Brighton & Hove LSCB

Serious Case Review

Executive Summary

in respect of

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Presented to the Brighton & Hove LSCB on 2nd December 2008

Report Authors

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1 Introduction

1.1. In June 2007 police attended the home address of (A), his wife (B) and their 8 year old daughter (C). At the premises they located the body of his wife who had been murdered by (A) some six weeks previously. The body had remained hidden in and around the house until its discovery. (A) was arrested and subsequently stood trial and found guilty of murder. The daughter had been living at the house during the whole period of time that the body was at the location.

1.2. Following the discovery of (B)'s body it was established that the family had a history of domestic violence going back a number of years. This had been known to statutory agencies in Reading, but had not to Police and Social Care in Brighton and Hove. Also (C), a pupil at a Brighton primary school, had spoken to her head teacher on several occasions over the preceding few weeks about her mothers disappearance.

1.3. Brighton & Hove Safeguarding Board agreed that the grounds for a serious case review under Working Together to Safeguard Children (DfES 2006) were met.

1.4. Individual Management Reviews were completed by relevant agencies in both Brighton & Reading.

1.5. A Serious Case Review Panel was appointed to oversee the process of the review.

1.6. The full Overview Report was prepared by Jane Wonnacott and Brian Boxall, Independent Consultants, In Trac-Training and Consultancy. The executive summary was written in conjunction with representatives from the Brighton & Hove Local Safeguarding Board.

2 Summary of contact between professionals and the family.

2.1. (A) first came to England in 1994. He was referred to a psychologist in Bournemouth in May 1996 and was diagnosed as suffering from anxiety and depression. In 1997 (A) went back to France, his country of origin, and married a Russian woman (B) whom he had met via the internet. They both returned to England and settled in the Bournemouth area. In July 1998 they had a daughter (C), and moved to Reading the following year.

2.2. Both (A) and (B) were European foreign nationals. This added a complexity to this case as there were concerns that (A) was obtaining un-prescribed medication either during his visits to his home country, or via his family. The nature of this medication was not clear to health professionals in this country, and made accurate diagnosis and appropriate medical treatment difficult.

2.3. In 2000 (B) attended Accident &Emergency in the Reading area to have a cut to her head sutured. The cut was a result of being pushed over by (A). She was seen by a local GP to have the stitches removed.

2.4. In 2001 Reading Police attended the family home address following an assault on (B) by (A). He had pushed her and placed his hands around her neck. He admitted the assault but (B) did not wish to make a complaint and the police therefore took no further action. In neither of these contacts were any referrals made to any other agencies.

2.5. In 2005 Thames Valley police attended the home address having received a 999 call from (C), age 6, reporting that her father was assaulting her mother. (A) was charged and appeared at court. Six months later the case was discontinued by the CPS due to (B) not wishing to continue with her complaint. On this occasion police passed a referral to the local social services due to a child being involved. A decision was made by social care to treat this as the first reported incident, and therefore send a letter to B and take no further action.

2.6. In 2006 the family moved to Brighton under a mutual housing exchange. No agency in the new area, including (C)'s new school, were aware of the past family history, including domestic violence.

2.7. They registered with local GP's who were sent the family's medical records. These did include information about some of the incidences of domestic violence.

2.8. During the whole period covered by the review (A)'s mental health was subject to a number of assessments and he disclosed having marital problems. The family were socially isolated and suffering financial problems as neither of them worked. In 2006 he tried to commit suicide.

2.9. In May 2007 (C) spoke to her head teacher expressing concern about her mother's sudden disappearance. The head teacher had concerns about the potential neglect of (C) and the safety of the mother whom she was convinced had come to some harm. At this time the school had no knowledge of the previous domestic violence issues in Reading, and there had been no contact between the family and Brighton and Hove children's services.

2.10. The head teacher contacted the children's social care team by telephone and reported her concerns. The manager who answered the telephone did not record this conversation but suggested that the head teacher should put this referral in writing. The school did send a faxed confirmation of the referral but the information was confined to issues in respect of the neglect of (C.) It did not note concern for mother's safety.

2.11. A social worker contacted (A). In the context of the identified concerns regarding neglect they were satisfied with the explanation he provided, and therefore closed the case.

