SERIOUS CASE REVIEW

Child W8

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CONTENTS

APPENDIX

INTRODUCTION

1.1. This Serious Case Review (SCR) is in respect of Child W8, who died in January 2018 at the age of 8 years.[1] Child W8 lived with her mother and two siblings. Child W8 was stabbed to death by her father.

1.2. The areas of learning identified include the following;

- Sometimes very serious harm to children is not predictable
- Referrals and assessments should consider and record the dynamics of the domestic abuse as well as risks to children and ensure adequate support is subsequently provided
- Agencies made aware of domestic abuse incidents should proactively enquire about Mother's (in this case) and children's safety
- Mothers and children are better protected and supported if midwives consistently use Routine Enquiry during pregnancy and the immediate postnatal period
- Entering a new relationship can be a risky time for families who have experienced domestic abuse even if the parents relationship with the previous partner finished some time ago

1.3. This report will be published on the Walsall Safeguarding Children Board (WSCB) website. The WSCB will also ensure that findings are widely disseminated locally. To avoid unnecessary disclosure of sensitive information, details in this report about what happened include only the facts required to identify the learning. The footnotes should be read alongside the main text. They include the author's comments as well as references to research, legislation, guidance and changes in local practice since the period under review.

1.4. This SCR considers multi-agency involvement from Child W8's conception in September 2008, until Child W8's death in January 2018. The WSCB agreed to undertake this review using a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted as they did at the time. In practice, engagement with staff by agency and overview authors was relatively limited; some of the events described were some years ago and many of the staff involved had moved on.[2] Family members were also offered the opportunity to speak to the overview report author. Mother and Father agreed to meet with the author. Their views are included at the relevant point in this report.

2. DETAILS OF THE FAMILY AND CASE CONTEXT

2.1. The parents of Child W8 are referred to as Mother and Father. Other family members will be referred to by their family relationship e.g. Sibling.

[1] Working Together 2015 states a serious case review should be held for every case where abuse or neglect is known or suspected and where a child dies

[2] The overview report author had direct contact with two school staff via panel meetings.

2.2. Child W8 was the second of 3 children born to her parents. Child W8 has been described by those who knew her as a sociable, adventurous and likeable child who was loved by both parents and well looked after. She was making good progress at school where she was also a member of the school choir, and an enthusiastic attendee at the after school club, where she got involved in football and drama. She also liked dancing and singing.

2.3. After their parents separated in 2012 Child W8 and her siblings lived with their mother. Father continued to be involved in the children's lives; for example, attending school events. The children's parents were able to make amicable and informal arrangements for regular contact, which took into account the children's needs and routines and included Mother going out to enable him to visit the family home, when she was not there.

2.4. Father was employed for most of the period under review. Mother mostly focused her energies on her children and volunteer activity in the community. The family had a large supportive extended family and did not stand out in any particular way in the local community where they lived.

3. THE STORY OF THE CHILD AND THE FAMILY

3.1. Whilst the period covered by this review does not start until September 2008, some previous history is of relevance. In June 2007, when Sibling 1 was a toddler and present in the household, Father was cautioned for assault after slapping Mother during an argument.[3] There were no visible injuries. Mother refused to pursue a prosecution and, according to police records, declined support. Mother does not recall any support being offered by the police, beyond being given a lift to Paternal Grandmother's house as somewhere else to stay, which she appreciated as it made her feel safer. 5 working days later Children's Social Care (CSC) received a copy of the police log. It would appear that CSC took no further action; the records do not state the reason for the decision. There is a record of this incident on Mother's GP notes – but not on Fathers or on Sibling 1.[4] There is no evidence of any other agency being informed of the incident.

