Serious Case Review

Overview Report and Executive Summary

Services provided for Child P and her family

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Introduction

Between January and October 2015 East Sussex Safeguarding Children Board conducted a Serious Case Review about a young child, referred to in this report as Child P, who was killed by her father. Child P and other members of her family moved to East Sussex in 2011 when the mother left the father. There had been a history of domestic violence and abuse over a period of some five years.

The functions of the Serious Case Review are to provide a rigorous analysis of the actions and decisions of professionals and to identify ways in which services for other children and their families can be improved. This report presents the full findings of the review.

I am grateful for the cooperation of everyone who has supported the work of this review over the last year, particularly to Child P's mother who was willing to meet with members of the team undertaking the review and has made a valuable contribution to its work.

In order to make the learning from the Serious Case Review as accessible as possible the findings of the overview report are presented in the following way:

- Part 1 of the report is an Executive Summary which provides an overview of the key events and findings
- Part 2 contains the recommendations made for individual agencies and the East Sussex Safeguarding Children Board
- Part 3 provides a full explanation of the most important findings of the review
- The appendices to the report contain detailed information about the key events in Child P's life and the services that were provided for the family, the views of her mother, further information about how the review was carried out and other background documents.

I hope that by setting out the report in this way it will be possible for readers with different objectives to find the information that they need.

This Serious Case Review deals with dramatic and tragic events that have been widely reported in the media and may continue to be of public interest. In deciding what to publish I have been mindful of the right of surviving members to a private and family life and have sought to balance this against the need for openness, accountability and learning. It is my sincere wish that the publication of this report will not trigger any further intrusion into the lives of surviving family members and friends of Child P.

Alongside this report the East Sussex Safeguarding Children Board has published a formal response to the findings of the Serious Case Review. This provides details of changes that have already been made to services and a plan setting out in detail the actions that agencies and the board will continue to take to implement the learning from the review.

In order to ensure that the learning from this review is available to all of the relevant local steering groups and partnerships I have arranged for it to be submitted to the following partnerships and boards in the expectation that they will in turn circulate it to bodies that can learn from its findings:

- Brighton & Hove Local Safeguarding Children Board
- East Sussex Safer Communities Board
- East Sussex Adult Safeguarding Board
- East Sussex Family Justice Steering Group

Reg Hooke

Independent Chair

East Sussex Safeguarding Children Board

Services provided for Child P and her family

Foreword by Independent Chair of East Sussex LSCB

1 Executive Summary

Key events

Summary of Serious Case Review findings

2 Recommendations

3 Serious Case Review Findings

3.1 Introduction

3.2 How should we understand the death of Child P? Could professionals have prevented it by taking different actions and decisions?

3.3 Safeguarding children affected by domestic violence while family members are still living together

3.4 The provision made for the family while living in a refuge

3.5 Maintaining the confidentiality of a victim's address and identity

3.6 Safeguarding victims and their children who have moved across local authority borders in order to be safer

3.7 Aspects of culture and religious belief that impact on risk where there has been domestic abuse and violence

3.8 The psychological evaluation undertaken for the court

3.9 Learning in relation to the involvement of the family court

Appendices

I Detailed narrative of events

II Views of Child P's mother

III Principles from statutory guidance informing the Serious Case Review, methodology and terms of reference

IV Membership of the Serious Case Review panel

V List of documents and material considered by the Serious Case Review panel

VI References

1. EXECUTIVE SUMMARY

1.1. Between January and October 2015, East Sussex Safeguarding Children Board (the LSCB) conducted a Serious Case Review (SCR) in relation to the services provided for a seven year old child, referred to in this report as Child P. The review was carried out under the guidance *Working Together to Safeguard Children 2013*. Its purpose was to undertake a '*rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children'*. The LSCB is required to *'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.*[1]

1.2. This document sets out the SCR findings which, in keeping with the statutory guidance, are published in full.

Reasons for conducting the Serious Case Review

1.3. In September 2014 Child P was killed by her father, who then took his own life. The family had been known to agencies with safeguarding responsibilities as a result of concerns about domestic abuse and violence since 2008, firstly in Brighton & Hove and (after 2011) in East Sussex. Private law proceedings in relation to residence and contact arrangements began in September 2009 and remained active at the time of Child P's death.[2]

1.4. The criminal investigation into the killing of Child P has established that in the early part of 2014 the father used a variety of covert and illicit means to secure details of the family address and details of Child P's routine.

1.5. The circumstances of Child P's death met the criteria for a SCR and the decision to conduct the review was made by the Independent Chair of East Sussex Safeguarding Children Board on 3 November 2014.

The focus and scope of the Serious Case Review

1.6. In its initial discussions the panel overseeing the review agreed comprehensive terms of reference, which are set out in Appendix 3 of the report. These terms of reference were used by participating agencies to compile individual management reviews and to focus their discussions with staff who had worked with the family.

1.7. As it progressed the panel determined that its work should most usefully focus on a number of matters linked to the safeguarding of

[1] *Working Together to Safeguard Children* (2013), 4.1 and 4.6

[2] These are now termed applications for Child Arrangements Orders under Section 8 Children Act 1989. The terms which applied at the time are used as they make the focus of the court hearings plain.

children who have been affected by domestic abuse and violence including the following:

- Safeguarding children affected by domestic abuse and violence while family members are still living together
- The experience of women and children escaping from domestic abuse and violence, living in refuges and re-settling thereafter
- Maintaining the confidentiality of a victim's address and identity
- Safeguarding victims and their children who have moved across local authority borders in order to be safer
- Aspects of culture and religious belief that impact on risk in domestic abuse cases
- Psychological assessment of children's needs to assist decision making by the courts
- The role of the family court

1.8. The review also considered whether Child P's death could have been prevented if the professionals involved had acted differently or taken different decisions.

1.9. Child P had an older, surviving half-brother who has a disability. He is now an adult. During the period under review he had extensive contact with children's social care, education, adult social care and health services as well as being involved in many of the important events in the family. He was not involved in the private law proceedings and he was an adult at the point when Child P was made the subject of a child protection plan.

1.10. The review considered carefully whether to evaluate the provision made to him, based on the material submitted. The review panel decided against this as it was judged that to do so would not add to the learning of the review and would require the publication of further sensitive, personal information. Although the provision made for this young person is not evaluated, events which had a significant impact on him are referred to in the report when this aids understanding of the services provided for Child P and her mother. The learning from this review will be submitted to the East Sussex Adult Safeguarding Board in order for the board to consider any implications for services to adults.

Agencies involved

1.11. The SCR considered the work of the following agencies and contracted professionals:

Services in Brighton & Hove and in West Sussex

- Brighton & Hove City Council Children's Social Work and Legal Services
- Sussex Partnership NHS Foundation Trust *
- Sussex Police *

- Sussex Community NHS Trust
- RISE (a domestic abuse charity which provides a range of services in Brighton & Hove, including the Independent Domestic Violence Advisor (IDVA) service)
- Brighton & Hove Multi-Agency Risk Assessment Conference (MARAC)[3]
- Western Sussex Hospitals NHS Foundation Trust
- NHS West Sussex Coastal
- Primary care health services

* involved in both local authority areas

Services in East Sussex

- East Sussex County Council Legal Services, Children's Social Care and Adult Services
- East Sussex Healthcare NHS Trust
- District Council area where the family was resident
- Local authority social care
- Sussex Partnership NHS Foundation Trust
- CRI (a charity which provides a Domestic Abuse Service in East Sussex, including the Independent Domestic Violence Advisor (IDVA) service
- Primary care health services
- Services providing refuges and associated services in East Sussex

Agencies with a national remit

- Child and Family Court Advisory and Support Service (Cafcass)

1.12. Full detail of the involvement of agencies is set out in the narrative in Appendix 1.

How the review was undertaken

1.13. Details of the steps taken to carry out the review are set out in Appendix 3.

1.14. In June 2015Child P's mother met the independent reviewer and a member of the SCR panel and gave her views about the provision that had been made for Child P and the decisions and actions of professionals. These are also summarised in Appendix 2 and are referred to at a number of other points in this report.

[3] The current working definition of the MARAC (Multi-Agency-Risk-Assessment-Conference) is given at http://www.safelives.org.uk/practice-support/resources-marac-meetings and at http://www.standingtogether.org.uk/standingtogetherlocal/standingtogethermarac/

Key events

1.15. Appendix 1 contains a detailed narrative of key events and professional involvement with Child P. This is summarised briefly here.

1.16. The parents married in 2005 and moved to Brighton & Hove in 2006 though for some time the father lived elsewhere studying and working. They were both at the time Muslim. Child P was born in 2006. The family had contact with a number of local services in connection with Child P's older half-sibling's disability.

1.17. There were no early concerns about Child P's health and development.

1.18. Between 2008 and 2011 agencies in Brighton & Hove became aware of incidents of domestic abuse and violence. The police cautioned the father for assaulting the mother in 2008. After the killing of her daughter the mother has described more episodes, some severe, that she did not report to the authorities at the time. Her description is of a relationship characterised by coercive and controlling physical and emotional abuse.

1.19. In 2009 the family court ordered that Child P should live full time with her mother. Noting concerns about the father's presentation in court and the content of his written evidence, the judge ordered that all contact between Child P and her father should be closely supervised.

1.20. Subsequently the parents made contact arrangements outside the terms of the court order and without the knowledge of professionals.

1.21. During 2009 and 2010 the parents renewed their relationship, in part as a result of the influence of their contacts with a mosque. In 2011 they moved into accommodation together. Very soon there were further episodes of violence. This led to a child protection conference as a result of which Child P was made the subject of a child protection plan. On the same date a MARAC[4] discussion was held. The Independent Domestic Violence Advisor (IDVA) service had referred the mother without her consent on the basis that she was assessed as being a high risk victim of domestic violence and abuse.[5]

1.22. In mid 2011, the parents agreed that the mother and Child P should move temporarily to the father's country of origin as he had persuaded the mother that she should go away while he stayed in the UK to 'sort things out' with the authorities. Professionals were not informed about this in advance. The mother returned after a short period, with the

[4] See footnote 3

[5] The vast majority of cases are referred to MARAC with the knowledge and agreement of the victim and this is the preferred practice. When the victim does not want to be referred, practitioners are expected to assess whether it is proportionate and necessary to refer, depending on the level of risk that they assess the victim as facing. http://www.safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

assistance of a number of agencies in the UK, having formed the view that she had placed herself and Child P at a high level of risk by moving abroad.

1.23. Police and social care staff met the mother on her arrival in the UK in order to assess the risk and determine how best to support the family. The mother and her two children moved to a refuge where they remained living until November 2011, when the mother and her two children moved to a house in East Sussex. A further house move occurred in July 2013 after the mother reported that the father had found out where she and the children were living.

1.24. Child P attended four schools in East Sussex, with a short time in a school near to the Refuge, and then changing when the family moved home, and once after the mother chose to transfer her. Child P experienced some mild behavioural and emotional problems, but there were never concerns about her health, development or educational progress.

1.25. The father made a series of applications in the family court from 2011 onwards and the case remained open and unresolved at the time of Child P's death in late 2014. The court made orders on several occasions to arrange contact, either supervised or indirect (via the exchange of cards and letters) but these proved unsuccessful. Shortly before the killing of Child P, Cafcass appointed a Children's Guardian under the Practice Direction governing the court's management of cases in which there is 'implacable hostility' between parents. The Guardian had not had contact with family members at the time of the death.

Serious Case Review findings

1.26. The findings of the review are set out in full in Section 3 of this report.

<u>The death of Child P</u>

1.27. The review has considered whether, knowing that there had been a history of domestic abuse in the family, professionals might have prevented Child P's death if different steps had been taken to shield her from contact with her father or to protect other family members.

1.28. Detailed discussions with Sussex Police have confirmed that Child P's father planned and carried out the killing in a secretive way, using the internet and a range of covert and possibly illegal methods to trace the family and obtain the means to carry out the killing. It has not been possible to establish exactly when and how he found out where Child P was living. There is no evidence that any professional was aware of this activity, nor did he make any threat to harm Child P or give any indication that he might do so. The review has concluded that no

professional working with the family could have prevented him acting as he did.

1.29. Child P's death is recognised as being one of a number (sometimes referred to as 'spite-killings') in which a parent kills a child or children in order to deprive the other parent of the child. Her killing was calculated to deprive the mother of her child while at the same time leaving her with a permanent memory of her death. Often such killings take place in the context of a custody dispute about a child and in a high proportion there has been a documented history of domestic abuse. The killing is then sometimes, though not always, followed by the suicide of the perpetrator.

1.30. These killings share some characteristics which can be recognized afterwards. However they also share features with hundreds of other cases which do not lead to the death of a child. In relation to Child P, the risks identified (by her mother, by professionals and by the family court) were that the father might seek to contact the family and either harm the mother or abduct Child P and remove her from the UK. These risks were addressed, in so far as they ever can be in practice, in the safety measures taken by the family, professionals and the courts.

1.31. A fuller account of all of these matters is given in Section 3.2 of this report. Although the review is clear that professionals could not have prevented this death, it has identified useful lessons which should inform work undertaken in families where there has been domestic abuse, including circumstances where there is continuing conflict over contact with children.

Help from services in relation to domestic abuse and violence

1.32. Between 2008 and 2011 the parents separated and then reunited, placing both the mother and her children at risk. Professionals responded diligently to reports of domestic abuse, which were all taken seriously, though the parents did not always take the actions that were recommended.

