surrey safeguarding CHILDREN BOARD

Overview report on the SERIOUS CASE REVIEW relating to Children **U and V**

Independent Chair of Serious Case Review Panel - Helen Davies

Independent Overview Report Author - Ron Lock

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CONTENT

1. INTRODUCTION

1.1 This Serious Case Review (SCR) has been undertaken following the tragic deaths of two children, who will be referred to as Child U and Child V within this report, who were found dead on a bridleway in Area 2 with their Father who was also deceased. Their deaths occurred in late September 2012. The subsequent Police investigation came to the view that both children had been stabbed by their father who then took his own life. Child U was almost 8 years old and Child V just over 6 years old when they died. The parents had been recently separated, and it was during a contact visit for the Father that the deaths occurred away from the family home.

1.2 If "abuse or neglect is known or suspected to be a factor in the death" of a child, this requires that the Local Safeguarding Children Board should "always conduct a SCR into the involvement of organisations and professionals in the lives of the child and the family"[1], and therefore in response to this guidance, and because the death of both children was believed to have been perpetrated by their father, then Surrey Safeguarding Children Board (SSCB) commissioned this SCR.

1.3 The purposes of this SCR reflect the relevant government guidance at that time to: -

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve intra and inter-agency working to better safeguard and promote the welfare of children.[2]

1.4 Each agency that had some direct involvement with the children and their family was required to undertake an Individual Management Review (IMR) to look openly and critically at its practice in relation to their involvement with them. In undertaking this, each agency was also required to produce a chronology of its contact with the family. The managers/officers conducting the IMRs did not at the time immediately line-manage the practitioners involved and were not directly concerned with the services provided for the children or their family.

1.5 Senior representatives from relevant agencies in Surrey were brought together to form a SCR Panel in order to review and analyse the material from the IMRs. The role of Independent Chair of the SCR Panel was undertaken by Helen Davies, and the Overview Report author was Ron Lock, both being independent consultants who were independent of all agencies in Surrey and had extensive experience in safeguarding children and young people.

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[1] Paragraph 8.9 – Working Together to Safeguard Children – A guide to inter agency working to safeguard and promote the welfare of children – Dept. for Children, Schools and Families – March 2010 *(NB: This guidance was reissued in March 2013 although very similar criteria for conducting a SCR is included)*

[2] Paragraph 8.5, Working Together to Safeguard Children – Dept. for Children, Schools and Families, March 2010

2 THE SERIOUS CASE REVIEW PROCESS

2.1 The period of time to be covered by this SCR was from the birth of the eldest Child "U" in November 2004 up until his and his sister's deaths on the 30th September 2012. Agencies conducting IMRs were also invited to include any information known to them which was outside of this timeframe but which may have had relevance to understanding the family history or to the analysis of later professional interventions.

2.2 **The following agencies were commissioned to complete the IMRs:**

- Surrey County Council (CC) Children's Services
- Ashford and St. Peter's Hospitals NHS Foundation Trust
- NHS Surrey GP Practice
- Mid Cheshire Hospitals NHS Foundation Trust
- Virgin Care
- Surrey Police
- Schools and Learning, Surrey County Council
- Surrey and Borders Partnership NHS Foundation Trust

Additional information was also received from Royal Surrey County Hospital NHS Foundation Trust, who because of their limited involvement, were not asked to undertake a full IMR.

2.3 **The SCR Panel members were:**

- Group Manager - Surrey County Council Legal & Democratic Services
- Designated Nurse Safeguarding Children – Surrey PCT
- Detective Inspector – Public Protection Investigation Unit - Surrey Police
- Head of Performance and Support – Surrey CC Children's Safeguarding Services
- Area Education Officer - Surrey CC Schools and Learning
- Consultant Child and Adolescent Psychiatrist, Named Doctor for Child Protection - Surrey and Borders Partnership Trust

2.4 All SCR Panel meetings were chaired by Helen Davies, Independent Safeguarding Consultant

Also in attendance at Panel meetings:

- Ron Lock – Overview Report Author
- Quality Assurance Officer – Surrey Safeguarding Children Board
- Safeguarding Board Administrator - Surrey Safeguarding Children Board

2.5 **Specific Issues to be considered for analysis were:**

a) Was the level and extent of agency engagement and involvement with the family appropriate?

b) Were any safeguarding issues recognised by agencies and how these were addressed?

c) Did the agencies communicate effectively and work together to safeguard the children's welfare?

d) Was the level and extent of domestic abuse known and was the impact/risk to U and V adequately assessed and responded to?

e) Were there any parental physical or mental health issues or issues of substance misuse which may have impacted on parenting capacity?

f) Whether there are any factors in the history of any adults that indicated that they may pose a risk to children.

g) Whether race, religion, language, disability or culture was a factor in this case and had been considered fully.

h) Were the children's wishes and views known and taken into account in assessments and planning?

i) Were there any organisational or resource factors which may have impacted on practice?

Additionally, consideration should be given to the areas identified in Working Together 2010 Page 245 for analysis of involvement that is not covered by the above specific issues.

2.6 Methodology/SCR Process

2.6.1 The circumstances of the deaths of these children was first considered by the Serious Case Review sub group of the SSCB on the 16th October 2012, which led to the recommendation to the SSCB Independent Chair that a SCR needed to be commissioned. The SSCB Chair wrote to involved agencies on the 25th October 2012, informing them of the decision to undertake a SCR. Members of the SCR Panel were selected and the Independent Chair and Independent Overview Report author were commissioned. The SCR Panel had its first meeting on the 9th November 2012.

2.6.2 In total there were five SCR Panel meetings, the first on the 9th November 2012 and the final one on the 19th March 2013. As part of the process, the IMRs were separately presented to the SCR Panel on the 8th January 2013, with revisions completed in time for SCR Panel to consider them at the next meeting on the 1st February 2013. Overall the IMRs were completed within deadlines with limited additions or revisions being required for their final versions. Because of a considerable delay in accessing the Father's former medical records from the Army, this delayed the completion of the SCR. The final Overview Report was presented to the SSCB Executive Committee on the 23rd May 2013.

2.7 Parallel Processes

2.7.1 The only relevant parallel process is that to that of the Coroner's inquest, which was held on the 5th December 2012 and which concluded that the two children were unlawfully killed and that the Father took his own life through a deliberate act. The inquest took the view that the Father had planned the deaths of his children but that there was no prior indication that this was going to happen.

2.8 Contributions by the Family

2.8.1 The Mother agreed to meet with the Independent Overview Author and was able to give information in respect of her experiences of work with the various professionals who were involved in providing support and advice to her and her family. The Mother's contributions have been included within the body of the report where appropriate.

2.8.2 Contact was also made with one of the Father's brothers who was keen to provide some input into the SCR process. Although he had no direct experience of the support services provided to the family, he was able to provide some context via his understanding of the family circumstances.

2.9 Individual Agency Involvement/Individual Management Reviews (IMR)

The GP Practice

2.9.1 The GP practice had the most continuous involvement with the family, dating back to 1996, and both children were registered with the practice since their births. The practice was also the first service to become aware of family difficulties when the Mother expressed concern about domestic abuse in October 2011, and then was instrumental in supporting her to report an incident of alleged domestic abuse by the Father in the late summer of 2012. The Father had also consulted the GP at this time.

2.9.2 The IMR provides detailed accounts of the GP practice's involvement with the family and within its analysis, recognises the supportive approach taken by the GP, but that there was nevertheless a need for greater understanding by the GP of what services for domestic abuse were available and to whom the GP could have made appropriate referrals on behalf of the Mother. The IMR finds that opportunities for referral to other agencies and assessment were missed and has made recommendations to ensure that the remit for the safeguarding lead in GP practices is fully understood and utilised.

