Child E’s links with his paternal family.

**Was there any indication of domestic violence or coercive control occurring before the incident and if so did the victim consider this to be control or domestic abuse:**

As already outlined, there is evidence that Julia was experiencing coercive control by Brenda and that this was, to some extent, recognised by Brenda’s close friends. However, the evidence from IMRs, Julia’s friends and her sister suggests that Julia herself saw Brenda as a very important source of help and support and did not recognise Brenda’s behaviour as controlling or abusive.

Julia has been described by her friends as *“always seeing the best in people”* and this seems to accurately reflect how she viewed Brenda. One exception to this was when Julia informed the police that Brenda had attempted to pressurise her not to continue with the prosecution against James. Again, this was an example of Brenda attempting to apply coercive control. On this occasion, Julia resisted this pressure and a successful prosecution followed.

**Key learning point 5**

By its nature, coercive control is often very difficult to identify. At its most effective the victim themselves may not recognise such behaviour as a form of domestic abuse. Contributions from Julia’s friends and her sister suggest that this type of behaviour may have been a factor in this case.

This highlights the importance of multi-agency policy, procedure and training which can assist front line staff in considering this type of abuse in the context of risk assessment processes and the development of effective prevention strategies. Where the victim is highly dependent on the potential perpetrator for emotional and practical support, this can greatly increase vulnerability to coercive control.

It also highlights that friends and informal networks can play a key role in identifying coercive control issues and may also be a valuable resource in developing prevention strategies.

**Do you hold any information offered by informal networks? The victim or perpetrator may have made a disclosure to a friend, family member or community member.**

Northumberland Children’s Services received one referral about reported domestic violence involving Julia and her partner James, which had originated from Julia’s sister. The referral expressed concerns about the welfare of Chld E, due to reported violence in the home. This resulted in an initial visit, by Children’s Services, where it was assessed that Child E was well and there was no need for any further investigation or intervention from Children’s Services. The assessment did not include any contact with the referrer, to enquire about the basis for her concerns.

Apart from the above example, the DHR has not seen evidence that agencies held significant information from informal networks. However, the DHR has had valuable contributions from Julia’s sister and three of her close friends. Findings related to these contributions are summarised in section 5.

**Given the commitment of all agencies to “Think Family” to what extent did your contact and involvement with the victim and/or perpetrator result in a formal or informal assessment of the wider family including any children or young people?**

**Learning point 6**

This question has proved to be of particular significance to the evidence reviewed by the DHR. The Think Family Toolkit[[3]](#footnote-3) emphasises that *all* services working with adults or children (e.g. Children’s Services, Police, education, NHS, voluntary sector services) should consider the family situation in *all* areas of their work. Specifically in relation to domestic abuse, it suggests that services which are “Thinking Family” should:

* *Prioritise the safety and welfare of children within the family, involve the child’s social worker and follow Local Safeguarding Children Board procedures when children may be at risk of suffering from harm (when domestic violence is suspected or a child appears to be neglected for example); and*
* *Consider the involvement,* ***potential contribution******and (when appropriate) the******risks******associated with all of the adults\**** *who have a significant influence on a family, even if they are not living in the same house, or are not formally a family ‘member’.* (\* This emphasis is not included in the original version)

In this case, the police showed evidence of “thinking family” on the occasions when they generated Child Concern Notifications, following reports of domestic violence incidents between Child E’s parents.

However, the DHR findings - with the benefit of hindsight - show that potential risks associated with Brenda were *not* identified. This is an observation of fact, not a criticism of any of the agencies involved, which did not have the benefit of hindsight.

The “Think Family” approach – and specifically the suggestion that agencies should consider the “…*involvement, potential contribution and (when appropriate) the risks associated with all of the adults who have a significant influence on a family..”* is of particular significance in this case.

The evidence from IMRs suggests that, when there were reported domestic violence incidents between Julia and Brenda’s son, the fact that Brenda was known to have a significant influence on the family was not sufficiently recognised.

The predominant indications at that time were that Brenda’s significance was more likely to be as a positive and safeguarding influence, rather than a potential risk. However, there were some less positive indications including particularly Brenda’s attempts to persuade Julia to withdraw support for a prosecution of James following a domestic violence incident. It was also known that there was conflict between Brenda and Julia in relation to contact arrangements with Child E. These factors should have led agencies to ensure that Brenda’s role (including potential positive and negative factors) in the family was informing assessments of risk, in relation to domestic violence between James and Julia and any associated risks to the safety and welfare of their child.