3.2. The family were registered with the local Children's Centre from August 2008 until 2013 when it closed and was replaced by one of Walsall's locality teams. When Children's Centres commenced all families with children under 5 years of age were offered the chance to attend activities and support programmes. In 2013 locality teams extended this remit to all children aged 0-18 years. Mother was described by staff as a "joiner" who attended a range of activities as both participant and volunteer. Mother told this review that she and the children had enjoyed the activities and opportunities offered at the Children's Centre. During their contact with the family over a number of years the staff recall a couple of casual conversations with Mother which indicated she was considering separation.

[3] During the trial it came to light that a previous conviction for actual bodily harm in 1990 related to a previous girlfriend

[4] Almost half of Walsall's GP practices have signed up to the first phase of the Identification and Referral to Improve Safety project which provides training and support to ensure those patients who need it are referred to specialist domestic abuse support

3.3. One night in May 2012, not long before midnight, a neighbour phoned the police to report that Mother was at her address saying Father had hit her. Mother told the police that Father had arrived home mid-evening, after work, via the pub. Mother told this review that this was not unusual. After Mother had gone to bed he woke her up, accusing her of having an affair and called her a slut. Mother reported that she went downstairs to avoid the accusations; Father followed her and became more aggressive including slapping her across the face and twisting her arm. Mother told police that Father had been violent to her since 2010 because he suspected that she had had an affair and that the incidents were increasing in frequency. Mother said he was not violent towards the children. Mother told the police that she had tried to separate from him 3 times and that she was dependent on him for money.[5] Father was interviewed by Police the following day and although he did not fully agree with Mothers account of his aggressive behaviour, he did accept another caution for common assault. Mother was not willing to pursue a prosecution.

3.4. Police officers were aware of the 2007 incident and the responsible sergeant appropriately graded the 2012 incident as "medium" and it was referred to CSC promptly the following day.[6] The referral was discussed at the daily DART (Domestic Abuse Response Team) meeting, which agreed a grade of 3 on the Barnardos risk assessment tool and that the Domestic Abuse Forum would make contact with Mother. The DART also recommended an Initial Assessment should be completed by a social worker.[7] A standard letter offering support was sent to Mother and a Street Interest Gazetteer (SIG) marker[8] was attached to the home address.

3.5. The Initial Assessment was completed outside of the 10 day timescale in Sibling 1's name only.[9] Nowadays periodic case audits demonstrate that Child and Family assessments[10] are

[5] Mother told this review that Father told her that if she were to leave she could not take the children. The child benefit was in his name so she had no money of her own

[6] Domestic Abuse Stalking & Harassment (DASH gradings: **STANDARD -** Current evidence does not indicate likelihood of causing serious harm. **MEDIUM -** There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse. **HIGH** - There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

[7] The DART was a long standing multi-agency meeting. The agencies met daily and included representatives from West Midlands Police, Children's Services, a health representative and a member of the central education support services. Walsall Domestic Violence Forum, the commissioned provider at this time for supporting victims of domestic violence, was also in attendance. There were no minutes from these meetings and those in attendance discussed police logs and decided between them what the appropriate course of action should be. The DART process ceased in 2015. Walsall Domestic Violence Forum ceased to exist on 31st March 2016. Current practice (since August 2017) is that all DASH risk assessments are screened by police officers in the Multi-agency Safeguarding Hub. Those rated as meeting a threshold of potential or actual risk of significant harm to a child are shared with health, education and children's social care staff.

[8] A SIG marker is attached to an incident location in order to alert officers and staff to particular information of relevance – domestic abuse in this instance.

[9] It was standard practice in Walsall in 2012 for assessments to be undertaken in respect of an index child only. This was not in line with national guidance http://workingtogetheronline.co.uk/documents/wt_2010.PDF

[10] Nationally Child and Family assessments replaced Initial and Core Assessments in 2013 to enable a more proportionate approach than the previous arrangements provided.

completed in a timely way for each child in the family. As part of the 2012 Initial Assessment a home visit was made to see both parents and Sibling 1 together and separately and checks were made with the health visitor and Sibling 1's school.[11] Neither agency contacted had any knowledge of previous domestic abuse or any concerns about the children. There is no record of any checks with Child W8's nursery, the children's centre, or the GP.