2.9.3 Following a formal request by the SCR Panel, the GP IMR author made enquiries about the ability to access the Father's previous army health records (He had a career in the Army up until mid-1990s) There was no automatic transfer of such records to a civilian GP. The SCR Panel decided that useful information, however old, could be potentially useful in understanding whether there were any previous mental health issues for the Father, particularly as he was a casualty in the Hyde Park bombing in 1982, and so a formal request for the records was made. These eventually arrived very late in the SCR process, but the GP IMR was redrafted to include this information and related analysis. A recommendation in this Overview Report has been made in respect of access to former Army medical records.

Mid Cheshire Hospitals NHS Foundation Trust

2.9.4 The reason for the need for this IMR was that the one alleged domestic abuse incident that was recorded in respect of the parents, and in which the Mother received injuries, occurred in late August 2012 in the Midlands whilst the family were away at a friend's, and the

Mother attended a local hospital there with her injuries the following day. Because there was no disclosure at the time by the Mother of any domestic abuse, and because her presentation in the company of the Father did not raise any concerns, then no related action was identified by hospital staff at the time.

2.9.5 The IMR considered that in the context of the Mother's presentation, that hospital staff were conscientious and responded appropriately in the circumstances and that there was nothing to suggest that the injury was anything other than an accident, as described to them by both parents. Records were however not made about whether the Mother was seen alone whilst at the hospital or of the Father's identity who attended with her. The IMR author understood that taking the opportunity to speak with patients in confidence was now being undertaken by practitioners. Recommendations have been made regarding improved training in respect of safeguarding children and vulnerable adults in relation to domestic abuse, backed up by an audit of its impact upon practice, including the need to ensure that the next of kin and accompanying adults are documented appropriately.

Surrey Police

2.9.6 Surrey Police's main involvement was in respect of the alleged domestic abuse incident which although it occurred outside Surrey, was reported to Surrey Police by the Mother a few days later, which they then investigated. As part of that investigation, both the Mother and Father were seen and Children's Services were notified of the alleged incident.

2.9.7 The IMR gives clear detail of Police involvement with the family during this investigation and whilst there were some minor administrative issues with the criming/ownership of the assault allegation, overall it was considered that the Police response to the domestic abuse allegation reported to them was appropriate. It is however a reminder of how processes can be complicated or compromised when incidents occur across county borders. The outcome of the analysis within the IMR appropriately reflected the need to remind officers of their safeguarding responsibilities with particular reference to always consider the needs of children when responding to incidents.

Surrey County Council Children's Services

2.9.8 Similarly to other agencies, Children's Services had just one period of involvement, again in response to the domestic abuse allegation in late August 2012, and the IMR considered that this response was appropriate in the context of how the Mother was presenting at the time. However the IMR recognises that there could have been greater attempts to ascertain the wishes and feelings of the children at the time, and recommendations are made as a result.

Surrey County Council Schools and Learning

2.9.9 This IMR reflects the time that both children had in the local playgroup and primary school, which they were both attending in September 2012, which was the time of their deaths. The IMR identifies how the school were appropriately attentive to the needs of the children at the time when it was apparent that there was marital discord, and when the parents had separated by the time the children had returned to school in September 2012 after the summer holidays. The IMR contained useful information about the children's personalities and how they presented at school.

2.9.10 One key area for analysis for this IMR related to the way in which the school responded to legal information provided by the Mother that the Father was not to have contact with the children following their return to school in September 2012. The IMR considers that this is a difficult issue for schools to deal with and that in this case, it was apparent that the "order" which the Mother had presented was not fully studied in that in reality it did not prevent the Father having contact. It also emerged later that this was an application to the court rather than the order itself. Subsequently recommendations have been made within the IMR in relation to this issue.

Ashford and St. Peter's Hospital

2.9.11 The hospital was involved in terms of maternity services re the birth of both the children, as well as involvement via some limited attendance by them at A&E Dept., but more particularly had contact with the Mother when her physical injuries were assessed from the alleged domestic abuse incident in late summer 2012.

2.9.12 The IMR recognises that the mother's presentation at the fracture clinic was a missed opportunity to understand the dynamics of the family relationships and risks, with the focus being on the medical model in relation to reviewing and repairing the injuries but little attention to aspects of her situation and the domestic abuse disclosure. Recommendations therefore relate to the need to strengthen knowledge and adherence to safeguarding procedures as well as to progress the implementation of a single patient electronic record.

Virgin Care

2.9.13 This IMR relates to the services provided by the health visitors, school nurse and speech and language service. Overall it was considered that these services were appropriately delivered and met the presenting needs of the children and family. Concerns were however identified in respect of the size of the caseload of the school nurse and the lack of clarity about expectations upon them when in receipt of domestic abuse notifications. The issue about the caseload was subsequently addressed by extra support being put into that particular school nurse team. Recommendations are appropriately made to improve understanding and expectations when responding to information about domestic abuse.

Surrey and Borders Partnership Trust

2.9.14 This IMR relates solely to services provided to another member of the family and therefore understandably whilst it is no doubt useful to the Trust in terms of its analysis, it has not been necessary or appropriate to include this within the overall analysis within this Overview Report. The IMR has appropriately not made any recommendations for changes to services as a result of its analysis of practice.

Home Start

2.9.15 Whilst Home Start did provide some support services, primarily to the Mother when the children were younger, records were not retained for that period of time and so no IMR could be requested. Because of the earlier timeframe of their involvement, the SCR Panel did not consider that the lack of information from them compromised the overall analysis of professional interventions with the family.

Royal Surrey County Hospital

2.9.16 The hospital only had limited involvement in the treatment of the Mother's injuries from the alleged domestic abuse incident, following a referral for specialist outpatient care from the Ashford and St Peter's Hospital. Therefore an IMR was not requested although the letter requested from the Royal Surrey County Hospital gave sufficient information to explain the minimal involvement which they had had.

Health Overview Report

2.9.17 The Health Overview Report helpfully sets the context of the provision of health services in Surrey and additionally comments on the individual Health IMRs which were produced for this SCR. The learning identified for health organisations includes the need for greater enquiry about domestic abuse and to consider its impact upon children within the family. Additional learning relates to the need to be alert to silo working and for health practitioners to be more rigorous in the need to gather information about significant males/fathers. The Health Overview Author rightly points out that these areas of learning are reflected in a number of SCRs on a national basis.

2.9.18 The Health Overview Report makes two additional recommendations to those already contained within the Health IMRs, and these reflect the need for the process of current health reorganisation to be able to continue to monitor how health agencies are embedding lessons learned from this SCR.

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3 THE FACTS

Family Background

3.1 The Father was formerly a soldier who left the Army in the mid-nineties. During his time in the Army he received injuries at the Hyde Park bombing in 1982. Both the Father and the Mother had previous marriages which had ended in divorce, with the Father needing to be prescribed anti-depressants by his GP at that time in order to help him manage any associated stress. He was again treated with anti -depressants from **December 2003 – February 2004** during a period of marital difficulties.

3.2 Their first child, **(**Child U), was born in **November 2004** and the couple's second child (Child V) was born in **July 2006.**

3.3 Generally the care of the two children was good and uneventful in that professional involvement was primarily limited to universal services only. During Child U and V's early childhood there were no safeguarding concerns identified by the health practitioners involved with the children. Both children had fairly normal patterns of attendance at the GP surgery. Whilst in total there were four A&E attendances by the children, none of these raised any safeguarding concerns.