1.33. In contrast to the professional perspective, which is limited by the information provided by the victim and the legal powers available to agencies, Child P's mother told the review that she often found it very difficult to take the action that professionals believed was needed to protect her and her children. She perceived some of the steps taken by professionals, including holding a child protection conference and referring her to the MARAC, as negative. She thinks in hindsight that more could have been done to protect her.

1.34. The mother also reported that living in the domestic violence refuge was a very negative experience because her perception was that her care of her children was being unfairly scrutinised. In contrast the records of the refuge, and of other professionals who were working

with the mother at the time, show that the vast majority of activity was focused on protecting the mother and supporting her care of the children.

1.35. These perspectives are explored in more detail in Section 3.3 of this report. Taken together they go some way towards explaining why very real difficulties can occur in forming trusting relationships between professionals and victims of domestic abuse, especially as in this case when there are legitimate and serious concerns about the potential risk to a child. Such risks need to be addressed while recognising that victims of abuse and violence need time and help to recover.

1.36. The review is concerned to ensure that, as well as emphasising the well-documented risks to children associated with exposure to domestic abuse, services are able to take account of this complexity when working with victims of domestic abuse who have children. For example, does feedback from adult service users on their experience of working with children's services inform service delivery? This complexity also needs to be addressed in training programmes dealing with domestic abuse and violence.

1.37. Although the refuge that the mother and Child P lived in is now managed and run by another organisation, the review findings will be brought to the attention of the body which commissions services in relation to domestic abuse in East Sussex and Brighton & Hove.

<u>The challenge to services when a family moves across local authority boundaries</u>

1.38. This aspect of service provision is discussed in detail in Section 3.6. It is widely recognised that women and children remain or may be more at risk after they have separated from an alleged perpetrator. In 2011 the mother and children moved from Brighton & Hove to East Sussex, having briefly fled and returned to the UK. The review has identified learning in relation to the management of risk when a victim of domestic abuse and violence moves across local authority boundaries and weaknesses in the functioning of the MARAC arrangements.

1.39. The function of the MARAC is to share information and coordinate a plan of action to protect high-risk victims of domestic abuse.[6] At a MARAC, information is shared on high risk domestic abuse cases and representatives seek to develop a coordinated action plan to promote the safety of the victim. Unlike other meetings with risk coordinating responsibilities, such as child protection conferences, MARAC does not have a continuing case coordination or review function. Responsibility for the completion of actions rests with the agencies involved and they

[6] Attendees are likely to include police, health, service, local authority children's services, housing commissioners and providers, Independent Domestic Violence Advisors (IDVAs), probation services and other specialists from the statutory and voluntary sectors.

are expected to liaise with each other, usually without further recourse to the MARAC, in order to manage and review the implementation of the action plan as a victim's needs or circumstances change.

1.40. There is national guidance for the transfer of cases between MARACs when a victim moves between areas.[7] This was published in 2012 and it had not been turned into specific local procedure in Brighton & Hove or Sussex during the period 2011-12 when the family in this case moved, first from Brighton & Hove to East Sussex and then within East Sussex from a refuge to housing provided by a district council.

1.41. As a result, there was no procedural requirement on any of the professionals working with the mother or Child P to notify the MARAC coordinator that a family had moved. This relied on either 1) professionals working in Brighton & Hove appreciating the value of alerting the local MARAC to the fact that the family had moved so that the information that had been collated by the Brighton & Hove MARAC could be transferred to its counterpart in East Sussex or 2) professionals in East Sussex recognising that it would be useful if the information held by the MARAC in Brighton & Hove were to be shared with the partner body in East Sussex. Although agencies were mindful of the risks to the mother, this did not happen. Even if they fully appreciated the role and importance of the MARAC it is unlikely that front line staff in any agency would have spontaneously taken on this role in the absence of formal local procedures.

1.42. More widely, the sharing of information between MARACs has been hampered because they are administered in different ways (usually by the police service or local authority) in different areas and there has been no uniform national roll-out or the development of compatible information technology systems. Consequently, there is no automatic 'safety net' which could identify that a case referred to a MARAC has been heard previously at another MARAC.

1.43. The serious case review recognises that since the death of Child P, work has been undertaken to develop these arrangements.[8] It has recommended that the East Sussex Domestic Abuse Management Oversight Group continue in order to achieve the objective of systematically sharing information between MARAC meetings both within local (Sussex and Brighton & Hove) networks and when families move more widely.

1.44. The movement of the family from one local authority area to another, to a refuge and then to social housing, also underlines the importance of a review of need and risk at regular intervals and when an agency

[7] See guidance at http://www.safelives.org.uk/practice-support/resources-marac-meetings/resources-people-attending

[8] Details are provided in the LSCB response published alongside this report.

becomes aware of a significant change in circumstances. Often different information will be revealed to different professionals and the level of risk may change, so update of the assessment and comparison to earlier assessments will be of value.

Disclosure of confidential information

1.45. This aspect of service provision is discussed in detail in Section 3.5. On three occasions while the family was living in East Sussex there is evidence or a strong suspicion that details of the mother's addresses or identity were disclosed to the father inadvertently or in error, by a bank, the Child Support Agency and by mother's own solicitor. Although there is no evidence that these actions led the father to know where the family was living, they might have. At the same time the review has identified that, given the existence of social media and very powerful search engines, it is increasingly difficult for families fleeing violence to rely on their whereabouts remaining secret. It cannot therefore provide the sole basis for safety planning. The father was a man clearly with intent to find the child and although nothing was discovered that meant that the family's safety was compromised, all agencies must ensure robust systems are in place.

1.46. The review has underlined that, even if they cannot be infallible, each agency needs to have reliable ways of protecting the personal details of vulnerable individuals from disclosure (such as prominent markers on front screens and methods of shielding records) and training for staff throughout the organisation to ensure that they are implemented. At the same time, policy, procedures and training need to emphasise that safety planning can never rely entirely on arrangements to shield an individual's address or identity from disclosure. Victims of domestic abuse and violence also need to consider how this might influence the way in which they use social media.

The role of the family court

1.47. It is outside the remit of serious case reviews to comment on the decisions and actions of the judiciary. However there is value in setting out an overview of the family court involvement in the case so that members of the judiciary who were involved and the wider family court system have an opportunity to reflect on the case history.

1.48. The court proceedings in this case became protracted. The repeated attempts of the family court and the local authority on its behalf to promote contact in various forms between the father and Child P met with no success. Decision making stalled. As a result Child P experienced considerable uncertainty for more than half her life about where she would live and whether or not she would see her father.

1.49. In such lengthy proceedings there is a danger that significant information revealed and established at an early point may become

lost, or parties may choose not to remind the court of its existence. Over the course of six years a substantial volume of reports had accumulated. Examples of this are provided in Section 3.9.

1.50. The risk of important history being lost was heightened because neither of the parties was consistently represented throughout the lengthy proceedings. The father represented himself on a number of occasions. The mother had 2 different representatives, and told the review that she constantly felt financially insecure because of uncertainty about the availability of legal aid.

Recommendations and action to implement them

1.51. Section 2 of the report sets out the recommendations for the LSCB and its member agencies made by the review.

1.52. It also sets out the content of a small number of recommendations made by individual agencies at the beginning of the review process, which have now all been implemented.

2. RECOMMENDATIONS

2.1. Multi-agency and partnership recommendations

	Section in the report	Reason for making a recommendation with reference to the case history	Intended outcome	Recommendation for member agency or LSCB
1.	3.3	Child P's mother found it difficult to have confidence in professionals and felt that her care of her children was being unfairly scrutinised. Professionals on the other hand were concerned about potential risks to her children, given their exposure to domestic abuse and the fact that Child P had been removed without notice from the UK.	Services will take full account of the complexity of the circumstances of women who have been victims of domestic abuse and who have children, while at the same time seeking to ensure that their children are protected from further harm. This will better address the challenge faced by professionals in building trusting, positive relationships with women in these circumstances	The East Sussex Domestic and Sexual Abuse Management Oversight Group, working with the LSCB, should seek to ensure that strategy, policy, training and practice reflect the complexity of a victim's experience of violence and abuse, including an understanding of the challenges and barriers.. Approaches developed must be consistent with practice which protects children from further harm
2.	3.3	Same evidence	Services will take better account of the experience of women with children who have been victims of domestic abuse	The East Sussex Domestic and Sexual Abuse Management Oversight Group, working with the LSCB, should secure feedback from victims of domestic violence and abuse who have had contact with services over their children so that recent experiences of service use – good and bad –inform policy and practice

	Section in the report	Reason for making a recommendation with reference to the case history	Intended outcome	Recommendation for member agency or LSCB
3.	3.4	Child P's mother identified a number of concerns about the provision that was made for her at the refuge. Although this service is now commissioned from a different provider there may be useful learning for those commissioning and providing refuges for victims of domestic abuse	Future provision of refuges will be fully informed by Child P's history	The Independent Chair of East Sussex LSCB should bring the findings of the SCR to the attention of East Sussex Domestic and Sexual Abuse Management Oversight Group and bodies that commission and provide refuge services in East Sussex, West Sussex and in Brighton & Hove
4.	3.4	The domestic abuse risk assessment on Child P's mother was completed in 2011 when she lived in Brighton & Hove, but it was not always updated at key points subsequently	Risk assessments will be updated so that they reflect fully current circumstances, including for example when they change address	East Sussex Domestic and Sexual Abuse Management Oversight Group should ensure that professionals understand that the assessment of risk is a process, rather than a one off event, and that risk assessments are updated when there are significant changes in circumstances. Referrals for services should be made before a woman is discharged from the relevant service
5.	3.5	Child P's address and important details of her mother's circumstances were inadvertently disclosed by a number of public and private bodies during the period covered by the review, though there is no evidence that this is what	Agencies have in place good systems which identify information about vulnerable service users that should not be disclosed. Staff in all agencies are trained to use the agencies system and to understand the significance of this issue	East Sussex LSCB should seek assurance from member agencies that they have systems in place which identify information about vulnerable service users that should not be disclosed, that staff understand the significance of this issue and are trained to use the agency's system

	Section in the report	Reason for making a recommendation with reference to the case history	Intended outcome	Recommendation for member agency or LSCB
		enabled her father to locate her		
6.	3.5	The number of occasions on which information about the mother and her address were inadvertently disclosed reflects the inherent difficulty in safeguarding personal details given the range of agencies holding data, the prevalence of social media and the capacity of search engines	Professionals and victims of domestic abuse will make safety plans that do not rely solely on protecting a person's address or other personal information	East Sussex Domestic and Sexual Abuse Management Oversight Group should ensure that policy, procedures and training convey a good understanding of the impact on safety planning of current use of technology by the public and organisations, including social media and powerful modern search engines
7.	3.6	The Brighton & Hove MARAC identified the mother as being at high risk of domestic abuse. Nationally there has been guidance on MARAC to MARAC transfer since 2012 but there was no policy and procedure in place in Brighton & Hove to require professionals to trigger the action necessary to ensure that information about risk and history were transferred to the MARAC in East Sussex. There is no common IT system to enable cross-border information sharing. It is recognised that since the SCR	Information sharing between MARAC bodies and professionals working with victims of domestic abuse who move across local authority boundaries will be strengthened, taking account of limitations imposed by the lack of a national approach to coordinating the work of MARAC bodies	The East Sussex Domestic and Sexual Abuse Management Oversight Group should develop effective arrangements for the transfer of cases and sharing of information from MARAC to MARAC both within local (Sussex and Brighton & Hove) networks and when families move more widely If there are national barriers to this, the group should seek to address them with the UK Government

	Section in the report	Reason for making a recommendation with reference to the case history	Intended outcome	Recommendation for member agency or LSCB
		began, work has been undertaken to implement shared systems for Brighton & Hove and East Sussex		
8.	3.7	Culture and religion were significant factors in the case history. Professionals working with the family recognised this at a general level, but did not seek to explore or understand them further	Assessment of need and risk in relation to domestic abuse will be informed by a good understanding of the cultural context within which abuse occurs and the distinctive features that may have shaped the actions of individuals and families	East Sussex Domestic and Sexual Abuse Management Oversight Group should ensure that policy, procedures and training in relation to domestic abuse enable professionals to take full account of culture, religion, ethnicity and language in the assessment of domestic abuse
9.	3.9	It is outside the remit of the Serious Case Review to evaluate the effectiveness of the judiciary and the administration of justice. However there are aspects of the case history which may provide a useful opportunity for the judiciary and court administrative services to reflect on	Members of the judiciary dealing with complex private family law cases and court administrative services will have an opportunity to reflect on lessons from this case history and the findings of the SCR	The Independent Chair of LSCB should submit a copy of the SCR report to the Designated Family Judge for Sussex (HHJ Jakens) and to the Sussex Family Justice Board for their respective consideration. That might usefully include consideration of whether the courts have access to sufficient numbers of expert witnesses who are knowledgeable about domestic abuse and violence
10.	3.9	During the review process professionals with key safeguarding responsibilities struggled to understand the roles of the court, the practice directions governing the case and the role of Cafcass in	The role of the court, the practice guidance and the role of Cafcass in private family law proceedings will be well understood by professionals working with children and their families	The LSCB should invite Cafcass to present a briefing session and supporting information to the LSCB

	Section in the report	Reason for making a recommendation with reference to the case history	Intended outcome	Recommendation for member agency or LSCB
		private family law proceedings. This finding mirrors those of other SCRs.		
11.	3.9	The mother says that her ability to participate in the family court proceedings was hampered by financial difficulties and the uncertainty surrounding legal aid funding	Professionals are aware of this difficulty so that they can assist victims of domestic abuse and violence in the most effective way	The East Sussex Domestic and Sexual Abuse Management Oversight Group should consider in future communications activity relating to how victims of abuse and violence can be made aware of eligibility and evidence requirements in relation to legal aid

2.2. Recommendations made by individual agencies

During the course of the Serious Case Review individual agencies identified specific actions that should be taken to improve services. These address the following areas and have all been implemented.