3.6. The assessment correctly identifies both parents stated-but-not-yet-achieved intention to separate as a risk factor and recommends that involvement is "stepped down" to the CAF (Child and Family) team which was a previous incarnation of "Early Help". There is no evidence that other agencies involved with the family were informed of the outcome of the assessment.[12] The CAF team had no access to the council electronic client information system and no other agency records exist which indicate CAF team involvement with the family. Mother told the author that she was not aware of the referral to the CAF team and that there was no further contact from any agency regarding this incident.[13] Parents did not separate until Father moved out more than 3 months later.

3.7. In September 2013 Child W8 started attending the primary school, alongside her older sibling. From then until her death there were no concerns about the care of any of the children, or any incidents of note known to agencies.

3.8. Just prior to Christmas 2017 Mother told Father she had a new (female) partner. Mother continued to make diplomatic arrangements to ensure Father does not bump into Mother's Partner accidentally when having contact with the children. Initially Father seemed to accept the relationship. However in January 2018 he sent a series of abusive text messages to Mother, including some which suggested he must have been watching the house. One day she discovered Father had managed to re-acquire a key to her house and let himself in without asking. Mother told this review that she had found this behaviour unpleasant but not so worrying as to think it necessary to contact the police.

3.9. About a week later, on the day before Child W8's death, Father collected her from school on the Friday as usual; Child W8 looked forward to seeing her father. On the Saturday morning Mother agreed to Father's request for Child W8 to stay with him until Sunday. On the Saturday evening, shortly after Father had posted a happy photo on Facebook of Child W8 eating pizza, Child W8 called her mother to ask her to collect her because her neck was hurting. On Mother's arrival at the property, Child W8 was not ready. When Mother did

[11] Usually agency checks would be done before any home visit – perhaps not on this occasion due to the prior discussion in DART, however there is no confirmation in health records that health staff were party to the DART discussions

[12] The health visiting records show a follow up enquiry to CSC by the health visitor some weeks later.

[13] Currently each agency is responsible for monitoring the effectiveness of their own "Early Help" activity and the Walsall Safeguarding Board performance monitoring framework includes measure that would identify any unusual patterns of re-referral.

not want to come in and wait, Father made a serious and credible threat to kill Mother. Having failed to drag Mother into the address, Father closed the door. Within minutes he had inflicted a fatal stab wound to Child W8's chest and then stabbed himself in the abdomen. Child W8 died later in hospital, Father had internal injuries which could have been fatal and required several weeks stay in hospital; the likelihood is that Father attempted suicide.

In summary;

3.10. This family did not stand out from the community in which they lived. The only non-universal involvement agencies had with the family relevant to this review was police and social care involvement for the two reported incidents of domestic abuse. Although Father enjoyed a regular drink of alcohol there is no evidence that this constituted serious problem drinking impacting on the children. Although he was feeling stressed before Christmas 2017 there is no evidence that this was severe enough to be recognised or described as a mental health problem. With the benefit of hindsight it can be seen that the harassment of Mother after the disclosure of her new relationship was evidence of possible threat to her, but prior to minutes before the murder there was nothing to indicate a level of anger or distress that suggested potential serious harm either to her or any of the children.

4. ANALYSIS

Response to domestic abuse

4.1. When the parents were together there were a number of domestic abuse incidents, of which 2 were reported to the police in 2007 and 2012. On both occasions there were no apparent injuries, and in common with many others in the same circumstances, Mother did not want to co-operate with a prosecution. As the police had insufficient evidence to go to trial, giving a caution was the most appropriate outcome available on both occasions. In 2012 the police were called by a neighbour. There is no record of any discussion with the two neighbours whose contact details were recorded. In 2012 the police recorded Mother's view that Father would not intentionally harm the children. There is no evidence that anyone ever discussed with either parent the emotional impact on children of living with domestic abuse.