3.4 There was involvement by Home Start for the period **February 2008 to June 2009** in order to provide some additional support to the Mother.

3.5 **In Autumn 2011,** the Mother presented to her GP with issues relating to domestic abuse, which she reported primarily related to verbal abuse and control by the Father. She stated that the abuse had been going on for more than two years. Anti-depressants were re-commenced and the GP advised the Mother to seek legal advice. The GP's records at the time identified that the Mother was "aware of the domestic violence unit".

3.6 The Mother again attended the GP surgery in **Spring 2012** when she reported that the situation had become worse and was concerned about the effect this was having on the children, and that she was unsure how much longer she could cope.

3.7 In **late August 2012**, on the morning following a party that the Mother and Father were attending at a friend's home outside of Surrey, the Mother presented to the local A&E Dept. saying that she had slipped the previous evening, sustaining an injury to her shoulder and arm, along with some facial injuries. It was confirmed that the arm was fractured. She also had a broken tooth, some of which was embedded in her lip. The Father was present at the A&E attendance and hospital staff considered that they were comfortable in each other's presence. No safeguarding concerns were identified and no indicators were apparent or identified by

hospital practitioners that the cause of the Mother's injuries were anything other than accidental.

3.8 Following the family's return to Surrey, the Mother visited her GP a few days later when she reported that although she had originally said her injury had been caused by her falling, that in fact following an argument, she said the Father had pushed her to cause her to fall forward onto a kerb stone. The Mother was clear that the Father had never been physically violent before, but that since the incident, had been feeling very threatened by him. The GP advised that she must contact the Police who in turn would contact Children's Social Care.

3.9 Later that day, the Mother attended the local police station where she reported the incident, again saying that this time was the first occasion that the Father had been physically aggressive towards her. She stated that the children had witnessed the incident and were currently staying with a friend. Later Police inquiries with potential adult witnesses identified that no one had witnessed an assault – the Mother had told people at the time that she had fallen.

3.10 Also on the same day, the Father voluntarily attended the police station where he was arrested and interviewed. He denied any assault and claimed that the Mother had fallen because she had been drinking and because the ground was muddy. He acknowledged that immediately prior to this he had become angry because of what he considered was inappropriate behaviour by his wife. The Father was released from custody on conditional bail until 22nd October 2012, and was not to contact the Mother in the meantime.

3.11 On the following day, the Father attended the GP surgery and presented to his GP as very upset that he had been arrested and been told to leave the family home. (At this time he was still living there, whilst the Mother and the children were living with a friend). Although the GP advised supportive counselling, the Father wished to be prescribed anti-depressants, and the GP agreed to prescribe a month's supply.

3.12 The Mother contacted the Police again on the **1st September 2012** to say that the Father was breaching the bail conditions as he had apparently tried through a mutual friend to arrange contact with the children. The Mother and the two children were currently staying at a friend's home. The Mother told the Police that she was seeking to take out an injunction against her husband and was going to seek a divorce. **On the next day,** the Mother again expressed concern to the Police about the Father breaching the bail conditions in that she said she had seen his car outside where she was staying. She was advised to seek legal advice. Police officers also visited the Father and gave him "strong words of advice" as there had been no breach of bail, and he was advised to sort out child contact arrangements via a solicitor.

3.13 The Father had telephone contact with the GP practice on the **3rd September 2012,** when he made reference to his involvement in the Hyde Park bombing and saying that he thinks that he may have post-traumatic stress disorder as a result. Arrangements were made for the GP to review the Father at the end of the month.

3.14 Police notifications of the reported domestic abuse incident were forwarded to Children's Social Care and the health safeguarding team, (forwarded on to the school nurse) **on the 3rd September 2012.**

3.15 As a result of the Police notification, the duty social worker made telephone contact with the Mother on the **4th September 2012,** who explained that as a result of the domestic abuse incident, she had ended her relationship with the Father. She also gave full details of all that had happened at the party and of subsequent events. She said that today she had visited a solicitor to seek advice regarding obtaining an occupancy order so as she could return to the family home with the children, and the matter was to be heard in court later in the week. She also said that she had details of the domestic abuse outreach service which she was considering accessing. Although the Mother said that she had no concerns that the Father would be abusive to the children and that she wanted them to retain a relationship with him, she was concerned he may try to abduct them as he would know that this would distress her. She however had no direct evidence of any threats by the Father of this nature. The social worker advised that she seek legal advice on this matter, and potentially gain a Prohibited Steps Order[3]. The Mother was also advised to ensure the children were safe and protected at all times, which she confirmed she understood and it was arranged that the Mother would call back if future advice or support was needed.

3.16 **On the 5th September 2012** the Mother advised the school that she and the children had left the family home and gave the head teacher a copy of a non-molestation order imposed on the Father. (It later transpired that this was likely to have been the Mother's application for the order). The Mother told the school that the Father was not to collect the children from school, and the head teacher duly informed school staff of this.

3.17 The Mother obtained a non-molestation and occupancy order at the Magistrates Court on **the 6th September 2012** which forbade the Father not to threaten, intimidate, pester or harass his wife, and not to damage, or threaten to damage any of her property. He could also not do this via any other person. The Mother explained via her later contribution to this SCR that arrangements were agreed in the court for the Father's contact with the children to be after school on Thursdays and from 10am to 5pm on Sundays, and that these took place as agreed over the coming weeks, (with four separate contacts ultimately taking place). Whilst these contact arrangements were agreed and recorded in court, there was no specific order made in respect of them.

3.18 The GP was contacted by the Police on the **10th September 2012** to confirm that the Police and the GP had the same information about the alleged domestic abuse incident. Although the Police were seeking a medical view about how the Mother's injuries might have been caused, the GP said that it was not possible medically to say whether the Mother had been pushed or fell.

[3] "An order that no step which could be taken by a parent in meeting his parental responsibilities for a child, and which is of a kind specified in the order, shall be taken by any person without the consent of the court" Section 8 (1) of the Children Act 1989.

3.19 It is understood that the Mother and the two children returned to live at the family home on the **12th September 2012** by which time the Father had moved out. On the **14th September 2012,** the Mother spoke with the teacher in the playground and said that things were not too bad and that she was getting on with her life, adding that the children were fine. At a hospital appointment to remove a small piece of tooth from her lip on the **13th September 2012,** the Mother confirmed to the doctor that she had contacted all relevant agencies in respect of dealing with the domestic abuse and that "It's been sorted out".

3.20 Although the Mother reported on the **17th September 2012** that she had received two "unpleasant" letters from the Father, which she believed meant that he was breaching his bail conditions/non molestation order, the Police did not consider that the letters themselves constituted a breach – neither letter was threatening but were claiming that he was not responsible for her injuries. It was at about this time that Child U told his school teacher that he would be seeing his Father for a coming weekend and that they were going fishing.

3.21 On the **26th September 2012** the Father wrote a letter to the GP (received either the next or following day) in which he stated that the allegations of assault by his wife were unfounded and that this had been an "annihilation of his stature". The purpose of the letter was to request confirmation regarding whether it was his wife who had instigated the allegations or whether it was the doctor who said that the incident at the party was no accident and that she had been assaulted.

3.22 On the **30th September 2012** the Mother reported to the Police at 7.24pm that the Father was supposed to bring the children home by 5.00pm, after having contact with them, but that he had not returned. She said he was not answering his phone and had been acting strangely recently and that "she had a bad feeling" about it.