2.12. At the time, the head teacher perceived that she was not being taken seriously due to a reputation with social care for over-reacting. Children's social care do not believe that this was the case. The head teacher continued to speak with (C) who provided more evidence that raised concerns about the safety of (B). In June, the head teacher again contacted the children's social care team. A practice manager recorded the conversation as a referral. The practice manager, having spoken to the head teacher was now fully aware of not only the concerns of possible neglect of (C,) but also the concerns about her mother's safety.

2.13. Over the following week the practice manager spoke to the head teacher several times. The head teacher also recalled having an opportunity to speak informally with an area manager about her concerns. The service manager does not recall this conversation.

2.14. The practice manager spoke to the local police child protection team supervisor who confirmed that (B) had not been reported missing. She advised the manager to make a missing person report.

2.15. The children's social care manager visited (A) and following the visit reported (B) as missing having been concerned about the answers (A) had provided. The police call handler did not record (B) as missing but created a concern for safety report. This was picked up by a sergeant the following day. Police attended the family home and located (B)'s body. (A) was arrested. This took place about 6 weeks after (C) had first spoken to her head teacher.

3 Key issues arising from the case.

Responding to incidents of concern

3.1. Whilst the family lived in Reading there were three known incidences of violence reported to different agencies. In two cases, there was no referral to children's social care. In the third, a referral was passed but the case was closed. Reading have now improved their procedures and the improved procedures would reduce the chance of a similar case being closed at this early stage.

3.2. At this time, the local accident and emergency department, the GP practice and police in Reading, all had knowledge of domestic violence. None had the full picture and each took action in isolation with no awareness of the probable escalation of violence or risk to both the victim, and the child.

Communication and response at the point of referral

3.3. This case highlights the need for:

- comprehensive written referral information
- recording all telephone referrals even when it is known that a written referral will follow
- organisations to consider how to enable professionals to consider seriously all information even when it appears far fetched, or outside their usual experience.
- consideration of the circumstances where professional relationships may inhibit the capacity of individuals to hear information from, or trust the judgement of others.

3.4. Brighton and Hove, has in place comprehensive child protection procedures in line with Working Together to Safeguard Children (2006), backed up by a training programme that covers a number of theses points. This review therefore highlights the need for continued audit and quality assurance to ensure that the procedures are understood, complied with, and that training is positively influencing outcomes.

Missing person response

3.5. Anyone can report a person missing. In this case (C) was, via the head teacher, effectively reporting her mother missing. Adults should have reported on (C)'s behalf when she first brought her mother's disappearance to their attention. Sussex Police had in place comprehensive procedure and guidance that should have ensured speedy and appropriate action in response to any report. The failure in this case was due to individual staff members not complying with the procedure.

Information sharing when families move area

3.6. The review identified a number of agencies who may have held information when families transfer.

- Housing
- Social care records
- School records
- Police records
- GP records.

3.7. If there is no ongoing child protection case or criminal investigation when an adult moves, then the only record that follows them are GP records. For children, school records will also follow.

3.8. In this case, GPs were also the only professionals in a position to link the mental health issues of (A), including his concerns that he might harm someone, with the incidents of domestic violence. If there had been a system within the GP practices of flagging domestic violence incidents on the partner's patient records, this might have promoted links to be made and enhanced the capacity of the GP to make an informed analysis of risk.

The role of the GP in child protection

3.9. Previous Serious Case Reviews have highlighted the need to understand the impact of family history, and the way in which risk and protective factors interact. Also the majority of Serious Case Reviews involve children who are not open cases to children's social care and it is likely that GPs are often the only professionals with access to some of the picture, particularly in highly mobile families. The capacity of family GPs to understand interacting risk factors and make a reasoned judgment as to how to respond is therefore crucial. They need to have a good understanding of the unique position that they hold in the process.

Impact of parental mental ill health on families

3.10. (A)'s mental health played a significant part in this case. It became clear from his GP records that he had significant mental health issues possibly related to events in his childhood that he was not willing to discuss. In adulthood he presented as depressed with anxiety attacks. He clearly felt that he might harm someone, as set out in the consultant's report in May 1996. This comment was a year prior to his marriage to B. His prediction was unfortunately to come true eleven years later.

Confusion between adult and children safety

3.11. Roles and responsibilities became unclear. The school were dealing with children's social care about the child, but also believed that they would be advised regarding the adult.