4.2. Referrals were made by the police to CSC on both occasions. It is not clear why the 2007 referral was delayed by 5 days and why no action was taken by CSC; an Initial Assessment should have been completed. In 2012 the referral record does not include all the relevant details known by the police, in particular that: Mother had made 3 previous attempts to separate; that she was dependent on him for money and her statement that the frequency of domestic abuse incidents had recently increased.

4.3. The Initial Assessment undertaken in 2012 did involve seeing each parent separately and an attempt to engage Sibling 1. It also recognised that intending to separate was actually a risk factor; frequent separation and reconciliation is a common feature in relationships involving domestic abuse. Separation is a dangerous time for escalation of violence.[14] What the assessment did not do was explore the dynamics of the couple relationship and nature of the domestic abuse, and the impact on all 3 children.[15] There is also no evidence of any discussion with Mother about managing the potential risks of separation, however mutual the decision might appear to be at that point.

4.4. Some agencies involved with the children were not made aware of the domestic abuse; due to incomplete checks, there is no evidence that any were aware of Mother's statement about the violence increasing in frequency or her attempts to separate. It is unclear why the outcome of the assessment was referred to the CAF team. If it was to manage the risk of Father continuing to live in the family home, there is no evidence of any consideration about which practitioner might already have a confiding relationship, and have reason to be in on-going touch with the family – i.e. the health visitor.

4.5. Mother told this review that she thought Father found the social worker quite intimidating. Whilst Mother thought this was not intentional on the social worker's part, she also though it was quite convenient, as in her view this, alongside the parents' belief that the social worker would be coming back to check about the separation, "kept Father in line". Father does not recall the visit in detail.

4.6. There is no subsequent evidence in any agency records of proactive enquiry with Mother about whether she and the children were safe – including by the health visitor while still involved with Child W8 and Sibling 2. Mother told this review that she was not aware that a referral had been made to the CAF team and confirmed that no-one offered her any further support after the social work assessment. She would have welcomed this as it was left her without support in navigating getting Father's name off the joint tenancy and getting him re-housed; which took over 3 months. Information about the incident in 2012 was not transferred from Sibling 1's school record to those of Child WS8 and Sibling 2 when they arrived in the same school.

4.7. There is also no evidence that midwives ever enquired about domestic abuse when Mother was pregnant with Child W8 or Sibling 2; it is unclear why this was not done as

[14] During the trial it came to light after separating from a previous girlfriend he had hidden under her bed armed with a knife - or of dangling his legs off a balcony while holding their young son. This was not known to agencies previously.

[15] Since then Walsall Children's Services have trained staff to use Barnado's Risk Identification Matrix, an evidence based tool which enables practitioners to assess whether a child is at moderate, serious or severe risk.

Routine Enquiry by midwives about domestic abuse during antenatal and immediate postnatal care was expected practice at this time.[16] The information Mother gave to the police in 2012 suggests there would have been historical and possibly current domestic abuse that she might have disclosed during her pregnancies; the reason why government health policy expects proactive enquiry, then and now, is due to evidence that women find it difficult to raise the subject of domestic abuse themselves but will disclose it if asked directly and sensitively.

Filicide [17]

4.8. The body of research on filicide is small and frequently hard to interpret due to methodological issues.[18] In 1969 Resnick[19] developed a typology which is still broadly accepted today. His five categories were; altruistic (sic), to protect the child in some way or relieve their suffering; as a result of an acute psychopathic episode; the child being unwanted; accidental killing; and spousal revenge. The latest triennial review of Serious Case Reviews[20] found a theme of a desire to exert control or exact revenge in filicide perpetrated by males, often after some kind of "trigger" event, for example a court case involving contact or residence.