3.23 It was at 6.16 pm that a member of the public contacted the Police and in response, Police Force 2 discovered the bodies of the Father and both children in his car. Surrey Police were informed; who later made the connection with the concerns raised by the Mother and duly informed her of the deaths. In the car, some letters were found that the Father had written to the Mother, and other family/friends, including to "The Police etc" which made it clear that he had taken his own life and that of his children.

3.24 Later evidence identified that there was no indication from his behaviour at lunch earlier that day at a local hotel with paternal family members and the children, that the Father wanted to harm himself or the children. It would appear that the deaths were planned insofar as knives recovered from the scene were taken there by the Father and were likely to have been kitchen knives that he had removed from the family home when he had previously left there, before the Mother and the children moved back in.

4 THE CHILDREN'S EXPERIENCE

4.1 Despite their tragic and traumatic deaths, it was nevertheless apparent that both of the children experienced fairly normal childhoods and that they had good attachments to their parents. The evidence from health visitor records was of two children who developed well physically and emotionally and at school they were well liked by teachers and their peers. However it appeared that over the last two years of their lives that they did inevitably experience some of the conflict and disharmony that existed for some of that time between their parents.

4.2 Child U was described by his school as being "delightful, kind, considerate and thoughtful" and was also sometimes a "day dreamer" but who was very protective of his younger sister. In respect of Child V, the description of her at school was of her being "delightful, lively and very bubbly – she skipped everywhere, was giggly and very chatty". Both children were well liked in their peer group. In her contribution to the SCR, the Mother agreed that these were accurate descriptions of her children.

4.3 To what extent the two children experienced either directly or indirectly, some of the domestic abuse and marital arguments that took place between their parents is not clear. Certainly the Mother expressed concern to the GP that the children were becoming affected by the verbal abuse from the Father towards her and of his controlling behaviours. This was when Child U was aged from 7 years old and Child U was aged from 5 ½ years old. The Mother later told the social worker that the children had asked her "why is Daddy being horrible?" Additionally as part of her contribution to this SCR, the Mother said that she considered that the children were affected by the Father's controlling behaviour and that as part of the domestic abuse he shouted a lot, with neighbours sometimes expressing concerns about this. She considered that the children therefore became anxious in his presence and were not always keen to be left in his care when she went to work.

4.4 Within school, it was considered that both children were quite open, although nothing significant or untoward was noticed about the children's demeanour and behaviour. However when Child U returned to school from the summer holidays in 2012 the head teacher noticed that he was "subdued as if he had the weight of the world on his shoulders", and that he seemed "half asleep" at times. This was the period when the children were living with their mother with friends, though once they returned to live in the family home later in September, Child U was said to be noticeably more relaxed and happy, and more positive about his work. Although Child V was very often open with her teachers and often spoke her mind, she did not express any concerns or behave in any way to indicate that there were difficulties at home.

4.5 The children were said to have witnessed the incident when the Mother was injured at the party although there were conflicting accounts of what parts, if any of the incident they directly witnessed. They clearly experienced the tension between the parents from late August throughout the month of September 2012, when their day to day lives were disrupted by the parental separation. For example on one occasion, Child U told the school teacher that

his mummy was picking him up "as his daddy was not allowed to". However there was never any concern expressed by the children about their Father's care of them and they had previously been just as happy for him to pick them up from school as they were for their Mother. Child U also had spoken positively about spending time with his Father once the contact arrangements had been set up.

4.6 Whereas "Children's symptoms of depression, anxiety, dysphoria (a state of unease or mental discomfort) and withdrawal have been shown to be adversely affected by exposure to inter-parental conflict" it is also commented that "Teachers who are not familiar with the circumstances behind a child's individual symptoms may be less likely to see such symptoms as a particular problem for that child" [4] For example this may mean viewing a child as a quiet child rather than a depressed child. It therefore remains unclear the extent to which the children internalised the parental conflict problems and to what degree their well-being was adversely affected by the home circumstances. How the parents separately managed the impact on the children would of course have been important in terms of how the children were able to manage what was happening around them, and there was one example when the Mother declined to discuss the marital problems over the phone with a social worker because of the presence of the children. This reflected that the children were therefore afforded a level of protection by their Mother of the traumas and details of the parental conflict.

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[4] Children living with domestic violence – Martin C Calder, Russell House Publishing, 2004

5 ANALYSIS

The appropriateness and extent of agency engagement and involvement with the family, particularly in respect of any safeguarding issues

Health Visiting Service

5.1 Generally within this case, the level of individual agency involvement with the children and the parents was delivered at an appropriate level and within the context of the needs that the family had at the time. In terms of the universal services of health visiting, hospitals and education, then the children's circumstances did not reach a level that would have warranted more targeted interventions. The family were however appropriately placed at an enhanced level of health visiting service for a brief period in 2008. The health visitor's referral to Home Start at the same time reflected that the mother needed some additional support during this period.

Education

5.2 As the two children presented well in school and had no worrying behaviours within school, it was understandable that this did not lead the school to provide any additional oversight or support of them, despite it being understood that the parents had separated at the time when the children returned to school after the summer holiday in 2012.

5.3 It was nevertheless apparent that school staff were alert to any possible impact on the children at this time, and on one occasion Child U was asked how he felt about what was happening at home. More particularly however, the head teacher reported being shown a "court order" by the Mother, who claimed that this meant that the Father could not have contact with the children and was not allowed to collect them from school. In response to this the head teacher ensured that the rest of the school staff were aware, so as they could enforce the Mother's request. This appeared to have been managed well in the circumstances and there were no reported incidents of the Father attempting to collect the children.

5.4 It became apparent from later enquiries via the SCR process that the Mother did not obtain the non-molestation order until the following day and that the head teacher had likely been shown the Mother's application for a non-molestation and occupancy order. The bail conditions already meant that the Father could not contact the Mother directly or indirectly and the non-molestation order forbade the Father from threatening or harassing his wife, but neither made any reference to the children, nor that he could not have contact with them. It was not therefore apparent that the head teacher had read the detail of the order that was referred to by the Mother or understood that it was the application rather than the order itself. In essence this made little difference to the actions by the school who chose to accept the formal request from the Mother that the children were not to be picked up by the Father, and he did not arrive at the school to challenge this arrangement. Nevertheless, the experience clearly suggests that when court orders are presented to school staff to support an action required by the school, that such an order should be read in detail to check the legal requirements. Whilst the IMR suggests that it was implicit in the detail of the document shown to them, meant that the Father could have had no contact with the children (because he would have needed to make contact with the Mother to do so), this was not the case. For example he could have arranged via a third person to make contact

with the children – which he in fact tried to do on one occasion. It was agreed within the court the next day that the Father could have regular contact and this was what eventually took place, with another person acting as the go-between, with the children being collected from them.

Hospital Services

5.5 The contact which the two 2 local hospitals had with the family in terms of the births of the children and in relation to a small number of A&E attendances was not significant in any way. Although it was apparent that no contact with the family raised any safeguarding concerns, there was one occasion when Child U was aged 2 ½ years, that he suffered an injury to his elbow apparently being caused by being pulled up by the hand from the floor. Although it was apparent that this injury and the explanation given, raised little additional questioning about the home circumstances and did not lead to any safeguarding concerns being raised at the time or via any report to the health visitor or Children's Social Care to request any follow up, potentially the description of how the injury was caused should have generated further enquiries. When the health visitor did eventually receive notification of the A&E attendance a week later, she followed this up with a telephone call to the mother, who now reported that Child U was fine. Similarly there was apparently no consideration by the health visitor that there was any safeguarding concern in relation to the incident, and therefore no further questioning made as a result.