East Sussex Children's Social Care

- To ensure that there are properly developed plans for cases where a case is allocated for the preparation of a Section 7 report to the family court

East Sussex Adult Social Care

- To review the Safeguarding Adults at Risk Competencies Framework to include an additional category of Domestic Abuse in line with the Care Act 2014
- To develop existing Reflective Practitioner Workshops to include topic based workshops on: domestic abuse and historical allegations of abuse

East Sussex Healthcare Trust

- All School Staff Nurses and School Nurses receive regular, documented clinical supervision which includes review of their caseload numbers and the support provided

East Sussex Legal Services

- Legal Services Team has revised its procedures for dealing with cases which come in as "one off" duty queries
- Legal Services Team has revised its procedures for dealing with emails concerning private law matters in the family courts

CRI-Domestic Abuse Service

- CRI has made changes to its intake forms to ensure that relevant information is sought when receiving a referral

3. SERIOUS CASE REVIEW FINDINGS

3.1. Aspects of service provision covered by the evaluation

3.1.1. This evaluation focuses on the following aspects of service provision:

- How should we understand the death of Child P? Could professionals have prevented it by taking different actions or decisions?
- Safeguarding children affected by domestic violence while family members are still living together
- The provision made for the family while living in a refuge
- Maintaining the confidentiality of a victim's address and identity
- Safeguarding victims of domestic abuse and their children who have moved across local authority borders in order to be safer
- Aspects of culture and religious belief that impact on risk in domestic abuse cases
- The psychological assessment undertaken for the court
- Wider learning in relation to the involvement of the family courts

3.2. How should we understand the death of Child P? Could professionals have prevented it by taking different actions or decisions?

<u>Background to the death of Child P</u>

3.2.1. It is the responsibility of the Coroner's Inquest to determine how Child P died and not the role of the SCR. In this case however it is apparent that the killing of Child P is linked to the history of domestic abuse in the family and it is legitimate to ask whether, knowing that there had been a substantial history of violence in the family, professionals might have prevented the death if different steps had been taken to shield Child P from contact with her father or to protect other family members.

3.2.2. In order to consider this in an informed way the SCR has discussed in detail the circumstances of Child P's death and events leading up to it with the senior investigating officer from Sussex Police and also sought the views of her mother.

3.2.3. These discussions have confirmed that Child P's father planned and carried out the killing in a secretive way, using the internet and a range of covert and possibly illegal methods to trace the family and obtain the means to carry out the killing. It has not been possible to establish exactly when and how he found out where Child P was living. However there is no evidence that any professional was aware of this activity, nor that any professional working with the family could have done anything that would have prevented him acting as he did.

3.2.4. Throughout the history both the mother and professionals working with her had identified that there were two specific risks arising from the father's attitudes and patterns of behaviour. These were firstly, that the father might seek to re-establish his relationship with the mother in order to harm her or to seek to control her life and relationships; secondly that he might seek to abduct Child P and remove her from the UK.

3.2.5. There was a high level of awareness of both of these threats and the actions and, as a result, the decisions of the professionals who had contact with Child P were extremely cautious. The risk of emotional harm to Child P arising from the fact that she might be forced to have contact with her father, whom as time passed she knew less and less well, was also at the forefront of professional thinking.

3.2.6. It was always the view of professionals that there should be no unsupervised contact between Child P and her father until there was evidence that it was in Child P's interests and that her father could conduct himself without causing her upset or placing her at risk. As a result, all of the professionals who reported to the court recommended that contact between Child P and her father should either be indirect (i.e. limited only to the exchange of information via the local authority) or closely supervised. This view was adopted by the court and reflected in the orders made throughout the case history. The point where the court believed that there should be direct contact without supervision was never reached.

3.2.7. The risk of abduction was unproven but also taken into account in the arrangements that were made to ensure that contact was supervised and that the family address should remain unknown to the father. In practical terms it proved impossible to ensure that this happened, and this issue is addressed further in Section 3.4 of this report. All of Child P's schools were aware of the need only to allow her to be handed over to adults known to and approved by her mother and this was always adhered to.

<u>The death of Child P viewed in the wider context of the killing of children in disputes about contact and residence.</u>

3.2.8. Neither Child P's mother nor any of the professionals working with her had considered it likely that her father would physically harm her, let alone kill her. The nature of her death is so unusual as to make it extremely difficult to imagine and therefore extremely difficult to build into any form of risk assessment. There is a case that an event so unusual is impossible to predict, unless there have been direct threats or previous attempts. Nothing like this had happened in this case.

3.2.9. There are a very small, but recognised group of case histories (sometimes referred to as 'spite-killings') in which a parent kills a child or children in order to deprive the other parent of the child. Sometimes such killings take place in the context of a custody dispute about a child and in many there has been a documented history of domestic abuse. The death of Child P fits this pattern. Her killing was calculated to deprive the mother of her child while at the same time leaving her with a permanent memory of her death.

3.2.10. The research most relevant to the killing of Child P is a report published in 2004 by Women's Aid which evaluated the killings of 29 children in 13 families where children were killed in the context of a contact arrangement. [9] More recently Cafcass has published a report summarising its learning from its contribution to SCRs in which it has been involved (all public law cases or complex private family law cases).

3.2.11. The Women's Aid research posed a series of challenges to professionals, the courts and government in relation to the potential risks to children in domestic abuse cases. It proposed ways in which children might be made safer by professionals and the courts being more aware of the motivations of those who harm women and the dynamics of such relationships.

3.2.12. Not all of the recommendations of that report have been implemented. However there is no doubt that in general the level of awareness of professionals of the potential links between domestic abuse and harm to children is much higher now than in the period covered by this research. In East Sussex, for example, domestic abuse is the most significant area of safeguarding training provided by the LSCB for staff. In this case it is clear that the expert witnesses, local authority social workers and the courts had been extremely cautious about recommending or granting contact to a father with a history of violence. Indeed the mother has speculated that the father's actions in killing his child may have been triggered by his feeling that the legal proceedings had moved to a stage where his contact might be stopped altogether.

3.2.13. Professionals had taken account of the comments made by the child and of her behaviour and emotional state. They were aware that the potential risk to the mother would continue after the couple separated. They were not aware that the father was secretly tracing the family, but if they had been it is almost certain that protective action would have been taken in conjunction with the mother.

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[9] Hilary Saunders (2004) *Twenty-nine child homicides: Lessons still to be learnt on domestic violence and child protection*, Women's Aid

3.2.14. The courts have specific arrangements for dealing with cases where there is domestic abuse [10] and will be mindful of mental health problems, where they are brought to the court's attention. Beyond this there is currently no possible means of reliably determining which of the very large number of parents involved in private family court cases each year are likely to kill their children.

3.2.15. The Cafcass report specifically indicates that this is not possible.[11] Its findings highlight that even basic characteristics of those responsible are impossible to predict. Whilst in the majority of such instances the perpetrators are men, in the two most recently reported incidents, women had been responsible.

3.2.16. The review has concluded that no one could have predicted or prevented the killing of Child P by her father. The SCR has however identified a number of aspects of the professional arrangements for responding to incidents of domestic abuse that could be strengthened. None of these was decisive in shaping the outcome in this case. These are addressed in the remainder of this report.

3.3. Steps taken to safeguard children who are living with domestic violence while parents continue to live together

3.3.1. This part of the report examines the provision that was made for Child P and her family during the period when the parents were living together. This was in Brighton & Hove, but the issues identified are likely to be equally applicable in any locality. Child P's mother has been very critical of some of the actions taken by professionals during this period. The evaluation highlights the difficulties that professionals experience in working with the families of children where there is domestic abuse. The events are summarised in sections 8 - 36 of the narrative in Appendix 1.

3.3.2. Child P's mother told the review that she did not feel that professionals took her reports about domestic abuse seriously and that they underestimated the risk to her and her children. She regretted not reporting all of the incidents that had occurred to agencies and that agencies would have had a better understanding of the risks that she and Child P had faced if she had done so. For example, if she had given witness statements it might have been possible for the police to prosecute the father.

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[10] https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12j

[11] '*The known risks are, on average, much higher in public law cases than in private law cases. However, fatal/serious maltreatment occurs in the context of low, as well as high, risk cases. This acts as a useful reminder that risk factors might be a crucial practice tool in identifying that significant harm has occurred, or is likely to occur, and thus guiding professional practice; but that they are of little or no value in predicting which children will die as a consequence of maltreatment*.'

3.3.3. Records from the agencies involved indicate that the police attended incidents, dealt with the alleged perpetrator and offered support and guidance to the mother on several occasions. There is no evidence that calls were not responded to or dealt with appropriately. The police shared information with the local authority when officers perceived there to be a risk to the children. Several offers of additional support were made by the family health visitor (who initiated a referral to the Independent Domestic Violence Advisor (IDVA) service), which then became involved with the mother.

3.3.4. The report written by the local authority for the family court in 2009 properly identified a range of concerns about the father's behaviour and led to a Residence Order being made in favour of the mother. The local authority and the police took steps to enable the mother to return to the UK from the Middle East after she had fled there with her daughter in 2011. The agencies met family members on their return, tried to understand why the mother had taken her daughter out of the country and provided her and her children with accommodation in a refuge.

3.3.5. It is understandable that professionals were extremely concerned that a child who was the subject of a child protection plan had been removed from the UK without notice or discussion. They found it difficult that (as it seemed to them) the parents worked outside of the order made by the court that the father should have contact only in a neutral venue and then re-established their relationship. They found it difficult that Child P's mother did not always respond to advice given and opposed the decision by the IDVA to make a referral to the MARAC. The mother can in turn explain that she found it difficult to overcome feelings of powerlessness in relation to her husband that had developed throughout their relationship; that she believed that professionals had a negative view of her, in part cultivated by her husband. It is clear that the father made her believe that the children might be removed from the family, though there is never any indication that this was considered.

3.3.6. Recent research has highlighted how very frequently women who have been victims of domestic abuse and violence find it extremely difficult to trust professionals.[12] Many experience practical and emotional difficulties in taking the action that others believe is needed to protect themselves and their children. Women who are

[12] Liz Kelly, Nicola Sharp and Renate Klein (2014) *Finding the Costs of Freedom: How women and children rebuild their lives after domestic violence,* Women's Aid / SOLACE

concerned to re-establish a degree of control over their own lives will naturally not always do everything professionals think they should. There is a perception among some women that children's social care services are not supportive. Research suggests that this may be because the understanding that many professionals have of domestic abuse and violence focuses too much on specific violent incidents (which can in theory be prevented by separation) and not enough on the pattern of coercive and controlling behaviour (that can in reality continue in a variety of forms after separation).

3.3.7. Commonly (as in this case) the perpetrator may seek to perpetuate the pattern of controlling and abusive behaviour through a prolonged dispute over residence and contact which may offer further attempts to negatively influence professional opinion against the victim.

3.3.8. Taken together, these different views and experiences go some way towards explaining why very real difficulties can occur in forming trusting relationships between professionals and victims of domestic abuse, especially as in this case when there are legitimate and serious concerns about the potential risk to a child.

3.3.9. The review has made recommendations in relation to this, building on the experience of Child P's circumstances and of research.

3.4. Provision made for the family while living in a refuge

3.4.1. This part of the report reviews the provision that was made for Child P and her family when the mother and her children were living in a refuge in East Sussex. This occurred between August 2011 (when the mother and Child P returned from the Middle East) and November 2011 (when they were rehoused in East Sussex). Key events are summarised in sections 37 - 47 of the narrative in Appendix 1. Through the period when the family lived in the refuge Child P was the subject of a child protection plan triggered by her exposure to domestic abuse in Brighton & Hove.

3.4.2. Child P's mother has been very critical of the actions taken by professionals during this period. Since the period under review the refuge has been recommissioned from another provider; however there may still be useful learning for professionals.

3.4.3. The mother told the review that during this time her capacity to look after Child P was repeatedly questioned, as if the problems that had occurred for the children were her responsibility. The mother told the review that she felt undermined by the scrutiny that she believes she was under. She told the review that the support that she had personally received in relation to domestic abuse was 'perfunctory'.

3.4.4. It is difficult to gauge the nature of the day to day interactions between the mother and workers at the refuge as none of those who worked with her remain in employment. However the records show that, from the perspective of the agencies involved, the mother received considerable practical and emotional support during this period. Given that Child P and her half-brother had witnessed episodes of domestic abuse over a substantial period, he had been assaulted, the family was in temporary accommodation and the residence and contact arrangements remained unresolved, it was entirely justified that Child P was the subject of a child protection plan.

3.4.5. Review of the reports prepared in relation to the plan and the core group meetings shows that they focus very largely on the practical and emotional support being given to the mother and children to recover from the impact of domestic abuse. They touch in only a minor way on concerns about the mother's capacity to parent and protect her children. The reports show that the mother saw reports that had been prepared for child protection conferences before they were submitted so that she could challenge unfair comments and make sure that her views could be included. They show that she had very few differences with the views of social workers and others as recorded at the time. The review recognises that a refuge environment will never be ideal or easy for parents or children.