3.12. There is a need for all services/professionals to not just restrict their thinking to what they know, or are responsible for, but to consider the whole picture to include both adults and children.

Child protection within a school setting

3.13. The review highlighted the issue of support for head teachers and other school staff in relation to safeguarding children. In this case, the head teacher acted as the child protection lead yet did not have access to external consultation, support or advice.

Listening to children

3.14. Following the murder of her mother (C) was extremely creative in engineering the visit of her father to the school. She must have been very anxious to take this action, and yet the only people who were listening to her and believing the extent of her worries were staff at school. It would have been good practice for a social worker to talk to (C) both times that the case was opened as a referral by Brighton and Hove.

Risk assessment in situations of domestic violence

3.15. If incidents are treated in isolation then potential future risk remains hidden. The use of a domestic abuse risk indicator/assessment tool may have assisted decision making. These tools need to be widely available, especially within GP surgeries.

3.16. If all agencies had proactively asked questions based on risk indicators, then a number of risks might have been identified, providing a more informed picture. This would have allowed for more evidenced, defensible decision making and proactive action to reduce the risk. The Brighton Domestic Violence Senior Officers Strategy group have produced a risk indicator checklist which would have been very helpful in this case.

4 Conclusions

4.1. This review, whilst examining the response of professionals to (C), has also examined issues in respect of domestic violence and abuse and the effect, not only on the child, but also on the victim as a vulnerable adult. Had the complexity of domestic violence been recognised, understood and acted upon, this *may* have altered the course of events that culminated in the death of (B). The review is not suggesting that any one individual's action would have changed the outcome, but a different response to a number of incidents might have altered the overall course of events.

4.2. When the family moved, because not all agencies had been aware of the previous history of domestic violence, the opportunity for this to be passed on and influence responses when (B) went missing was lost. The need to continue to both sharpen risk assessment processes, particularly within GP practices where domestic violence is occurring, and strengthen information sharing across agencies is crucial.

4.3. (C) was a child who was clearly aware of the risks to her mother, evidenced by her call to the police at the age of six and her later behaviour in engaging the head teacher in trying to find her mother. Talking to (C) as part of an assessment by social care may have reduced the length of time she remained in the home with her father and the body of her mother. This case is therefore a reminder of the need to ensure the voice of the child is heard.

4.4. There is no evidence that any individual or agency could have predicted, or prevented the death of the child's mother with the information they had available. However, the confusion and delay in the initial referral process, and the later short delay in reporting the mother missing to the police, did cause the child unnecessary emotional anxiety and distress as well as increasing risks that she could be harmed.

5 Overview report recommendations

Whenever suspected domestic violence is presented, agencies should use the standardised domestic violence risk indicator form that has been developed by the Brighton and Hove Domestic Violence Senior Officers Strategy Group. Front line staff should receive training in its use.

Brighton & Hove LSCB should ensure that domestic violence incidents, where there are children in the family that come to the attention of health service agencies including GP's, should always be reported to children's social care teams.

Brighton & Hove LSCB and domestic violence forum should revisit the recommendations in the 2006 domestic violence gap analysis report . This is to audit progress and consider future action required to support implementation of outstanding recommendations

Brighton & Hove LSCB should give clear guidance concerning the need for clear accurate contemporaneous recording and ensure that this is occurring across all professions.

Brighton & Hove LSCB should ensure that GP records are reviewed at the point of transfer by the receiving practice and all domestic violence incidents noted and the records flagged.

PCTs in Reading and Brighton should ensure that where contact with a GP raises issues that may indicate risk to another family member, this is flagged on that partner's notes.

Structures for those with child protection responsibilities within schools should be reviewed. The Child Protection Liaison Officer should always have a named consultant with whom they can discuss issues that may indicate concerns about a child.

Brighton and Hove CYPT should issue guidance to governing bodies asking them to give careful consideration as to whether a head teacher is the most appropriate person to undertake the role of the Designated Child Protection Lead.

Brighton and Hove LSCB should ensure that their regular audit processes consider referrals to social care in order to ensure that they contain complete information including previous telephone contacts.

Brighton & Hove LSCB should publicise information across the professional network about the definition of a missing person how to report someone missing.

The Brighton & Hove LSCB training programme should be reviewed in order to ensure that communication between professionals is addressed at both the practical and the psychological level. i.e. that it explores the impact of relationships and biases on analysis and decision making in child protection.