5.6 There was just the one incident which led to the involvement of the hospital in Cheshire who needed to respond to the A&E attendance by the Mother following her being injured at the party held locally. The service which was delivered from a medical perspective was thorough and met all of the Mother's needs in respect of the injuries she had suffered. The respective IMR author was confident that "No safeguarding concerns, vulnerable adult triggers or domestic abuse indicators were identified by practitioners in the care of the Mother from the point of admission until the time of her discharge." It was clear that the Mother made no allegation of domestic abuse and was consistent in her story of an accident, and the hospital reported that she and the Father, who accompanied her to the hospital, appeared comfortable in each other's company. The hospital however did not confirm that it was in fact the Father who was accompanying her. Although it was not recorded, the doctor thought that she had a conversation with the Mother on her own during her attendance at the hospital. This would have been good practice in these circumstances.

5.7 In her contribution to this SCR, the Mother confirmed that it was the Father who accompanied her to the Hospital and that she did not disclose any abuse to the hospital staff. She said that she felt she was a long way from home, felt very vulnerable at this time, the children were not with her in the hospital and she was concerned about how she would get home if she told anyone about the truth of how she received her injuries. She said that the Father was being very controlling at the time and would not leave her on her own. She could not understand why the hospital staff thought that she and the Father were comfortable in each other's company, as she felt that there was evidence in their behaviours in the hospital of the tension that existed between them. The Mother confirmed that she was not seen alone apart from a very brief time when having x-rays undertaken.

5.8 The Mother acknowledged that it would have been difficult for staff to have picked up that her injuries were the result of a domestic abuse incident and therefore have questioned her about this, but she was nevertheless surprised about the lack of enquiry and that staff had

not picked up on the tension in their relationship. Whilst in this scenario, it could not necessarily be expected that the hospital's suspicions would be raised that domestic abuse was the cause of the injuries, if the Mother had been seen alone and more probing questions asked, there would have been a greater chance of this being revealed.

General Practitioner

5.9 Similarly to other local health services, the family's involvement with the GP surgery was primarily related to ordinary day to day medical issues, although these did include some short episodes of depression separately for the parents. These were dealt with in a standard way by prescription of anti-depressants, and the episodes themselves were not long term. The Father also presented with depression following the final separation from his wife.

5.10 However the major difference from other health services was that it was only the GP practice which was contacted by the Mother about domestic abuse issues. In fact it was the Mother who chose, in October 2011, to disclose verbal abuse and controlling behaviour by the Father and of the adverse effect this was having on the children, and then six months later, that it was deteriorating. Whilst the GP had no doubt been a helpful "sounding board" for the Mother on these occasions, the GP did not follow up with any further advice or make enquiries with any other agency about what more specialist help could be offered to the family, and especially to address any needs that the children might have in the situation. Whilst the presentation by the Mother of the home situation could not be said to have represented a significant level of risk to her or the children on this occasion, or that it required a child protection referral to be made, some follow up with further advice to the Mother by the GP would have been helpful and the GP could potentially, with the Mother's agreement, discussed the situation with Children's Social Care or the school nurse and agree the most appropriate response. As a minimum this should have been formally considered. The Mother explained in her contribution to the SCR that the GP had been supportive but that she nevertheless felt very isolated at this time and didn't know how to resolve the situation or whether to leave her husband. Greater information and advice at this time from the GP therefore may have been helpful.

5.11 The situation was much more concerning on the occasion when the Mother presented at the GP surgery with injuries following her return home after receiving hospital attention in Cheshire. Not only did the Mother say that the injuries had been caused by her husband pushing her, but also because since then she said he had been threatening and that she was feeling threatened. She also said that he was shouting at the children. When interviewed for her contribution to the SCR, the Mother said that she had not initially intended to disclose to the GP about the cause of her injuries, but that the doctor quickly "got it out of her". The GP then recognised the greater seriousness of the matter and therefore urged the Mother to immediately make contact with the Police. This clearly had an impact, as the Mother then went to the Police station later that day to register her allegation. This GP consultation also clearly raised safeguarding concerns about the children, and the GP dealt with this by saying that the Police would involve Children's Social Care.

5.12 Whilst the Mother followed the GP's advice, and the Police did then later involve Children's Social Care, the GP had relied on the Mother to take the appropriate actions and not confirmed by way of information sharing or referral, that the Mother's concerns were going to be fully investigated. The Police later made contact with the GP to confirm the surgery's understanding of the concerns and to potentially gain more information – however ideally there should have been communication from the surgery to the Police at the time that the

Mother raised the concerns. It was clear however that the GP was reassured that the Mother would take her advice, but there was no guarantee that she would eventually do so. Clearly if she hadn't, then there was the potential that the children could have been left exposed to some risk.

5.13 The Father had sought help from the GP surgery very soon after his arrest by the police for the domestic abuse allegation. He saw a different GP than the Mother, and he wished to be prescribed anti-depressant medication to manage his upset. It was appropriate for the GP to have advised the Father to receive counselling, though understandable that the Father's request and preference for medication was ultimately agreed. Even if the two GPs who had seen the Mother and Father had spoken or liaised over what was happening in their relationship, it probably would have had little impact on how they were separately dealt with. The fact the Father's GP offered to review the anti-depressant medication in a month's time was a reasonable response in the circumstances.

The Police

5.14 Police involvement in Surrey related first of all to their response to the Mother's allegation of the domestic abuse incident, following her disclosure to the GP. This investigation presented some challenges in that it had been reported to the Police five days after it had taken place, and that it had occurred in the North Midlands. There was a delay in identifying and making contact with potential witnesses, and some were spoken to on the phone which did not have corresponding statements recorded. Statements were however obtained from the hosts of the party.

5.15 Whilst the normal agreed procedure in this sort of situation would be for the Police force in the area where the alleged crime was committed, to conduct the investigation of the incident, this did not happen on this occasion, with Surrey Police taking on this role. It was therefore because of the geographical factors that Surrey's attempt to investigate the incident was compromised. The reason for the investigation being conducted this way was that the victim (i.e. the Mother) was local and the on-going domestic situation could be monitored locally. In this scenario it could be seen why the investigation was conducted from Surrey and, ultimately it was not apparent that the outcome would have been any different. However, formal agreed procedures should have been followed, although the Police IMR considered that what happened on this occasion was not reflective of wider practice across Surrey.

5.16 When the Mother later contacted the Police re concerns on more than one occasion that the Father was breaching the bail arrangements or non-molestation order, she was appropriately advised and the Father seen by police officers as a consequence, to remind him of what was expected of him in relation to the orders in force. Whilst the Mother explained that she was generally very appreciative of the response and support by the Police, especially regarding her initial allegations, she later said as part of her contributions to the SCR, that she felt they could have been more responsive on the occasion in mid-September 2012 to her concerns that the Father was breaking the bail conditions. From an objective perspective however, it would appear that the Police's response was appropriate in the circumstances.

5.17 Because at the time of the deaths of the children, they were found in Area 2, then there was a delay by Surrey Police in notifying the Mother of the deaths, which was said to be due in part to the different practices of deployment of Family Liaison Officers. Once again, it was

the issue of cross border working which generated some difficulties in achieving prompt effective practice.