3.4.6. Although the refuge which the mother and Child P lived in is now commissioned by another provider, these findings will be brought to the attention of the body which commissions services in relation to domestic abuse in Sussex and Brighton & Hove.

3.4.7. The review has noted that it would have been good practice to review the domestic abuse risk assessment at the point when the family left the East Sussex refuge.

3.5. Maintaining the confidentiality of a victim's address and identity

3.5.1. During two periods (once when the parents had temporarily separated while they were living in Brighton & Hove, and after their permanent separation in 2011) plans to safeguard the mother and children relied on the father not being able to obtain the family address and other personal information. For a variety of reasons this proved to be impossible.

3.5.2. While the family was living in Brighton the father followed the mother to find out where she lived. In the months before he killed Child P the father obtained details of the family's whereabouts using covert means. However on three other occasions while the family were living in East Sussex there is evidence or a strong

suspicion that details of the mother's addresses or identity were disclosed to the father inadvertently or in error by a bank, the Child Support Agency and by the mother's own solicitor.

3.5.3. The insistence of the family court on contact arrangements being made which enabled Child P to have the shortest possible journey from her home (because the court understandably wished to avoid her having a lengthy, tiring journey) led at one point to contact being arranged in a building very close to her school.

3.5.4. In addition the local authority mistakenly revealed that the mother had reverted to the use of her unmarried name. In another report it gave a strong indication of the area in which the mother lived and the evening on which she attended evening classes in the preamble to a report for the court on contact arrangements.

3.5.5. Whilst it is not certain that any of these episodes led to family members being placed at risk of harm, they raise questions as to whether, when personal records are now stored on the databases of numerous companies and public bodies, it is possible even with the best of intentions, to guarantee that address details and other personal information will not be disclosed. Systems are too complex and there are, in the face of devious individuals determined to obtain information, too many opportunities for human error.

3.5.6. It is important to recognise in addition that modern search engines offer an extremely effective way of bringing together disparate information from public records and social media in order to identify a person's whereabouts.

3.5.7. Although every agency and the courts will have procedures in place to address this problem, it is important for professionals to recognise the very great difficulty of achieving this, and to take realistic account of this when planning for the safety of victims of abuse and children. The advice given to victims about how to use social media will also need to reflect these challenges.

3.5.8. The review recognises that, even if they cannot be infallible, each agency needs to have reliable ways of protecting the personal details of vulnerable individuals from disclosure (such as prominent markers on front screens and methods of shielding records) and training for staff throughout the organization to ensure that they are implemented. The LSCB should seek assurance in relation to this from its member agencies.

3.5.9. At the same time, policy, procedures and training need to emphasise that, for the reasons set out in 3.5.5 above, safety planning can never rely entirely on arrangements to shield an individual's address or identity from disclosure.

3.6. Safeguarding victims and their children who have moved across local authority borders in order to be safer

Background

3.6.1. The Multi-Agency Risk Assessment Conference (MARAC) is an important part of the UK Government's Call to End Violence Against Women and Girls Action Plan.[13] The function of the MARAC is to share information and coordinate a plan of action to protect high-risk victims of domestic abuse. [14] At a MARAC, information is shared on high risk domestic abuse cases and representatives seek to develop a coordinated action plan to promote the safety of the victim. The primary focus is the adult victim; however links are also made with agencies responsible for safeguarding children and managing the behaviour of the alleged perpetrator.[15] It is good practice at the meeting to identify a lead agency / professional for the victim, for the alleged perpetrator and for any children in order to coordinate this activity.

3.6.2. Unlike other meetings with risk coordinating responsibilities, such as child protection conferences, MARAC does not have a continuing case coordination or review function and a case is only discussed again at MARAC if it is re-referred because there has been a further incident of domestic violence or abuse. Responsibility for the completion of actions rests with the agencies involved and they are expected to liaise with each other, usually without further recourse to the MARAC, in order to manage and review the implementation of the action plan as a victim's needs or circumstances change.

3.6.3. Referral to MARAC and risk management more generally rely on the assessments provided by professionals working with victims of abuse and violence. In order to be effective, risk assessment should be a continuing process, rather than a one off event. There are many reasons why risk assessments should be reviewed or repeated. Often different information will be revealed to different professionals who will have different roles or be working at different points in time. The needs of a person or the assessed level of risk may change. It will be particularly relevant to update

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[13] This is not statutory guidance but part of an '*overarching strategic narrative'.* Cabinet Office, HM Government (2011) *Call to End Violence Against Women and Girls: Action Plan,* https://www.gov.uk/government/publications/call-to-end-violence-against-women-and-girls-action-plan

[14] Attendees are likely to include police, health, service, local authority children's services, housing commissioners and providers, Independent Domestic Violence Advisors (IDVAs), probation services and other specialists from the statutory and voluntary sectors.

[15] More information on MARACs is available at http://www.safelives.org.uk/practice-support/resources-marac-meetings.

the risk assessment when a victim of abuse moves, particularly if this is across a local authority boundary because there may then be a substantial number of new services in touch with the family. It is also widely recognised that women and children remain, or may be more at risk, after they have separated from an alleged perpetrator and moved.

Guidance on sharing information between MARACs

3.6.4. There is national guidance for the transfer of cases between MARACs when a victim moves between areas.[16] This was published in 2012 and it had not been turned into specific local procedure in Brighton & Hove or Sussex during the period 2011-12 when the family in this case moved, first from Brighton & Hove to East Sussex and then within East Sussex from a refuge to housing provided by a district council.

3.6.5. As a result there was no procedural requirement on any of the professionals working with the mother or Child P to notify the MARAC coordinator that a family had moved. It relied on either 1) professionals working from Brighton & Hove to note that the family had moved and to identify the value of sharing the information that had been collated by the MARAC in Brighton & Hove with its counterpart in East Sussex, and alerting the Brighton & Hove MARAC or 2) professionals in East Sussex recognising that it would be useful if the information held by the MARAC in Brighton & Hove was shared with the partner body in East Sussex. Although agencies were mindful of the risks to the mother, this did not happen. Even if they fully appreciated the role and importance of the MARAC it is unlikely that front line staff in any agency would have spontaneously taken on this role in the absence of formal local procedures.

3.6.6. Agencies would have needed to do this in addition to managing the transfer of information and records to counterparts in their own agency or profession in the other authority area. This was largely done. There was a delay in the notification made by social care staff in Brighton and Hove to counterparts in East Sussex, though there is no evidence that it adversely affected the management of the case.

3.6.7. More widely, the sharing of information has been hampered because MARACs are administered differently (usually by the police service or local authority) in different areas without a uniform national roll-out or the development of compatible information

[16] See guidance at http://www.safelives.org.uk/practice-support/resources-marac-meetings/resources-people-attending

technology systems. Consequently, there is no automatic 'safety net' which could identify that a case referred to a MARAC has been heard previously at another MARAC.

3.6.8. During the course of this review, Brighton & Hove City Council and East Sussex County Council have been undertaking a joint procurement process for a range of services, underpinned by a joint case management system which will make it easier to identify victims of domestic abuse and violence who have moved between those authorities. The administration of the MARACs in Brighton & Hove and East Sussex will also be combined.[17]

3.6.9. While the development of joint arrangements will provide a greater likelihood that the need to transfer information and coordinate work will be identified and will provide a safety net in some instances, arrangements for the transfer of cases between MARACs will continue to rely largely on agencies identifying cases that have transferred out or into their service, establishing information as to where the victim of abuse is moving to (or has moved from). Services will continue to need arrangements to make enquiries with a service user who has moved into either area about the service(s) with which they have engaged in their originating area in order to trigger information sharing requests. However in future this would be supported by operating protocols that MARAC member agencies endorse and implement.

3.6.10. Professionals who are working with women who have experienced domestic violence and abuse and who have moved into their area will also need to be more aware that information may be available from the MARAC in the area from which they came. Professionals who are undertaking a risk assessment, including using tools such as the DASH Risk Identification Checklist, should seek to confirm details of services previously involved in order to inform their assessment and next steps.

3.6.11. As well as being familiar with important local developments professionals also need to be aware of their responsibilities in relation to women and their children who have moved to or from East Sussex to other local authorities further afield.

3.6.12. The SCR has made recommendations in relation to these issues.

[17] Details are provided in the LSCB response published alongside this report.

3.7. Aspects of culture and religious belief that impact on risk where there has been domestic abuse and violence

3.7.1. The father described himself as being a devout Muslim. However at various points in the case history the vulnerability and risk to the child and mother may have been influenced by religious and cultural factors. For example the mother cited her religious beliefs as being one of the reasons why she decided to return to live with the father, while they were living in Brighton & Hove. The parents sought guidance from an Imam over their relationship difficulties. After this both the mother and the children were exposed to further risk.

3.7.2. This underlines the need for professionals to understand the role of religion and culture in individual cases. To a degree this was recognised. The Brighton & Hove MARAC meeting noted that 'cultural factors' added to the risk to the mother, presumably a reference to the fact that the couple's religious beliefs had influenced their decision to reconcile. However prior to the meeting and subsequently there is no evidence of any attempt to understand what these cultural factors were and how they operated. It is not clear why there was a reticence on the part of professionals to do this or, if it was discussed, why no records were kept.

3.7.3. Assessment of need and risk in relation to domestic abuse must be informed by a good understanding of the cultural context within which abuse occurs and the distinctive features that may have shaped the actions of individuals and families. The review has made a recommendation in relation to this.

3.8. The psychological evaluation undertaken for the family court

3.8.1. In 2012 the family court ordered a psychological assessment in order to determine whether there should be contact between Child P and her father and, if so, whether it should be supervised (by which the judge made it clear that she meant closely monitored) or unsupervised. This led to the parents and Child P being separately seen by an experienced clinical psychologist who acted as the court's jointly-appointed expert.

3.8.2. The psychologist was asked to address eight questions, including: whether the father posed a risk to Child P; whether any such risk could be mitigated and, if so, what kind of therapy or treatment would assist; whether the mother could support contact between Child P and her father in the future; if contact should be reinstated and, if so, how that should happen. With the agreement of all

parties, the psychologist was asked to establish the wishes and feelings of Child P and to comment on whether it would be in her interests to see her father.

3.8.3. The psychologist conducted clinical interviews and administered a range of psychometric tests on Child P and both parents in order to gauge the type and seriousness of any risk and to make recommendations. She judged that while the father had '*personality and psychological difficulties which need to be addressed therapeutically, he does not pose a risk to the safety of (Child P) and would not pose a risk to (the mother) all the while the couple do not re-establish their relationship'*.

3.8.4. Notwithstanding this assessment, the report submitted to the court was very cautious in its recommendations, stating that before there was any direct contact between the father and Child P, he ought to undergo a period of therapy in order to '*address his anxieties and rigid thought processes'*.

3.8.5. Having assessed the mother the psychologist judged that it was '*equally important for (her) to gain insight and understanding of (the father's) psychological and personality functioning as this would enable her to manage situations in a way that would reduce her distrust and anxiety'*.

3.8.6. This report set the parameters within which professionals and the court understood the needs of Child P for the next two years. In the event the clinicians who subsequently saw the father were unable to establish any common starting point for therapeutic intervention because he did not accept that he needed to make any change in his attitude or behaviour.

3.8.7. In her contribution to the SCR Child P's mother was extremely critical of the way in which she believed this assessment had been conducted and of its impact. Although it had been established that the father had committed domestic violence, she felt that the couple were 'treated as equals' as far as the assessment was concerned i.e. they went through the same interview process and the same testing. She said that there had been as many questions about her behaviour and mental health as his, which made her feel that she was as responsible as him for what had happened. This was exacerbated by the fact that the psychologist had interviewed the father first, which made the mother feel that she was having to answer issues raised by him, as she believed she had previously done with other agencies.

3.8.8. The mother had found it difficult to believe that the report had found that her husband presented a low risk or no risk to her daughter, but did not know how to respond to this. She told the

review that the report had a 'corrosive' impact on her self-esteem, in part because in her view it set out her problems and the father's as if they were comparable, not recognising that his behaviour had been the cause of her problems. In her view the assessment did not take account of the fact that the father was a dangerous person, who repeatedly lied about his past. It should have tested what he said, rather than taking it at face value.

3.8.9. The view of the mother is that the assessment was insufficiently informed by an understanding of the patterns of behaviour that occur in abusive relationships and therefore misses the point that the mother's 'distrust and anxiety' were founded on her experience of abuse, which had been recognised by the court.

3.8.10. The independent overview author had a lengthy discussion with the report author about these concerns. The psychologist understood why the mother might view the assessment in this way, particularly given the killing of her daughter. She underlined that her brief was set by the court (with the agreement of all of the parties) and that while it focused in large part on the risks arising from the father's behaviour, her instructions also required her to interview the mother, because if the court were to order that contact should take place, the mother (who had the full time care of Child P) would need to be able to allow this to happen and to enable her daughter to attend sessions which it had been judged were in her daughter's interests.

3.8.11. The psychologist's notes indicate that the vast majority of the assessment (over five hours) focused on the father, in contrast to less than two hours spent with the mother. The psychologist was also clear, on the basis of previous experience, that in order to be able to advise the court properly on the potential future risks, she needed to try to understand why the mother had previously left the father and returned to him, why she had made other decisions that had placed her child at risk and why she had now left him again.