4.9. O'Hagan's review of the literature[21] indicates that: those filicides which are not associated with a chronic history of abuse and neglect often involve the parent attempting or committing suicide at the same time or shortly afterwards; contact provides the opportunity to kill, especially in the many cases that are premeditated; a significant minority of cases involve mental health problems (known or undiagnosed) especially for young mothers; and a high proportion involve domestic abuse where a risk factor is separation, or the discovery of a new relationship, either of which can prompt both men and women, but especially men, to kill their children and/or partner in revenge.[22] The impact of an ex-partner being involved in a same sex relationship would be likely to exacerbate any distress as it may be interpreted as calling into question the basis of the whole of the previous couple relationship, as well as a perceived threat to an

[16] Audits of Routine Enquiry by midwives are being undertaken within the health trust to make sure practice has improved.
[17] Filicide is defined as the killing of one's own birth child over the age of 12 months
[18] Small numbers, inclusion of a variety of parental relationships, birth adoptive and step, inclusion of neonaticide (within 24 hours of birth) and infanticide (within 12 months of age) both of which tend to have some very different characteristics to Filicide, a greater focus on female perpetrators many of who are locked up in psychiatric institutions, lack of access to parents who committed suicide
[19] Resnick PJ (1969) Child Murder by parents; a psychiatric review of filicide American journal of psychiatry 126:1414-20
[20] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 Department for Education
[21] O'Hagan K (2014) Filicide-suicide; the killing of children in the context of separation, divorce and custody disputes Palgrave Macmillan
[22] Judged to be revenge by the context or remarks of the perpetrator, conclusions drawn by judges, psychiatrists and relatives.

individual's sense of masculinity or femininity. O'Hagan's own research also identified a wider context for some of the killing-in-revenge examples; a shifting balance of power, control and status within the family (for example reduction in influence over the children as mother's gain in confidence and the children get older) and community (poor health, financial difficulties, unemployment). The former may have been a factor in this case too.

4.10. The features described above are correlated with filicide rather than being causal; they are fairly commonly occurring risk factors for something which is very rare i.e. having low predictive value. This often means, as in this case, they are usually only visible with the benefit of hindsight.

4.11. Father's motivation can only be inferred due to his lack of comment during the police investigation and trial. Certainly only "spousal revenge" in Resnick's typology appears relevant. Mother's account of her life after the couple separated shows her increasing confidence and independence and suggests Father may not have regarded his moving out in 2012 as finally ending the couple relationship. Father's harassing behaviour towards Mother not long before the murder suggests increasing jealousy and anger at her new relationship. However, at the same time, this couple had been previously amicably separated a number of years and there had never before been any evidence of any concerns about Father's attitude to, or behaviour with, any of the children; he was always seen as a loving father. Whilst threats to kill should be taken very seriously and carefully evaluated,[23] no threats of actual violence were made to Mother until minutes before the murder. This is why Mother understandably saw no reason to report his harassing behaviour to the police.

5. GOOD PRACTICE

5.1 When undertaking a review, it is important to also consider any good practice. A number of positive interventions have been noted and it is important to highlight them again here. They include:

- In both cases when the Domestic Abuse was reported to the police Father was arrested and cautioned and information shared with Children's Social Care
- Children's centre had a good range of welcoming and accessible universal programmes and involved parents as volunteers
- The health visitor contacted Children's Social Care to find out the outcome of the assessment.

[23] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/domestic-abuse/ & Saunders H (2004) Twenty -nine child homicides Women's Aid Federation of England

- The family and the school where they attended were offered prompt support after the murder; Mother told this review she was appreciative of the support and way it was being tailored sensitively to the on-going needs of both herself and Child W8's siblings

6. SUMMARY AND CONCLUSION

6.1. Murders of this kind are very rare. It is only with the benefit of hindsight that some possible antecedents to the killing of Child W8 can be seen. However, O'Hagan argues that the risks associated with the discovery of a new relationship are not well known amongst practitioners. Therefore, despite this murder not being predictable it would be useful to raise awareness about heightened risks of violence to women (and their children) when an abusive ex-partner discovers that they have a new relationship.