Children's Services

5.18 The involvement by Children's Services related to their response to the one domestic abuse notification that they received from the Police, and in essence their response was prompt and appropriate in the circumstances. It was acceptable practice for the Mother to be contacted by phone in the first instance by Children's Services, and it was apparent that there was a detailed discussion about her concerns, including the safety of the children. Whilst direct contact with the family would have been an ideal and more efficient response to understand the situation, a telephone call was realistic in the circumstances as a process to identify whether this situation was a priority over others. Within the telephone contact, the Mother gave a clear indication that she felt she was in control of the situation and had made an informed decision to end her relationship with the Father, and was putting arrangements in place to support that decision. The Mother was also clear that there had been no pattern of physical abuse or violence from the Father in the past. She had also shown her sensitivity to the children by not discussing the problems in their presence and there was discussion about how she would manage contact arrangements, including via seeking legal advice. It was therefore understandable in context, that with the reassuring response by the Mother generally, the fact that she had been to a solicitor, and was content to make further contact with Children's Services in the future if necessary, that "no further action" was the decision by Children's Services at this time.

5.19 Following the range of interventions identified above, particularly those in early September 2012, soon after the alleged domestic abuse incident a few days earlier, there was a gap in agency involvement for much of the rest of September as no incidents arose or were reported by the family, to warrant any formal intervention. Therefore there was no record of any build-up of tension within the home that would have suggested that the situation had worsened or was moving to a crisis. Despite the Mother stating on her application for the non-molestation order on the 3rd September 2012 that she feared "for the safety both of herself and the children", in her conversations with the head teacher at a similar time said that she did not want the marital difficulties to impact on the children and that she had no concern for their safety in their Father's hands. Whilst this appears contradictory, in effect no concerns arose at this time. In fact it was apparent that the Mother had settled on arrangements to enable the children to have contact with the Father, and so outwardly, as she had later described to the school, she considered that they were "getting on with their lives".

The effectiveness of inter-agency communications in safeguarding the children

6.1 The key issue about inter agency communication in this case was whether the information about domestic abuse within the family was appropriately shared and that this was done with the safeguarding needs of the children in mind. As part of agreed procedures, the Police informed the Contact Centre for Children Services about the domestic abuse incident alleged by the Mother. The same report was also received by the school nurse on the same day. There was no automatic expectation that the school nurse would share the details of the concerns with the school, and there was no record that this was done. Helpfully, the Mother had already done this of her own volition. The school nurse did however check with the Contact Centre what action had been taken and she was told that the Mother had been

contacted and advice given to her. The Contact Centre did not however have a record of this communication from the school nurse. At that stage, no decision had been made about any follow up action but according to the school nurse, there was agreement that the Contact Centre would let the school nurse know of the eventual decision – however there was no record that this took place or that the school nurse chased up a response. It was considered by the SCR Panel that it was likely that the contact from the school nurse did take place and there was probably a failure to record this by the Contact Centre. The reason for this lack of follow up by either professional may well have been that by this time the domestic abuse situation was not seen as critical and actions were therefore potentially downgraded. This should not however distract from the importance of recording telephone conversations, and confirming the outcomes of interventions or responses to concerns.

6.2 It was acknowledged in the GP's IMR that the GP who tried to advise the Mother about how to manage her domestic abuse situation, firstly in relation to the disclosures of verbal abuse the previous year, did not know who or where to seek appropriate advice from on such matters. As happened in this case, a GP surgery may often be the first point of contact for a victim of domestic abuse, and so it is imperative that they are aware of the related signs and symptoms, but more importantly of its clear links to the protection of children. Additionally, there is the need to know how and where to access the correct form of help. Potentially if access to more specialist services had taken place at the time of the Mother's concerns about escalating verbal abuse in March 2012, then the circumstances may have reached the threshold for an assessment to be undertaken by Children's Services.

6.3 It was reassuring to the GP when the Police made contact following the Mother's allegation of assault by the Father, to confirm that action was being taken but also to clarify the GP's understanding of what had transpired and the GP's opinion of the possible cause of the Mother's injuries. Despite it being reassuring to the GP, it would have been more appropriate if the GP had initiated the communication with the Police. The GP however usefully told the Police of the earlier concerns about verbal abuse and threatening behaviour by the Father in the home. The Children's Services IMR suggests that in the knowledge of the GP's early involvement in respect of the domestic abuse, that it would have been expected for the GP to notify the Contact Centre of their assessment of the Mother's ability to protect the children. If this was a realistic expectation, then in the absence of contact from the GP, the Contact Centre should have communicated with the GP practice to seek this information, in the anticipation that it would inform the decision about the necessity regarding any future interventions. This is another example of how communication is not viewed as a two way process, with responsibilities on both communicator and recipient of information.

Was the level and extent of domestic abuse known and was the impact/risk to U and V adequately assessed and responded to. Were the children's wishes and feelings taken into account?

7.1 It was apparent that all agencies that were directly involved or informed of the domestic abuse incident in late summer 2012, were fully aware of its extent and of the intended actions by the Mother to address these problems. There was less evidence however that the impact or risks to the two children were simultaneously addressed. For example, the Police did not have any direct contact with the children and the description of the events did not raise any immediate issues about possible safeguarding concerns for the children. In this context it was understandable that the Police did not take any additional action to address the needs of the children, as this was not an occasion when the Police attended an address

where a domestic abuse incident had occurred. The fact that the Mother went to the Police directly to report her concerns and reported that the children were staying at a friend's home, meant that the Police would have needed to take a purposeful stance to see the children. Nevertheless, no matter how much a domestic abuse incident does not appear to directly involve the children, there is nevertheless always an impact upon them and domestic abuse is always a child protection matter. It was not apparent on this occasion that the lack of seeing the children was identified as a possible shortcoming of the Police enquiry, and that as a result this would be confirmed in the notification to Children's Services that this was outstanding.

7.2 It was also not apparent that the needs of the children were given priority within the GP surgery and the risks to them identified or discussed with the Mother and the Father. This potentially related to a lack of appropriate training in respect of the impact of domestic abuse upon the children. Nevertheless it needs to be acknowledged that it was the GP's robust response to the Mother in late August 2012 which led her to ultimately report her concerns to the Police who in turn involved Children's Services.

7.3 When the Contact Centre engaged in the telephone conversation with the Mother about the domestic abuse incident, the Mother was encouraged to ensure the safety of the children and the issue of contact was discussed. In this way the possible needs and risks to the children were appropriately raised. However it would have been additionally useful if there had been dialogue about how specifically the children were being affected and how the Mother could address this and potentially discuss with the school any additional needs they would have at this time.

7.4 In this respect therefore the children's wishes and feelings were not ascertained or taken into account, to help inform the best way forward. There appeared to be an understanding that the Mother was taking the correct protective action and that there was therefore less need to explore the impact and feelings of the children. In fact there was evidence to suggest that this was the case, but to specifically ask the questions and probe about the circumstances and reactions of the children, would in itself confirm to the Mother that they are the priority in the situation. Also it is the outcome of those particular enquiries which should be the main determinant of how or whether Children's Services should proceed with further interventions.

7.5 Generally the school focused on keeping the school environment normal for the children and there was some attention given to the children's behaviour and demeanour to make sure that there were no adverse signs that that they were experiencing difficulties. Staff did not actively encourage either child to talk to anyone about their parent's separation, and the IMR reported that the school "took the lead from the child in such situations". This may well have been the most appropriate strategy overall and was understandable in the circumstances – certainly the children did not present any worrying behaviours. The school had a policy of encouraging children to confide in three trusted adults to whom they could tell of any worries which they might have – this was meant to apply to children who may be particularly vulnerable, although it was not apparent that this was utilized in respect of these two siblings. The respective IMR identifies that this policy needs greater clarity about its purpose and application.