3.8.12. The assessment established on the basis of a one hour session of tests and a clinical interview that '*Child P has a need to see her father and she was able to express this need consistently and with clear understanding… albeit she experiences ambivalence in relation to him'.* The report noted that Child P had witnessed violence against her mother, heated conflict between her parents in which her mother had also been aggressive and physical assaults on her older, disabled half-brother.

3.8.13. The Women's Aid research previously referenced counsels caution in assessing the needs of children on the basis of a single clinical

interview with an unknown person, suggesting instead that in such cases '*children should be assessed … over several weeks to establish the child's perspective and whether the child is at risk, and to make appropriate recommendations for the child's welfare, because children are very unlikely to disclose abuse during a one-off interview with a person, whom they do not know and trust'.* [18]

3.8.14. The psychologist was clear that Child P (who had not seen her father for some ten months at the time of the assessment) had strong, positive memories of him, was finding it difficult to deal with not seeing him and an 'unusually strong' desire to have contact.

3.8.15. It is noted that the assessment of the father described his reported depression, which he linked to not seeing Child P. He gave a persuasive, but uncorroborated account of his own childhood and family background, which the report conveys as if it has been taken at face value. He also minimised the extent of his behaviour, which would be expected.

3.8.16. The psychologist is clear that it is for the court, and the parties involved in the proceedings, to test and weigh assertions about past behaviour (which cannot be verified in an assessment interview) and the recommendations made by experts. Section 3.9 of this report notes how difficult it can be for this to happen as cases become protracted and papers accumulate, particularly if the representation of parties changes or parents are forced to represent themselves.

3.8.17. The review notes that valid psychometric tests were undertaken and it has no reason to believe that they were not interpreted properly. It recognises that the recommendations made to the court about contact were extremely cautious, and that, to the extent that the father would cooperate, they were implemented by the court.

3.8.18. The psychologist recognises that, with the benefit of hindsight, the assessment that she made proved to be incorrect. However she stands by the way in which it was undertaken and does not believe that any psychological assessment could have predicted the outcome in this case, or distinguished the father from many other parents who are angry and controlling.

3.8.19. The serious case review has noted the negative reported experience of the mother and the description given by the psychologist of the role of the court-appointed expert who is

[18] Hilary Saunders op cit (page 7)

required to explore the areas of potential concern agreed by the parties in a dispassionate way. It is important to recognise that at the time the father was even more strongly critical of the findings of the assessment, though of course for different reasons.

3.8.20. The experience of the mother in relation to this specific episode echoes her experience of other services, which in turn women who have been victims of abuse and violence described in section 3.3. This serves to underline the complexity of the task and the fact that it is extremely unlikely that in such a difficult situation any of the parties are likely to be pleased by the outcome of an assessment. It also underlines the need for court appointed experts to have a good knowledge of the patterns of behaviour which typically exist in domestic abuse and violence cases so that – as happened in this case – recommendations are made cautiously.

3.8.21. In this case East Sussex County Council's legal service was responsible for identifying the court-appointed expert, as the local authority had prepared reports for the court. Local authorities and Cafcass are frequently asked to advise on or commission expert witnesses on behalf of courts in both private and public law proceedings. The review will recommend that experts are able to demonstrate to the commissioning solicitor that they have a sufficiently well-developed understanding of domestic abuse and violence before being recommended to the court in such cases.

3.9. Learning in relation to the involvement of the family court

Introduction

3.9.1. The family court considered applications about contact and residence over Child P between September 2009 and the time of her death. A summary of the court involvement is set out in the table below.

Family court involvement

3.9.2. It is outside of the remit of SCR to comment on the decisions and actions of the judiciary. However the review believes that there is value in setting out an overview of the family court involvement in the case so that members of the judiciary who were involved and the wider court system have an opportunity to reflect on the case history.

September 2009	Both parents were living in Brighton & Hove. They had separated. The father applied for a Residence Order in relation to Child P. The court considered information from the police and social care as well as lengthy statements made by the parents.

	Cafcass provided safeguarding checks. As the local authority social care service was already involved it provided the report under Section 7 Children Act 1989.[19] The court granted the mother residence of Child P and ordered that father's contact with Child P should take place in a neutral venue. The parents subsequently arranged contact outside of the orders made and without the knowledge of professionals working with the family. Father began to visit the family home. He refused to participate in a risk assessment proposed by the court. Subsequently the couple reconciled and lived together again. They separated in mid-2011 when the mother moved to a refuge in East Sussex.
September 2011	The parents had been separated for some months and the father had not seen Child P for four months. He made an application for contact. The local authority was again asked to prepare the Section 7 report for the court and information was provided by Cafcass about the outcome of previous contacts and safeguarding checks (known as a Schedule 2 letter).
December 2011	The court ordered the joint instruction of a clinical psychologist to undertake the assessment of the father and his application for contact. The parties and the local authority agreed the issues to be addressed.
April 2012	The psychologist recommended that the father should undergo a period of therapeutic input. He subsequently had contacts with NHS psychology services but it proved impossible to agree a plan of work with him.
June 2012	At this point Child P had not seen her father for 12 months. The court ordered that indirect contact between Child P and her father should commence, in the form of exchange of cards, sent via the local authority every three weeks. The judge asked the mother to encourage Child P to respond positively. The father sent cards and letters. It is impossible to tell from the records how well these engaged Child P.
September 2012	The court ordered two exploratory sessions of supervised contact between Child P and her father. Social care was asked to write a report on the sessions and both parents were required to attend a parenting information session (which is a common step in private law cases where there are matters in dispute concerning children)
November 2012	The court ordered a further four supervised contact sessions. The final hearing was listed for May 2013 and the local authority was asked to provide an updated report on contact and a report from Child P's school. Records show five sessions supervised by the allocated local authority social worker in December and January 2013 (including one that had been arranged under the terms of a previous order).

[19] The court may ask Cafcass or the local authority to assist its decision making when considering making an order by preparing a report on the welfare of a child http://www.legislation.gov.uk/ukpga/1989/41/section/7

February 2013	East Sussex social care reported on the sessions to the court. It concluded that there had been difficulties in the way in which the father interacted with Child P, beyond the normal awkwardness that might be expected to arise from unfamiliarity. The local authority reported that it could not continue to fund the provision of contact. The court agreed with the recommendations of the report, ordering that the father should fund further supervised contact and provide notes of the sessions to the court. The social worker was asked to establish Child P's wishes and feelings and to obtain an updated report from the school. A final hearing of the applications was scheduled for May 2013. In the meanwhile arrangements for indirect contact would resume.
May 2013	The court was not in a position to hold the scheduled final court hearing so this was re-listed for June 2013. It appears that no one had been asked to prepare the issues to be considered.
June 2013	The father made a further application for contact on the basis that the mother had not complied with the previously made order. Cafcass began safeguarding and background checks and identified the agency's previous involvement with the family. The father's solicitor wrote to Cafcass in July 2013 inviting it to arrange contact, but not to make any further investigations into the background of the case. No contact was arranged
August 2013	The court noted that there had been no contact sessions. Parties were asked to proceed with supervised contact every three weeks. The case was to be returned to court once there had been four supervised contact sessions
October 2013	Following the court case the father contacted Cafcass to ask for support in arranging supervised contact. He sought a contact centre in a specific area, indicating that he had some knowledge of the part of Sussex in which the family was living. Cafcass suggested contact take place at a centre in West Sussex, a considerable distance from the family home. The judge indicated a concern that travel distance for the child should be minimal. The father rejected contact at the two centres suggested. The first supervised contact session took place in October 2013. This was the father's first contact with his daughter in approximately 10 months. The mother stated that Child P reacted badly to the contact and so a hold was placed on further contact sessions. This was the last time the father had contact with Child P before he killed her.
January 2014	The court ordered the reinstatement of indirect contact, with a review hearing scheduled. Neither Cafcass nor the local authority was involved at this point, so neither attended court. The next court hearing was on 29 April 2014.
April 2014	The court ordered a further period of indirect contact and that the mother should provide information to the father about his daughter's interests so as to assist in this. Consideration was given to the need for a Family Assistance Order (Children Act 1989) to facilitate further supervised contact. The local authority was not positive that this could be made to work,

	given previous failures
August 2014	The father asked the local authority to arrange supervised contact. This was at odds with the order made by the court. The local authority had by that time closed the case, following the previous court hearing. A further application by the father led the judge to liaise with Cafcass which agreed to appoint a Children's Guardian under Rule 16.4 of the directions governing the management of private family law cases. This recognised that this was a case in which the 'implacable hostility' of the parties was working against the interests of the child and that Child P needed to be separately represented by a Children's Guardian and solicitor.
September 2014	The case was allocated and Cafcass located the mother. A worker began to make arrangements to gather information and see Child P before the next hearing.

3.9.3. A number of points are evident. Those who are regularly involved in such proceedings will be better placed than this review to reflect on these issues in the wider context of the arrangements for private family law.

Observations

3.9.4. The case became protracted, as a result of which Child P lived with considerable uncertainty as to where she would live and whether or not she would see her father, for more than half her life.

3.9.5. From mid-2012 until the death of Child P in September 2014 repeated attempts were made by the court, and by the local authority on its behalf, to promote various forms of contact between the father and Child P. None met with any success and the decision making process remained, in practice, stalled.

3.9.6. On several occasions the parties failed to comply with court orders but no measures were taken to enforce them.

3.9.7. On more than one occasion the court made an order which sought to determine the details of interpersonal behaviour (for example instructing that the mother should encourage Child P to respond positively to cards and letters sent by her father, or provide him with details of her preferred leisure activities). Such directions went in the face of the natural inclination of those involved and could not be monitored or enforced.

3.9.8. In protracted proceedings there may be a danger that significant information revealed and established at an early point may become lost, or parties may choose not to remind the court of its existence. Over the course of six years a substantial volume of reports had accumulated.

3.9.9. For example, it was established at an early hearing in 2009 that the father had followed the mother to her home after she had separated from him. The psychologist's assessment in 2012 relied on the fact that the father had not stalked or followed the mother. This factor (which it is widely agreed would increase the index of risk) did not inform later reports by the local authority, which the court had asked the authority to focus narrowly on Child P's contact with the father.

3.9.10. The risk of important history being lost was heightened because neither of the parties was consistently represented throughout the lengthy proceedings. The father represented himself on a number of occasions. The mother had 2 different representatives and told the review that she constantly felt financially insecure because of uncertainty about the availability of legal aid. The case review recognises that this is an issue which professionals who are working with victims of domestic abuse and violence who are involved in the family courts need to be mindful of. The review has made a recommendation in relation to this.

The allocation of responsibility for the Section 7 reports

3.9.11. The risk of important information being overlooked may have been exacerbated by the intermittent involvement of Cafcass and two local authorities. Section 7 reports were prepared by the local authorities because at the point when they were commissioned the local authority had some involvement in the case. The reports prepared were perfectly good (and were welcomed by the court) but reports prepared in the later stages of the case history were narrowly focused. For example social workers in East Sussex felt that the efforts to promote contact between Child P and her father were not in her interests and would continue to be fruitless. However staff in the local authority did not express this view and limited their reports largely to factual reporting on the practicalities of contact, as they had been asked to do.

3.9.12. The preparation of Section 7 reports in private law cases may either be undertaken by Cafcass or by the local authority. A national protocol exists in order to help the agencies and the court determine which agency should take responsibility.[20] It states that when an agency is or has recently been involved with the family (i.e. within the last month), it should be allocated the case. Cafcass

[20] Cafcass and Association of Directors of Children's Services (2012) *Good Practice Guidance: determining whether Cafcass or a local authority should prepare a section 7 report.* https://www.cafcass.gov.uk/media/126318/good_practice_guidance_-_determining_whether_cafcass_or_a_local_authority_should_prepare_a_section_7_report.pdf

is allocated new private law cases unless there are exceptional circumstances.

3.9.13. It is therefore not unusual for local authority social workers to undertake Section 7 reports and in some instances (where there family circumstances are well known to the agency or where there are complex safeguarding concerns) it will make sense for the local authority to prepare the report. On the other hand many local authority social workers and managers do not have a detailed understanding of the role of the courts in private law cases or how the powers and duties of the court might best be used to promote a child's interests.

3.9.14. This case is one such example. The critical issue was that it was taking a very considerable amount of time for the parents and the court to resolve the uncertainty in Child P's life. There is an argument that (notwithstanding that the protocol was correctly interpreted) Child P's interests would have been better served if Cafcass had been more involved in this case, and prepared some or all of the Section 7 reports. This is likely to have allowed better oversight of the issues of residence and contact and a better understanding of the role and powers of the courts that a specialist can bring. This may in turn have led to the drift in the case management, which is with hindsight a concern, being more readily identified and assertively addressed.

3.9.15. This suggests that whilst adherence to the national protocol will lead to the most effective outcome in the majority of cases, there will be some instances in which it should be interpreted more flexibly.

<u>Professional understanding of private law proceedings and the role of Cafcass</u>

3.9.16. Linked to this the review has noted that the role of Cafcass in private law proceedings is poorly understood in partner agencies, even by senior members of staff with safeguarding responsibilities. Previous serious case reviews have identified the need for Cafcass to inform local safeguarding children boards about its role in such proceedings.[21] Work on this is required in East Sussex and the review has made a recommendation in relation to this. This could include a discussion of the local implementation of the protocol referred to above.