6.2. The social care record in 2012 does not include significant details about the nature of the domestic abuse. This meant that the Initial Assessment in 2012 was not sufficiently comprehensive in exploring the dynamics of the domestic abuse and potential risks to both Mother and children especially Sibling 2. Neither did it ensure that parents had information about the impact on children and that Mother had the necessary information and support to manage the intended separation. Health agencies were also not sufficiently proactive in making enquiries about Mother's safety during pregnancy and after the domestic abuse came to light.

7. RECOMMENDATIONS

The individual agency reports have made single agency recommendations. Walsall Safeguarding Children Board has accepted these and will ensure their implementation is monitored.

To address the multi-agency learning, this Serious Case Review identified the following recommendations for Walsall Safeguarding Children Board (WSCB):

Recommendation 1

That WSCB seeks evidence that practitioners show professional curiosity and are competent in working with families where domestic abuse is a feature; in particular that practitioners understand, identify and record the nature of the domestic abuse and risks to children in referrals and assessments and take steps to ensure victims subsequently have adequate support in keeping themselves and their children safe.

Recommendation 2

WSCB considers how best to raise awareness about the increased risks of violence at the point of leaving an abusive relationship and on discovery of a new relationship.

Appendix 1

Terms of Reference

1. Introduction:

The request for a Serious Case Review was agreed by the Independent Chair of WLSCB on 15th February 2018.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances.

Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Serious Case Reviews and other case reviews should be conducted in a way in which :

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

(Working Together Chapter 4 para 11, March 2015)

2. Case summary

Child was at her father's address. She called her mother who has then attended the address in order to collect her. Father has taken the child back into the address and stabbed her. On arrival Police performed CPR and an ambulance attended the scene. The child was taken to hospital where she was pronounced deceased.

3. Terms of Reference for the SCR

3.1 Subjects

W8
DOB: XXXXX

DOD: XXXXX
Address: XXXXXXX

3.2 Scope

The SCR will cover the period September 2008 to January 2018. In order to identify specific, relevant information please see the practice themes identified within section 5.

(The Review should also consider any additional relevant information that may fall outside of the scoping period, where this may have a bearing upon the overall findings of the Review.)

4. Methodology

This Serious Case Review will be undertaken using a hybrid methodology that will analyse the complex circumstances that practitioners work in and provide opportunities for shared learning and lead to improvements in the way in which agencies understand their roles and responsibilities and work together to promote the safety and well being of children.

Agencies will be asked to review their own involvement with the family and to produce an Internal Management Report. This will be followed by the sharing of the written material in order that learning can be shared in and analysed taking into account the view of the professionals that were involved at the time. This process will involve round table Practitioner Meeting(s) to ensure practitioner and first line manager involvement in the review. This methodology takes into account the requirements in Sec. 1 above.

The panel will comprise:

Chair
Children's Services (LA)
Healthcare NHS Trust
CCG
Police
School

5. Areas of consideration:

Agencies are asked to explore *two* key practice themes when reviewing records: parental conflict / domestic abuse and other personal adult relationships (engaged in by parents). Within the context of these two themes, please consider:

a. Did practice within your service meet the required standard in this case? (Please expand on your answer providing evidence).

b. Comment on liaison between professionals and record keeping in the case generally.

c. Please identify examples of good practice, both single and multi-agency.

d. Comment on the quality of management oversight.

e. Consider if there were any known safeguarding risks in relation to the father and how these were managed.

f. Consider the voice of the child (what was life like for W8?)

The Review should also consider any additional relevant information, where this may have a bearing upon the overall findings of the Review.

6. Family Engagement

An important part of a Serious Case Review is the involvement of family members so that their thoughts and viewpoints can be incorporated both to the review itself and any learning. The Board will need to consider the appropriate point at which to inform the family of the review that takes into account the current circumstances. The overview author will make contact with relevant family members once authorised. The family will be offered feedback at the end of the Serious Case Review process.

7. Overview Author

Walsall Safeguarding Children Board have commissioned Karen Perry, an Independent Safeguarding Consultant to undertake this SCR.