Were there any parental physical or mental health issues or issues of substance misuse which may have impacted on parenting capacity or that could pose a risk to the children?

8.1 There was certainly no history in respect of either parent that they could pose a risk to children. Additionally there were no physical health or substance misuse concerns about the parents. In respect of mental health, then both parents suffered with periods of depression but none of these episodes suggested that this impacted on their parenting ability.

8.2 Whilst the Father attended the GP surgery soon after the marital separation and said he was feeling depressed, there was no connection with his parenting ability or that this had been adversely affected in any way. In fact he did not have the care of the children at this time. Interestingly however, he did tell the GP that he felt he may have suffered post-traumatic stress disorder as a result of his experiences at the Hyde Park bombing incident. It is not clear what motivated the Father to make this link at this time. His army medical records were not available to the GP to check if this was the case or not – in fact the GP was not aware of the Father's previous army career.

8.3 As part of the SCR process, the GP IMR author was asked to explore the situation in respect of an ex-soldier's army medical history. It was confirmed that when a soldier leaves the service for whatever reason, he gets a final medical and at that medical he is provided with a full print off of his service medical records that he can take to a civilian GP in order to register. He is also provided with the address and details of who the civilian GP needs to write to (Army Personnel Centre in Glasgow) in order to obtain the actual medical records. The service person himself must give consent for the Medical records to be released to the GP for data protection reasons. The Civilian GP has no automatic right to that information. Potentially the reference to post traumatic stress disorder (PTSD) could have prompted curiosity from a GP about his army health history, but the Father died shortly after he made this reference to the impact of his army experiences.

8.4 Eventually the Father's army records were obtained following formal requests for the SCR process to have access to them. These were studied by the author of the GP IMR. Whilst these records identified the physical injuries he sustained at the Hyde Park bombing, there was little reference of any psychological impact upon the Father. One letter by a plastic surgeon in 1984 referred to the Father suffering a "systemised neurosis relating to this fiendish event", but no referral was made to assess or treat this. Similarly, as part of a criminal injuries compensation report at the same time, it was stated that the Father "obviously underwent a severe emotional experience …..there is no doubt that there are deeply seated emotional scars". Once again there was no evidence of any related diagnosis, assessment or treatment of any emotional problems as a result of these comments. Upon discharge from the army, the summary of his medical history transferred to the NHS in 1994, stated "none relevant".

8.5 In her contribution to the SCR, the Mother was very sceptical that the Father had suffered from PTSD as a result of the bombing incident in London. She said that his injuries were minor and that the incident was something he was able to speak of openly and tell people about, and that there was never any evidence to her that he was in any way affected by what happened in any emotional way. However, as part of the contribution by one of the Father's brothers, he stated that the Father suffered from deafness as a result of the bombing incident and that in his view the incident had had a continual emotional impact upon him and how he presented. Whilst this brother posed the question whether the treatment of the Father's depression would have been greater if the army records had been

available for the GP to consult, the review of these records which has now been possible, suggests that they added no additional issues of concern to warrant greater monitoring or different treatment.

Whether race, religion, language, disability or culture was a factor in this case and had been considered fully

9.1 For the short periods of time that most of the professional agencies were involved with the family, there was no evidence that the family as White British, presented with any factors which would suggest that issues such as race, religion, disability or culture had any impact either on the services which were being offered to the family or upon the sorts of problems being presented.

Were there any organisational or resource factors which may have impacted on practice?

10.1 Within all of the IMRs, the only one which identifies that organisational factors may have had an impact on practice, was that of the school nurse team, which at the time of the domestic abuse allegations were holding a safeguarding caseload of double that in other teams. There were also some staff vacancies. Nevertheless, the school nurse had made enquiries with Children's Services about the domestic abuse notification and so in this culture had taken an initial proactive approach to understanding any initial possible risks associated with the domestic abuse incident.

6 PREDICTABILITY AND PREVENTABILITY

11.1 Overall, it is clear within the work that was undertaken by professionals with this family, that this was generally done so appropriately and effectively within the particular circumstances presented at the time. Whilst there have been some lessons which have been learned, overall these did not reflect any significant issue that would have impacted on the final tragic outcome.

11.2 It needs to be recognised that up until the incident of extreme violence which resulted in the deaths of the two children, that this family presented as very normal in many respects. The children were well cared for and were popular in school. Whilst domestic abuse is always an issue of child protection concern, there was only one incident which had an element of physical violence within it (according to the Mother) and there was no previous pattern of violence within the marriage. Whilst the verbal abuse, reported earlier, was of a concern, once again in comparison with the issues of domestic abuse and violence that the Police and Children's Services deal with on a day to day basis, the circumstances presented by this family, whilst of concern and in need of attention, would not have led to high levels of safeguarding concerns. This made the later shocking events even less understandable. Therefore in this way there was no way that any professional could have predicted the eventual outcome or could have prevented it.

11.3 There is a body of research that has considered the issue of filicide, (the act of the murder of a child by a parent), and one of the most influential pieces of research has classified six different set of characteristics of child murder[5]. Of these characteristics, two could potentially apply to the acts by this Father; the first would be in relation to "Altruistic Filicide - where the parent kills the child because it is perceived to be in the best interests of the child", and the second would be "Spouse Revenge Filicide - where the parent kills the child as a means of exacting revenge upon the spouse, perhaps secondary to infidelity or abandonment"[6]. In fact the most common motive found in the original research was that of altruistic filicide and the least common that of spousal revenge. By the content of the letters written by the Father at the time of the deaths, where he was stating that he and the children were "going to a better place" and also blaming his wife for what he was doing, his actions appeared to reflect these two particular characteristics.

11.4 Whilst the presence of psychosis or psychiatric problems has often been found to exist in those adults who commit filicide, there was no such evidence of this in respect of the Father. However, "The presence of significant life stressors has been reported by filicidal fathers, including financial difficulties, impending marital breakup and fear of separation. Some paternal filicides reportedly have occurred in the aftermath of arguments concerning marital infidelity, and being separated at the time of the offence has been noted to be an important precipitating factor"[7].

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[5] Resnick, PJ, "Child Murder by Parents: a psychiatric review of Filicide. American Journal of Psychiatry 1969

[6] Sara G West, "An Overview of Filicide" – Psychiatry MMC – February 2007

[7] Bourget, D et al ; A Review of Maternal and Paternal Filicide –, Journal of the American Academy of Psychiatry and Law – March 2007.

11.5 Whilst this might generate some understanding that the Father took the lives of his children and his own life in circumstances that research has shown to previously exist in similar deaths, it in no way helps in consideration of whether there was any level of predictability or preventability. In fact one piece of research identified that the act of murder of the child occurred impulsively and that "such an act of violence was out of character and totally incongruous with how they lived their lives up to the time of the crime"[8]. Furthermore, "Whilst suggestions have been made for the prevention of certain types of filicide, little is known about prevention of filicide-suicide"[9].

11.6 Recent research[10] has identified that men are at a greater risk of suicide in the aftermath of a relationship breakdown and that men are less likely to enjoy the network of friends to support them at such times. In fact as part of her contribution to the SCR, the Mother felt that the Father might have benefited from greater support and advice at the time of the parental separation. Additionally his brother also contributed that the Father was in need of greater support and advice at this difficult time for him. Unfortunately the Father did not specifically seek this, other than one consultation with his GP. Additionally this particular research has also identified that "services designed to support the relationship needs of individuals and couples are not "male –friendly" enough".

[8] Pappietro, DJ and Barbo, E; "Towards a psychiatric understanding of Fillicide", Journal of the American Academy of Psychiatry and Law – Dec 2005.