[21] Oxfordshire LSCB (2014) *Serious case review into the death of Child N: overview report*.

The approach of the court in determining whether there should be contact when there are allegations of domestic abuse and violence

3.9.17. The orders made by the court in this case will have been guided by case law and a practice direction which sets out how courts should address the needs of children in cases where there are allegations of domestic abuse. These have been referred to previously. It is outside the remit of the review to comment on the way in which they were implemented.

3.9.18. The practice direction was strongly influenced by a paper prepared as advice to the courts in relation to a series of cases where the court needed to decide on contact arrangements in cases where there had been allegations of domestic abuse.[22] Part of this paper, dealing with the steps that a perpetrator of domestic abuse should be expected to take in order to satisfy the court that contact is in a child's best interests, is reprinted as Appendix 7 of this report and will be of value to all professionals dealing with children in such circumstances.

3.9.19. The review has recommended that this case history should be put forward for discussion and learning at the East Sussex Family Justice Board.

[22] Claire Sturge and Danya Glaser, 'Contact and domestic violence – the experts court report', *Family Law* (September 2000). *For the cases Re L (Contact: Domestic Violence); Re V (Contact: Domestic Violence); Re M (Contact: Domestic Violence); Re (Contact: Domestic Violence) [2000] 2 FLR 334 we were asked, by the Official Solicitor, to prepare a report giving a child and adolescent opinion on, amongst other matters, the implications of domestic violence for contact.*

Appendices

Appendix 1	Detailed narrative of events
Appendix 2	Views of Child P's mother
Appendix 3	Terms of reference and method for carrying out the review
Appendix 4	SCR review panel members
Appendix 5	Documents and materials considered
Appendix 6	References
Appendix 7	Excerpt from Claire Sturge and Danya Glaser, 'Contact and domestic violence – the experts court report', *Family Law* (September 2000)

Appendix I

NARRATIVE OF PROFESSIONAL INVOVLEMENT WITH THE FAMILY

1. This narrative is based largely on professional records and interviews with staff and managers. Information provided by Child P's mother, which is highlighted in italics, has been included at a number of points.

Background family history

2. The father was born in the Middle East in 1967 and was of Arabic, Muslim origin. Home Office records show that he entered the UK illegally in either 1998 or 1999. He claimed asylum based on the grounds that there were accusations in his home country that he had been part of a radical religious group and that he would also be persecuted for having fought with Islamists in Bosnia. He was granted asylum, with indefinite leave to remain, in 2004.

3. The mother was born in the UK in 1971. She is of white, UK origin and has an adult son who was born in 1993, the half-brother of Child P. He has a disability as a result of which he has been in receipt of health, education and social care services throughout the period under review.

4. The mother converted to Islam before meeting the father. The father is alleged to have assaulted a previous partner on a number of occasions, while living elsewhere in England and Wales resulting in at least one hospital attendance.

5. The parents were married in 2005 and moved to Brighton in 2006 where Child P was born. The mother made contact with the local authority and other services in relation to the needs of her older child shortly after moving to Brighton.

6. Not all of the above information was known to professionals dealing with Child P and her parents. The mother reported that the father had terrorist or extremist sympathies and had fought in Bosnia as part of a statement made to the family court in 2009. The father always acknowledged that he had been in Bosnia, but stated that he had been an aid worker. Either version of events, or parts of both, may have been true.

7. Some information about allegations of physical violence in the father's previous relationship was held by the police on local records in the areas where incidents were reported. Not all of it was accessed when the police provided information to other agencies or to multi-agency meetings. Details of this are set out below.

Birth of Child P and services provided in the early years of her life

8. Between 2006 and 2009 the father was studying and working away from Brighton and had addresses elsewhere where he mainly lived.

9. There was only sporadic agency involvement with the mother and Child P during this period, focused on the needs of the older child in the family.

10. The health visitor's new birth visit following the birth of Child P took place in September 2006. Records passed to the health visitor from the antenatal service led the health visitor to offer continuing regular visits. The mother declined, electing instead to receive a universal service and access child health clinics when she felt it to be necessary. The routine post-natal screening for depression and other mental health concerns and the 6-8 week maternal and infant checks were unremarkable. Child P had contacts with health services over normal childhood ailments.

11. In May 2008 the father received a police caution for assaulting the mother. She stated that it had caused pain but no injury. It is not clear from the records whether either child witnessed the assault and there is no record that the incident was referred to the local authority social care service. The health visitor became aware of the incident and made additional visits.

12. In July 2008 the local authority and the police investigated complaints made by Child P's half-brother that he had been hit with a belt by the father. He admitted the assault, explaining it as a result of differing cultural norms about chastisement, and agreed that he would not do it again. The family were allocated a social worker in the disability service and for some time the focus of social work activity continued to be in relation to Child P's older half-brother.

13. In August 2008 the mother reported to her GP that she was feeling depressed due to relationship problems.

14. A two year health visiting developmental check took place in November 2008. The mother told the health visitor that the recent domestic violence incident had been a one-off. The health visitor offered to remain involved, though there were no health or developmental concerns for Child P.

15. In January and February 2009 the mother took Child P for treatment at A&E twice after a reported domestic accident and ingesting medication. There were no concerns about the child's wider welfare or the response of the mother.

16. In February 2009 the mother reported the father's angry, abusive behaviour (directed at both mother and Child P) to her health visitor. The health visitor made follow up visits and phone calls in March and

April. On the second occasion it was reported that the relationship between mother and father had improved and that he had moved into a flat which allowed him to be nearer to Child P. The health visitor planned a further follow up visit with mother's agreement.

17. It is apparent from gaps and discrepancies in agency records that no professional knew exactly where the father was living, though he had returned to live in Brighton to be nearer the family. Brighton social care records suggest that the father had been living in the family home, but there was then a separation. Other records refer to the father staying with the family for Christmas.

18. Records show that in July 2009 the father was living in accommodation near to the family home. The police attended a domestic incident at the mother's home. Mother reported that the father had tried to snatch Child P, but there was no report of physical assault or injury. The father claimed that he only wished to see his daughter regularly.

Child P's mother told the serious case review that during this time there were many more serious episodes of domestic abuse that she did not tell professionals about. She said that the father went out of his way to influence professionals at this point, seeking out meetings with them and providing negative information about her.

Beginning of court proceedings in relation to Child P

19. In September 2009 the father applied for a Residence Order in relation to Child P. The court considered information from the police and social care as well as information provided by the parents.

20. The father made allegations in relation to neglect and physical abuse of Child P and her older brother and sexual abuse. He admitted chastising the brother with a belt. The father's submission to the court contained extremely demeaning statements about the mother. He presented himself as having offered significant assistance and encouragement to all of the family members, who had, he stated, benefited from his involvement in their lives.

21. Child P's mother alleged in turn that she had been a victim of domestic violence throughout their relationship and alleged physical abuse of Child P and her sibling. She also inferred from Child P's behaviour that she had been touched sexually. Cafcass was approached to provide checks and a report under Section 7 Children Act 1989, but because the Brighton & Hove social care service was already involved it provided the report ordered by the court.

22. The court granted the mother residence of Child P and ordered that father's contact with Child P should take place in a neutral venue. The judge was concerned by the father's evidence in court and his written submissions. The father did not take up offers by the local authority to arrange supervised contact. However contact (including visits to the family home) was taking place both during and after the legal proceedings. Child P's mother subsequently admitted this. Father refused to participate in a risk assessment proposed by the court.

Child P's mother told the case review that during these court proceedings the father stalked her and the children in order to find out where they were living. He admitted this in court, but claimed that this was for their benefit as he was a positive influence on the children's wellbeing.

23. In October 2009 the health visitor referred the mother to a local domestic violence project. A three year check showed no developmental or behavioural concerns about Child P. A further review in March 2010 found her to be a confident and outgoing child, with no health or developmental concerns.

Reconciliation of the parents

24. During late 2009 and 2010 the parents became reconciled. In June 2010 the maternal grandmother phoned Sussex Police to say that the father had broken a court order and gone to the family home. Police attended promptly and found no cause for immediate concern. Mother reported that the father had visited earlier but had left after a few minutes and caused no problems.

25. In September 2010 social care staff became aware that the father was visiting the family home regularly and seeing the children, despite having refused to undergo an assessment or take up offers of supervised contact. Previous incidents of domestic violence were noted. Social care notified the police, who noted the information but had no role to play. During this period the parents spoke to an Imam in a Brighton mosque about their relationship, which assisted their reconciliation.

26. The mother was being offered support by the specialist domestic violence and abuse service in Brighton & Hove during this time (2009-10).

27. The father was asked to become involved with counselling and psychology services but all offers were refused. The mother and the father moved to accommodation together in April 2011.

Further domestic violence leading to permanent separation of the parents

28. In May 2011 the mother called the police after a row over the children had escalated. The police assessed the risk as being 'medium' because of the presence of two vulnerable children and shared information about the incident with the local authority social care service. Four days after the first incident, a further incident occurred as a result of which the mother asked the father to leave the home and remove his possessions. She contacted a helpline, which in turn referred her to an IDVA (domestic violence advocate). The local authority was informed again. There was no evidence of any physical harm to the children.

29. The domestic abuse project sent a referral to the MARAC[23], against the wishes of the mother. At the end of May the mother called the police to a third reported incident, during which mother locked herself and Child P in the toilet because of threats made by the father. He subsequently denied the allegations. A risk assessment was undertaken which scored the risk to the mother as 'high'.

30. On 2 June 2011 the circumstances of the family were discussed both at the MARAC and at an initial child protection conference. Risk factors identified included child assault, the mother's reported suicidal ideation and 'cultural issues'. The mother had reported her belief that the father had suffered from PTSD, making him impulsive and unpredictable. It was reported that she feared being ostracised from the mosque if she did not reconcile with the father. The conference was unaware of the extent of the father's violence because Child P's mother had not reported all of the incidents. Records of alleged assaults that had taken place in other police force areas in relation to another woman were not identified in the police submission because, in line with the established police policy, it did not include a national search of the local intelligence

[23] MARAC (Multi-Agency-Risk-Assessment-Conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. http://www.standingtogether.org.uk/standingtogetherlocal/standingtogethermarac/ …. After sharing all relevant information they have about a victim/survivor, the representatives discuss options for increasing the safety of the victim/survivor and turn these into a co-ordinated action plan.

sources of other police forces (which include unproven allegations) for the MARAC.

31. Child P was made subject to a child protection plan, under the category of emotional abuse. The child protection conference expressed concerns about the risk of domestic abuse, whether the mother had or would act protectively, her capacity to parent Child P and reported concerns about her mental health.

32. On 12 June 2011 the mother left the UK with Child P to stay with members of her husband's family in his country of origin. She did so without notifying any professionals and left her son in the care of the father, despite his admitted abusive behaviour towards him.

33. The mother's reasons for going to stay with the father's family could not be fully established. She later told staff at the refuge that she felt obliged to do this because she feared her children being removed by social services if she stayed in Brighton, though there is no evidence that this was being contemplated or discussed. She told the serious case review that she was frightened and placed her trust in the father who had assured her that he would 'sort things out' with the authorities.

34. The mother told the SCR that once she was overseas she felt isolated and felt that she and her daughter might be at great risk of harm. After making phone contact with the police and other government agencies the mother was assisted to return. Given the highly unusual circumstances police and social care staff met the family at the airport, debriefed the mother, sought to assess how Child P was and arranged for the family to stay in a refuge in East Sussex.

35. During her debrief the mother stated that the father had threatened to kill her if she took their daughter away from him; however she did not believe this threat. Brighton & Hove social care staff believed that the mother had come to the realisation that the father would not change. She had believed that previously when they had been reconciled things had improved; however when they moved back in together, he had rapidly become controlling and violent. Social care records state in the assessment that the mother may still not fully appreciate the real risk to her from her husband and possibly his family.

36. At this point Child P presented as a happy, energetic girl who gave the impression she felt like she had been on holiday.

<u>Events while the family were living at the refuge August – November 2011</u>

37. The mother remained living in the refuge until when she was nominated for social housing in October 2011, which was allocated soon after.

Child P's mother told the case review that her experience of living at the refuge was very negative because of the behaviour of other residents, but mainly because she felt that her care of Child P was being closely scrutinised and that she felt as if she was treated as being 'the problem'.

38. A review child protection conference held in August 2011 recommended that Child P should remain subject to a child protection plan and that there should be a full assessment of risks in the family, pending which there should be no contact between the father and Child P. Plans were made to transfer responsibility for the family to East Sussex. In fact Brighton & Hove retained responsibility for supervision of Child P and monitoring of the protection plan until early 2012. Information about the placement and the case more generally was not shared with East Sussex children's social care staff until December 2011.

39. Child P's mother was assessed by the IDVA service at the refuge. She alleged that Child P had suffered emotional abuse because she had witnessed domestic violence. Child P was referred to the children's therapeutic service and the IDVA service remained in contact with the mother. Mother told a health visitor in East Sussex that she had felt that professionals did not support or believe her when she first reported domestic violence.

40. In September 2011 the mother's bank statements (which showed patterns of expenditure and cash withdrawals) were sent by her bank wrongly to her husband's address. The bank acknowledged an error and made financial compensation. The mother decided to change her name by deed poll, though she told the serious case review that her reasons were not linked to her recent negative experience with the bank.