Past concerns for the welfare of the child and those arising from incidents of domestic violence and abuse presented agencies and professionals with opportunities to adopt a wider view.

The intention behind both safeguarding children and domestic violence joint working procedures is to maximize information sharing and effective joint working in ways that focus on the vulnerable parties so as to minimize risk. Whilst the statistical incidence of homicide by family members other than partners or ex partners is low, it is significant. The wider learning from this review is to ensure that current and future joint working procedures relating to safeguarding children and domestic violence reflect this.

**Conclusion**

It is reasonable to conclude that there was not an opportunity to directly predict or prevent this homicide. However, had the information that was available been reviewed from a more holistic perspective by all agencies within existing procedures and joint working arrangements, then the level of understanding may have prompted a range of professionals to focus more clearly on Julia as a victim of domestic violence. This may in turn have enabled her to recognise the impact of controlling and coercive behaviour from Brenda and more actively seek help and support. Whether this could ultimately have saved Julia’s life is unknown, but recognition of negative aspects of her relationship with Brenda may have helped her to manage risks more effectively.

**8) RECOMMENDATIONS**

**Introduction**

The following recommendations are informed by the learning points highlighted in the previous section. These learning points relate primarily to agency responses to events which took place some years before the homicide (2005 to 2007), when Julia was a victim of domestic abuse perpetrated by Brenda’s son.

This pre-dates the introduction of MARACs which are widely recognised as having improved multi-agency responses to cases of high risk domestic violence. However, this DHR has highlighted some very important areas of learning, which should inform the future development of MARACs and all other aspects of multi-agency responses to domestic abuse.

**Recommendation 1 *(See learning points 1 and 5)***

Multi-agency policy, practice guidance and training on domestic abuse should include reference to “Think Family” principles and how these should be applied when there is evidence of domestic abuse. This should include specifically the learning from this case about the importance of all MARAC partners carefully considering the roles of adults who may not reside in the family home, but have significant influence on family relationships. Guidance and training should also signpost practitioners to the Think Family toolkit and other resources, which can help to promote effective multi-agency work with families affected by domestic abuse. Individual agencies should identify which policies and guidance documents should reference “Think Family” and update the Community Safety Partnership (CSP) on actions taken, in respect of this recommendation

**Recommendation 2 *(See learning points 1 to 5)***

The learning from this case should be brought to the attention of key strategic and multi-agency groups, including the Community Safety Partnership, Safeguarding Adults Board and Safeguarding Children’s Board.

Each of these bodies should ask their members to review (and if necessary revise) policies, procedure and practice, to ensure that they reflect key learning from this case. Reviews should focus particularly on the following areas:

* The extent to which all agencies are practicing “Think Family” approaches in their response to domestic violence, including the importance of considering the roles of significant others who may impact on family relationships.
* Whether policies, procedures, guidance and training sufficiently highlight risks associated coercive control as a form of domestic abuse.
* How multi-agency responses to domestic violence ensure that risks to children are prioritised, whilst also ensuring that adult victims receive high quality support, along with multi-agency strategies to prevent further domestic abuse.

**Recommendation 3 – Northumbria Police *(See Learning Point 3)***

Reference to be made within the police instructional information system (i.e. local police guidance for all officers) relating to the investigation of domestic abuse. Information also to be circulated to advise all officers faced with such circumstances that a domestic abuse risk assessment checklist should be completed at the earliest opportunity and submitted to the Central Referral Unit for a full assessment of risk. The initial objective assessment should also include the attending officers’ assessment of risk based on professional judgment and consideration of wider familial links. This will also extend to the submission of a Child Concern Notification in circumstances where a child is associated with any of those involved in the incident.

1. Pseudonyms are used throughout, to help protect the confidentiality of the victim and family. Julia’s child is referred to as ‘Child E’. This child was of junior school age at the time of Julia’s death. [↑](#footnote-ref-1)
2. This report has also been reviewed by the Independent Police Complaints Commission, who concluded that an independent investigation was not required. [↑](#footnote-ref-2)
3. Think Family Toolkit: Improving support for families at risk, Strategic overview. Department for Children, Schools and Families Education, 2009. [↑](#footnote-ref-3)