[9] Freedman, S et al, "Fillicide-Suicide; common factors in parents who kill their children and themselves" – ", Journal of the American Academy of Psychiatry and Law –2005

[10] "Try to see it my way: Improving relationship support for men", Relate report - February 25th 2013

7 LESSONS LEARNED

12.1 It would be good practice for a professional to confirm with a parent that they have taken agreed actions to address domestic abuse within the home by their own contact with an appropriate agency, and if not to make an appropriate referral on the parent's behalf. In this way, meeting the safeguarding needs of a child would not be potentially compromised or delayed. Research is clear that numerous incidents of domestic abuse usually take place before a victim feels able to report it, so there might always be reluctance for the victim to take their concerns further. For the professional to make the referral on the victim's behalf or to directly support them to do so, would be the most productive in safeguarding terms.

12.2 It is an important principle for professionals to confirm to their colleagues, when it has been agreed to do so, that certain actions or interventions have been undertaken in respect of addressing safeguarding issues. There is a responsibility to chase up the professional if the required communication is not forthcoming.

12.3 It needs to be recognised that greater care is required by professionals when cross-border issues exist within the process of addressing safeguarding concerns. In such circumstances, information sharing can be compromised as well as the application of relevant procedures.

12.4 Domestic abuse is very much a child protection issue, and if professionals who regularly work with families have limited knowledge or understanding of this as a problem, and of the resources available to address it, then it would be likely that the safeguarding needs of children will be overlooked.

12.5 Unless children are actively spoken to, engaged and observed by professionals when there are safeguarding concerns, it would not be possible to accurately assess or understand their needs, wishes and feelings.

12.6 When legal orders are presented by parents in order to advise and request professionals to act in a particular way in order to protect their children or prevent contact by another parent or adult, then it is incumbent on that professional to confirm the exact requirements and conditions of the legal order being presented**.** This could be done either by the use of specialist advice or checking back with the parent how their expectations match what is contained within any order.

12.7 Within domestic abusive relationships, research has indicated that is at the time when the adults separate, that the greatest physical risk exists for the partner victim and potentially to the children.

12.8 Violent acts which lead to the death of children can occur without any prior indication, predisposing factors or known intentions, and that on such occasions there would be nothing that a professional could do to prevent such a tragedy.

8 RECOMMENDATIONS

NB: These recommendations are made to primarily address multi agency safeguarding issues and have not repeated or replicated those made within the IMRs, which are listed as an appendix.

13.1 The Surrey Safeguarding Children Board to make a recommendation to the relevant national body to request that army medical records of former army personnel can be accessed when there are concerns about the person's presenting health which could have an impact on the safeguarding of children.

13.2 The dissemination of learning to professionals of the findings from this Serious Case Review will need to include the "lessons learned" section of this report but also should provide information about the study of Filicide and of the associated research.

13.3 At times of transition and reorganisation within the Health service, the SSCB must be assured that relevant Health organisations are held to account for the implementation of relevant IMR recommendations.

Ron Lock

30.5.13

APPENDIX 1

Individual Management Review Recommendations

Mid Cheshire Hospitals NHS Foundation Trust

NB: The vulnerable adult agenda is gaining increased significance and organisational responses are developing and evolving at a fast pace within the Cheshire and North West locality.

1. Mid Cheshire Hospitals NHS Foundation Trust are responding to this progression within the mandatory training agenda. From April 2013, *all* staff within the organisation will receive an initial induction session and then regular update sessions around *Safeguarding* in the widest sense.

2. The sessions will be delivered by the safeguarding Team and will not only include safeguarding children; but also vulnerable adult triggers and professional responses to the recognition of domestic abuse.

3. It is hoped that this new training approach will build upon staff knowledge and increase staff confidence and competence in supporting vulnerable families.

4. Anecdotal evidence from staff evaluation of safeguarding children sessions has revealed that the discussion of case studies can effectively reinforce the practicalities of addressing safeguarding concerns.

5. The IMR author is aware that this approach will also be employed to the vulnerable adult / domestic abuse training agenda. The IMR author will therefore be recommending and ensuring that the reinforcement of *who* is attending with a patient is included and why it is of importance – using this Serious Case Review as an example.

6. To demonstrate the effectiveness of the training and it's key messages; the IMR author proposes for the Safeguarding Committee to conduct a random audit of Casualty Cards in April 2013; to verify if next of kin and accompanying adults are documented appropriately. The audit should then be repeated in April 2014; after the first year of the revised safeguarding training has been delivered. The audit results, trends and recommendations can be reported through the Safeguarding Committee, governance structure and annual report.

Surrey Police

1. The Head of Public Protection should remind all staff via a communication on the Surrey Police intranet of their safeguarding responsibilities. There should be specific emphasis on the need for officers / staff to consider the potential for children to be at risk when responding to incidents and to make sure that any children are seen (preferably at the home).

Surrey County Council Children's Services

1. For Contact Centre Duty Managers when outlining the task to be undertaken to always state that the views and wishes of the child should be sought.

2. For Managers in the Central referral unit when outlining the task to be undertaken to always state that the views and wishes of the child should be sought.

3. For Contact Centre Managers to record the reasons for their decisions referencing the impact/level of risk of the incident to the child.

Schools and Learning, Surrey County Council

1. All CPLOs to be provided training on court orders and their impact, including roles and responsibilities of all staff.

2. All Head Teachers to receive a briefing note on good practice in relation to understanding, monitoring and escalating issues where a child is known to be subject to a Court Order.

3. The Child Protection policy at Ashford CofE School to be reviewed and updated in line with the findings of this IMR.

4. All schools to be issued with the learning summary of this case once published.

Ashford and St Peter's Hospitals NHS Foundation Trust

NB: The key recommendation from this report is that there needs to be compliance in practice with safeguarding policy, procedure and training.

1. Ensure that all staff attend on-going training in Safeguarding Children and Domestic Abuse at Level 3 and the training uses relevant case material for discussion. All temporary staff must have safeguarding awareness training as part of their local induction and supplier agencies must provide assurance that temporary staff have received safeguarding training at the appropriate level.

2. A & E weekly Safeguarding meetings to be multi-disciplinary and shared with Social Care. There must be a culture of child first and professional curiosity regarding other family members in adult services.

3. A & E to devise and implement a trigger list for Safeguarding Adults to be reviewed at every A & E attendance. A & E need to provide assurance to the Trust that they have a robust/consistent approach when undertaking initial assessment of all patients.
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4. The Trust must identify the approach to implementation of a single patient electronic record.

5. In the meantime a procedure is required to ensure that previous records of attendances in A & E are reviewed at each attendance.

6. Share lessons learned with all staff in A & E, Paediatrics & through Safeguarding Children Training across the Trust.

Virgin Care

1. The role of the school nurse in receiving police reports needs to be made clearer and this also needs to be reflected in their 0-19 policies and procedures regarding their role and responsibility on receipt of police reports.

2. Other agencies need to be made aware of the role and responsibility of the school nurse which clarifies their expectation.

3. That a practitioner from Virgin Care to be present on the multi-agency pilot scheme in Woking for triaging police reports.

4. The health needs assessment needs to be updated to included information learnt from serious case reviews as key questions asked at first contact.

Health Overview Report

1. NHS Surrey need to ensure that lessons from this review and provider action plans developed in response to this review are included in the hand over process to new commissioners from 1.4.13 to ensure monitoring that lessons are being embedded into practice

2. Commissioners need to be assured that practice within commissioned services acknowledges and responds to the impact of domestic abuse on children