41. When Child P started at the local primary school (Primary School 1) the mother was very cautious about the school taking or publicising photographs which might identify Child P (for example on its website).

42. Father made an application for contact and Cafcass was again approached to provide safeguarding checks. Cafcass connected the case to the previous court papers. Contact was made with Brighton & Hove which had previously prepared a Section 7 report and papers were provided for the local authority in East Sussex containing full details of previous contacts. Father denied any allegations of domestic abuse when discussing the application with Cafcass and stated that he was becoming depressed as a result of not seeing his daughter.

43. The Cafcass officer had a lengthy phone conversation with the mother, in which she refuted the father's allegations and made a number of counter-allegations. Cafcass records show a very high level of concern for the mother and child. The court ordered a further assessment to take place and ordered parties not to disclose the mother's new address. Cafcass involvement was again limited as the local authority was involved with the family and would take responsibility for the preparation of a further report under Section 7 Children Act 1989. Information was to be provided by Cafcass about the outcome of previous contacts and safeguarding checks (known as a Schedule 2 letter) and this occurred.

44. The mother wrote to the court expressing very grave concern about her safety and that of her children and specifically alleging her understanding that the father had arranged for a passport to be obtained in the name of his daughter from his country of origin in order to abduct her and take her abroad.

45. In October 2011 the IDVA service arranged with mother's agreement for therapeutic intervention for Child P and a range of practical and emotional support for the mother. An individual safety plan (i.e. the practical steps the mother would take if she was contacted or threatened by the father) was worked out and mother was helped to have access to legal advice.

46. Mother expressed her satisfaction with the way in which Child P was settling at her school though also fear that the father might be able to identify where they were living. The initial psychological assessment of Child P revealed that in school she seemed very settled.

47. In October 2011 two residents of the refuge spoke to a project worker alleging that the mother was hitting Child P. The project worker reported this directly to the manager who stated that it needed to be referred to the allocated social worker. There is no evidence that this happened, either in Brighton social care records or in the refuge records.

<u>Key events while the family were living at East Sussex address 1 (November 2011 – July 2013)</u>

48. In November 2011 the family were rehoused in a village in East Sussex and Child P changed school accordingly. There was a full handover of background information to Primary School 2, with mother again emphasising that she did not want photos of Child P to be publicised. The school complied with this. Child P settled extremely well into the school. Her mother remained anxious and had contact with the school several times per week. Arrangements were made to ensure that Child P was in the sight of school staff the whole time and that she was only

handed over to adults specified by the mother. Child P remained a pupil of this school until July 2013.

49. Police records were updated to add warning marker flags to the address (in order to aid a rapid and proportionate response if there was an incident) and the local PCSO started to make regular visits to reassure the mother and family. In 2012 he served as a safe intermediary between family members in order to secure safe return of possessions to the mother.

50. In November 2011 the local authority (Brighton & Hove) filed a Section 7 report. Noting the history of domestic abuse, the continuing conflict between the parents, and the need to maintain the child's address confidential, it proposed a supervised contact arrangement which would need to be kept under review to ensure that it continued to be in Child P's interests and that family members were safe.

51. In November 2011 the mother and children moved from the refuge to social housing in East Sussex (East Sussex address 1).

52. In December 2011 the family court ordered the joint instruction of a clinical psychologist to undertake the assessment of the father and his application for contact with Child P. Brighton & Hove social care, which was responsible for preparing the Section 7 report, would be the lead solicitor on instructing the expert and drafting the letter of instruction which all parties would agree.

53. On 18 January 2012 Brighton & Hove social care convened a review child protection conference on Child P. This decided that given the change in her circumstances there was no need for her to be the subject of a child protection plan as she was no longer at risk of significant harm. The mother was adamant that her relationship with the father was over and that she had no plans to reconcile. Child P was settled in school, making friends and, making good academic progress. Child P had been seen in school by the school nurse and found to be healthy and thriving, with no concerns.

54. From this point, 18 January 2012, provision would be coordinated for her as a child in need (CIN) by East Sussex social care, which would take over the responsibility for reporting on her welfare and contact arrangements when requests were received from the family court.

55. In February this address was inadvertently disclosed to the father in correspondence from the Child Support Agency. It is not clear when the mother became aware of this, though she is likely to have received the same correspondence at the same time. She brought this to the

attention of the police in June 2012 and to the attention of the district council in June 2013.

Mother told the review that at that time she did not fear that the father would approach her or her daughter because he still held the belief that he could be successful in the court hearings and so was moderating his behaviour.

56. On 24 February 2012 a social worker visited the family and agreed the arrangements of a support plan for Child P as a child in need. The records suggest that this was undertaken with brief involvement of the SENCO (a teacher).

57. In April 2012 Child P began fifteen sessions of music therapy funded by her school. This was perceived as being very beneficial and continued for over a year. The allocated social worker left her post as a result of which the case could not be allocated in the local authority and was held by a manager.

58. The clinical psychologist who assessed family members under the terms of the family court order provided her report. The report consisted of a number of standardised psychological tests of family members, together with review of documents and clinical interviews. It concluded that the risk of violence to Child P by her father was low. Nevertheless it recognised the significance of the previous domestic violence and the difficulties arising from his personality and temperament. The psychologist recommended that there should only be indirect contact between Child P and her father (i.e. communication through letters) but that if separate therapeutic interventions with the parents proved successful and it was viewed as being in Child P's interests, direct contact should be initiated. That contact should be supervised until such time as it was seen to be working in Child P's interests and safe for all concerned.

Child P's mother was extremely critical about the way that the report had been conducted and its impact. Her views are set out in Appendix 2

The psychologist discussed these issues with the overview report author at some length. Her responses, which balance the views of the mother, and explain the role of the assessment in relation to the questions asked by the court, are set out in section 3.8.

59. Following this report the father made a number of contacts with psychology services, initiated by GP referrals. In June 2012 he was assessed by a behavioural psychologist working as part of the primary care mental health treatment service. From the father's perspective his difficulties arose from the fact that he could not see his daughter and would at best only be able to see her a couple of times a week in future. He did not accept the finding of the expert report that he had underlying personality traits and a pattern of behaviour which made it very difficult to negotiate contact arrangements. The father claimed that a referral made for CBT in 2010 had not been helpful (though the review has found no record of this episode). The psychologist wrote to the father's GP confirming that, as there was no common starting point to agree why the therapy was necessary, there was no point trying to offer treatment.

60. The father was made aware of this assessment and sent a copy of the correspondence. The father's GP wrote to the family court advising that treatment options available within the NHS had been exhausted. The father subsequently had a lengthy consultation with his GP about what he referred to as the false allegations of domestic abuse made against him. His solicitor sought clarification from the court appointed expert that CBT was her recommended treatment.

61. In May 2012 the mother requested an urgent GP appointment for a CAMHS referral, due to her claim that Child P had started to self-harm. She believed that this had been triggered by the recent psychology assessment. The mother later recognised that Child P had not been self-harming.

62. The response from the CAMHS service was that the referral was not appropriate for the service and alerted the allocated social worker over what seemed to be poor supervision. CAMHS recommended a referral to the domestic violence Children's Therapeutic service. The Children's Therapist contacted the mother to offer Child P support. Mother declined the service, reporting that Child P's behaviour had improved and that she was now receiving music therapy at school, which was working well.

63. In June 2012, adopting the advice of the psychological assessment, the family court ordered that indirect contact between Child P and her father should commence, in the form of exchange of cards, sent via the local authority every three weeks. The judge ordered the mother to encourage Child P to respond to cards and letters from the father.

64. Shortly after this the mother told the police that the Child Support Agency had disclosed the family's new address to the father in

correspondence. There was no response from the force's adult safeguarding unit but the PCSO made additional visits to reassure the family. The mother told the district council about this in June 2013 when she asked to be rehoused.

65. Shortly after this a report prepared by East Sussex social care for the court revealed that the mother was now using a different name. The local authority apologised over this.

66. Social care began enquiries into concerns that Child P's older half sibling was being left to supervise her and was not able to do so competently. Mother later phoned the police to report her own concerns about her son's aggressive behaviour to Child P, as well as to their cat. Authorities continued to seek a suitable residential adult care placement for the half sibling or a respite arrangement. Records indicate that Child P continued to achieve well and flourish at school

67. In September 2012 Child P began the school year. Additional support for Child P was identified and this also allowed additional contact between her mother and the school. The family court judge ordered two exploratory sessions of supervised contact between Child P and her father. East Sussex social care was asked to write a report on the sessions and both parents were required to attend a parenting information session (which is a common step in cases where parents are experiencing difficulty in making suitable arrangements).

68. In October 2012 the father saw his GP about further depression and reported that he had been suspended from work because of an argument with a colleague. This was one of a series of repeated, lengthy consultations about his depression and the impact of not having contact with his daughter that he had with GPs throughout the period under review. These consultations were with a large number of different GPs. At no point did he say anything which indicated a threat to harm either the mother or Child P.

69. The GP consultation resulted in a further referral, this time to a psychiatrist in the adult community mental health service. The referral noted the differences in opinion between the psychologists as to the father's suitability for treatment. This led to a full psychiatric evaluation of the father which resulted in a referral for a further assessment for suitability for CBT, though noting that there was a lengthy waiting list. In the meanwhile the father continued to be prescribed medication for anxiety and depression. The further assessment for CBT took place in March 2013 and similarly concluded that the father was not likely to respond positively to CBT as he had no motivation to change his strongly held beliefs. He was also not eligible for NHS mental health

treatment (other than that which could be provided by his GP) as he did not have significant mental health problems or 'increased levels of risk'.

70. In November 2012 the family court ordered a further four supervised contact sessions. The final hearing was listed for May 2013 and the local authority was asked to provide an updated report on contact and a report from Child P's school.

71. There was now an East Sussex allocated social worker. Records show five sessions supervised by the allocated social worker in December and January 2013 (including one that had been arranged under the terms of a previous order).

72. In January 2013 the school noted some deterioration in Child P's behaviour.

73. East Sussex social care reported on the sessions to the court in February 2013. It concluded that there had been difficulties in the way in which the father interacted with Child P, beyond those that might be expected to arise from awkwardness and unfamiliarity. The father seemed preoccupied with using the sessions to find out about Child P's life with her mother and seeking evidence against her, rather than interacting with Child P in a way that would 'put her at ease and lead to a positive experience of contact for her'. The report noted that Child P's mother did not feel that contact was having any benefit and would not agree to unsupervised contact.

74. Noting that the original expert opinion had advocated up to six months of psychological treatment, the local authority reported that it could not continue to fund the provision of contact and proposed that he make provision for this himself.

75. It is striking (though not in the end significant) that even in the course of the preamble to the local authority court report, apparently innocuous information was provided (about the location of the social work team undertaking the work, and the fact that the mother attended an evening class on Wednesdays) which might have assisted someone who was determined to trace the family.

76. The court agreed with the recommendations of the report, ordering that the father should fund further supervised contact and provide notes of the sessions to the court. The social worker was asked to establish Child P's wishes and feelings and to obtain an updated report from the school. A final hearing of the applications was scheduled for May 2013. In the meanwhile arrangements for indirect contact would resume.

77. It is not clear from the records how the father, who had very limited means and no obvious network of support, would make provision for contact to be supervised and reported to the court.

78. The May 2013 court final hearing was re-listed for June 2013. There had been no indirect contact and no involvement between the local authority and Child P over this period.

79. In June 2013 the mother informed the district council of the disclosure of her address by the Court and Tribunal Service over a year before, seeking advice on rehousing. The mother was advised to fill in papers requesting a transfer, and to contact the police, which she did. The mother was rehoused in early August. Mother told school that Child P's previous reported self-harm had a benign explanation.

80. In late June 2013 the father made a further application for contact on the basis that the mother had not complied with the previously made order. Cafcass began safeguarding and background checks and identified the agency's previous involvement. At that point Cafcass had no current knowledge of the circumstances of Child P or where she lived as it had not been involved since 2011. The father's solicitor wrote to Cafcass in July 2013 inviting it to arrange contact, but not to make any further investigations into the background of the case. Background information was received from Brighton & Hove in August 2013 and the papers on the case were consolidated.

81. At the end of the school year Child P was achieving at just above national expectations. She moved to a new school in September 2013, remaining there until April 2014.

<u>Key events while the family were living at East Sussex address 2 (July 2103 – September 2014)</u>

82. In August 2013 the family court noted that there had been no contact sessions. Parties were asked to proceed with supervised contact every three weeks. The case was to be returned to court once there had been four supervised contact sessions.

83. Following the court case the father contacted Cafcass to ask for support in arranging supervised contact. He sought a contact centre in a specific area, indicating that he had some knowledge of the part of Sussex in which the family was living. Cafcass suggested contact take place at a centre in West Sussex, a considerable distance from the family home. The judge indicated a concern that travel distance for the child should be minimal.

84. In October 2013 during contact with Cafcass the father rejected contact at the two centres suggested and indicated that he knew roughly where his daughter lived.

85. The first supervised contact session took place in October 2013. This was the father's first contact with his daughter in approximately 10 months. The mother stated that Child P reacted badly to the contact and so a hold was placed on further contact sessions. Shortly after this she reported the father to the police over an historical allegation of fraud.

86. She had contact with the East Sussex IDVA service indicating her belief that the father did not know where she lived and that as a result she felt safe. She stated that the police had marked her address on records in order to be able to respond in a proportionate way to any concerns

87. In January 2014 the family court judge ordered the reinstatement of indirect contact, with a review hearing scheduled. Neither Cafcass nor the local authority was involved at this point, so neither attended court. The next court hearing was on 29 April 2014.

88. In February 2014 Child P showed some signs of behavioural and emotional difficulties at school. After fighting with another pupil Child P was temporarily excluded (effectively sent home with her mother to calm down for half a day).

89. In April 2014 the mother reported to the police that her solicitor had inadvertently revealed her new address to the father in legal papers. She was concerned that he would seek to remove Child P and that previously he had stated in court that he had been stalking them. She stated that she was very worried for the safety of the children. The police recorded this information correctly in records and sought to pass it to the neighbourhood policing team for further action. It was passed in error to the wrong neighbourhood team where it was closed without further action.

90. It is not certain whether in fact the father received this information (as he had moved house) or whether he noticed it in the correspondence. For some time after this he engaged in a number of clandestine methods to find out the exact address and to establish Child P's routine.

91. In April 2014 Child P changed primary school. This move was not associated with the disclosure of information but appears to have been triggered by the mother's annoyance at how Child P's behaviour had been managed.

92. At the end of April the family court ordered a further period of indirect contact and that the mother should provide information to the father about his daughter's interests so as to assist in this. Consideration was given to the need for a Family Assistance Order to facilitate further supervised contact. The local authority was not positive that this could be made to work, given previous failures. It was indicated that it would not be necessary for the local authority to attend the next scheduled hearing.

93. In June 2014 a relative of the father phoned the police to indicate that he had been out of touch with his own family for several weeks. The father was located by the police and found to be safe and well

94. Child P's end of term school report was very positive, with educational attainment matching national expectations.

95. In August 2014 the father sought action from the local authority to arrange supervised contact. This was at odds with the order made by the family court. The local authority had by that time closed the case, following the previous court hearing. The father made a further court application which was referred to Cafcass. The judge liaised with Cafcass which agreed to appoint a Children's Guardian under Rule 16.4 of the directions governing the management of private family law cases. This recognised that this was a case in which the 'implacable hostility' of the parties was working against the interests of the child and that Child P needed to be separately represented by a Children's Guardian and a solicitor. Cafcass did this and the mother was located.

96. The mother completed court papers asking for her address and new name to be kept confidential from her husband. Cafcass received all of the previous court papers. The father applied for unsupervised contact. The mother opposed all contact on the grounds that it had had a harmful effect on Child P.

97. In September the case was allocated and the Cafcass worker began to make arrangements to gather information and see Child P before the next hearing.

98. Some days later Child P was killed by her father who immediately took his own life.

99. Information provided to the SCR indicates that between May and September 2014 the father had known roughly where Child P was living and that he used the internet, employed others and made journeys to the area to seek to locate her exactly and establish her routine. Professionals were unaware of these activities which only emerged during the criminal investigation into the killing of Child P.

100. It is also now believed that the father had accessed information about Child P and her mother from Facebook. This may have included information that the mother had a new partner and that Child P had been baptised in her local village church.

Appendix II

VIEWS OF CHILD P's MOTHER

Introduction

1. This section summarises information provided to members of the serious case review panel by the mother in an interview. Her views have been set out as she gave them. At significant points in Appendix 1 her views have been added to the narrative account, where they are judged to be significant.

2. Not all of the views expressed by Child P's mother are supported by the records of agency involvement or the assessment of the serious case review. Where this is significant the reasons are explained in section three of the report.

Support in relation to domestic abuse in Brighton

3. Child P's mother gave a detailed account of events during the early period when the family had lived in Brighton (between 2006 and 2009) and there had been less involvement with agencies. During this time the father had in fact been living away from the family home for long periods, while he finished his post graduate education and then while he worked. However he gave professionals the impression that they had been living together for longer, which suggested that he knew what was going on in the family and could speak about it with authority to professionals. It also meant that he made people believe that there had been periods when there had been no incidents of domestic abuse, whereas this was in fact only because the parents were living in different parts of the country. In fact whenever they were together there were episodes of abuse, some much more serious than she had told social care, the police or specialist domestic abuse services.

4. Child P's mother believed that during this time her social worker, who came from the disabled children's team, was suspicious that there were more incidents of domestic abuse. However the father had gone to great lengths to control the information that was provided to professionals, for example by making sure that he had meetings with the social worker, which he used to create the impression that she had a disability and difficulties bringing up the children.

5. In hindsight she realised that this pattern of controlling behaviour led her to doubt herself, to think that it was her who was in the wrong and to underestimate the level of risk that she faced.

6. At one point Child P's mother left the father and moved to temporary accommodation. However she could not sustain living separately from him because of the financial pressures, the pressure from him and her desire to bring a sense of 'normality' to the family (i.e. having a mother

and father who were together). This was the experience that she wanted for her children and it was in line with her religious views. She did not feel that she received much support during this period, but acknowledged that that there had been support from Women's Aid.

7. During their separation the father had been stalking her, trying to find out where she lived. He later admitted doing this in a court hearing in Brighton, though he presented this as having done it for 'her own good' because he was concerned about her and the children.

Travel to the Middle East

8. Child P's mother had travelled once previously to the father's country of origin. She explained why she agreed to go to stay with members of the father's family in 2011. The couple had moved back together earlier that year. There was further domestic violence and an incident that directly affected her son and Child P's mother began to realise that it would not stop. Mother reported being frightened by the intervention of the local authority and the police, who were both concerned about the children. She felt vulnerable and powerless and feared losing the children. She also felt that she had let the children down. There did not seem to be a level of support that matched the fear that she had of the father. He said that he would 'sort it all out' by talking to social services and that she would be better off, out of the way while this happened.

9. Child P's mother said that she unwisely agreed to travel to the Middle East, taking her daughter to stay with members of his family. One sister was very domineering and insisted on taking their passports. This led her to realise that they were at a very high level of danger and to seek support from UK government agencies there and in England to come back.

10. Social care and the police had enabled her to return to the UK; however Child P's mother did not feel that agencies took her fears seriously enough. She told the review that she was disappointed that the local authority had told her husband that she had returned to the UK.

11. Her fears were that the father would either try to attack her, or snatch her daughter. She had never feared that he would kill her, because he wanted to have custody of her. Reflecting back, Child P's mother said she now realised how desperate the father would be to remain in their lives. In hindsight this meant that the refuge was far too close to their old homes and that it would have been much better to go to Ireland or somewhere abroad.

The refuge

12. Soon after she moved to the refuge Child P's mother realised that the father had managed to deceive her bank into sending copies of her statements to his address. She realised that this could reveal her whereabouts by revealing details of her bank transactions. The bank never admitted it had been at fault, but gave her some financial compensation. She had changed her name at about this time, but the mistake by the bank was not what caused her to change her name, as she wanted to revert to her single name for other reasons.

13. Although she realised that the father might try to identify her whereabouts, she did not feel at that point that he was likely to harass her, so she did not ask for protective measures like additional locks and alarms. She always believed that he would see harassing her as 'beneath him', and he was always more likely to do something 'drastic' if he did anything at all.

14. While Child P's mother was living at the refuge, there were discussions about domestic violence to give her support and a greater understanding of the perpetrator's behaviour and its impact on her. For example she discussed diagrams about a 'cycle of violence' (which shows how violence is part of a wider pattern of behaviour within an abusive relationship). However she felt that this work had been 'perfunctory' and the main thing that she felt was that her parenting had been under the microscope and her care of Child P had been scrutinised in a way that made her feel as if she was the problem.

15. Child P's mother did not feel that it was a good environment because a number of the other women residents misused drugs. She also stated that the scrutiny that she felt she was under at the refuge made her feel that 'she was the problem'.

Later house moves

16. Child P's mother reiterated that even when she thought that the father had found her address she did not fear that he would do anything drastic because at that stage he was still living with the 'delusion' that he would obtain full custody of Child P, or at least share custody 50:50. This meant that he would moderate his behaviour so as to appear to be responsible in the eyes of the court.

17. Child P's mother was asked about her requests to move house and how these requests linked with her fears that her address had been disclosed. She confirmed that there had been a lag in time between her believing that the father knew her whereabouts and asking to be rehoused. In part this was because she did not think he would do anything drastic while he still believed he could have the full custody of his daughter. In part it was just too difficult and expensive to move

house, school and break links with people in the community because she was constantly having to budget very tightly. She had invested time and effort into a home and did not want it to be disrupted.

18. She did not think that in the end the father knowing where she lived was the decisive issue. It was more likely that he was motivated by the fact that he believed that the court was going to decide that all contact with Child P should be stopped.

Psychological assessment for the court

19. This took place in early 2012. Child P's mother was extremely critical about the way it had been conducted and its impact. Although it had been established that the father had committed domestic violence, she felt that they were treated as equals as far as the assessment was concerned i.e. they went through the same interview process and the same testing. There seemed to be as many questions about her behaviour and mental health as his, which made her feel that she was as responsible for him for what had happened. She had had to answer for her actions just as much as him. This was exacerbated by the fact the psychologist had interviewed the father first, which made her feel that she was having to answer issues raised by him. She had taken Child P with her to the appointment but had been surprised to find that the psychologist had wanted to interview her immediately after seeing her. She had not known that this was going to happen and felt that it would have been better if Child P had been prepared for the fact that she was going to be interviewed.

20. She had found it difficult to believe that the report had found that her husband was a low risk or no risk to her daughter, but did not know how to respond to this. The report had a 'corrosive' impact on her self-esteem, in part because it also set out her problems and the father's as if they were comparable, not recognising that his behaviour had been the cause of her problems.

21. The assessment did not take account of the fact that the father was a dangerous person, who repeatedly lied about his past. It should have tested what he was telling people, rather than taken it at face value.

Later social work contact and support

22. Mother described one social worker as 'naïve'. One was described as 'astute'. Child P's mother believed that this social worker could not understand why the court was insisting on there being any contact at all between Child P and her father. However her voice did not seem very influential in the court hearings.

23. At times the contact arrangements were very dangerous. Mother described how for a period contact took place in a building that was

next to her daughter's school, so it would be very easy for the father to know about where the family was living, and he could see her school uniform etc. She would naturally want to talk about school friends and activities etc.

Overview / looking back

24. Child P's mother felt that the father had known their whereabouts for some time leading up to the killing and that he may have just been keeping an eye on them to know what they were doing. She believes his motivation for killing Child P was that he feared that the outcome of a new round of court hearings would be that he would be denied contact altogether.

25. Child P's mother regretted that she had not had the courage to give evidence against her husband when he had been violent early on. She would have preferred charges to have been brought, because he did not take any of the other orders or arrangements (for psychological help, contact arrangements etc) seriously.

26. She felt that support had been lacking in the early years and that, as time passed, events that had happened in the early period (such as the fact that the husband had stalked the family) had gradually been forgotten.

27. Child P's mother realised now that having separated had not made her or her daughter any safer

28. She felt that when she voiced fears about what could happen (i.e. that Child P could be abducted or she could be seriously harmed) there was a perception that she was 'crazy'.

29. Child P's mother had been very aware that she risked being viewed as 'obstructive' in the court process to a reasonable resolution if she voiced the level of concern that she had actually felt.

30. She had been constantly in a struggle to fund involvement in the court because of the fear that legal aid would not be available. The fear of financial difficulties constrained all her other choices (for example it meant that it was not realistic to move home throughout the period under review because that was very expensive).

Appendix III

Principles from statutory guidance informing the Serious Case Review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

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

Working Together to Safeguard Children 2015 (Sections 4.9 and 4.10)

Terms of Reference for Individual Management Reviews

1. Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare? Did the agency understand the implications of domestic abuse and mental health needs in their work? Should the practitioners not have worked in this way, comment should be made about the reasons for this.	**Management reviews found that professionals were aware of and sensitive to the needs of Child P and her older half-brother. There was a good awareness of the impact of domestic violence and mental health needs. There are difficulties, inherent in a situation in which parents remain together in a family where there has been domestic violence, which make it difficult for the victim and professionals to have a trusting relationship which are discussed in Section 3.2. The review has recommended that in future agencies need to use the CAADA-DASH risk assessment at intervals through their contact with a victim of abuse so as to ensure that as full a picture as possible of risk is obtained.**
2. When, and in what way, were the child's wishes and feelings ascertained and taken into account when making decisions about the provision of children's services? Was this information recorded? If this work was not undertaken, the reason for this not taking place should be noted.	**Agency records feature very detailed observations of Child P and show a great sensitivity to her needs. The review has identified some concerns about the way in which the needs of Child P were assessed in the psychological assessment, which are discussed in Section 3.7**
3. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?	**Yes. There is no concern that policies and procedures were not followed**
4. Did your agency consider that the threshold was reached for any relevant legal intervention at an earlier stage?	**The family court was involved almost continuously throughout the case history and there were no grounds for seeking any other legal intervention. The family court could have ordered further assessments or made an interim care order, but there were no**

	grounds for this
5. What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way, and if this was not the case, what was preventing this?	**Assessments and decisions were made in an informed and professional way. There are difficulties, inherent in a situation in which parents remain together in a family where there has been domestic violence, which make it difficult for the victim and professionals to have a trusting relationship which are discussed in Section 3.2**
6. Were concerns about these family members shared between the relevant agencies, including commissioned services, in a timely manner, with appropriate communication and analysis? How did your agency work and liaise with services in other local authority areas when this became required – were there any issues with the transition of services? Should communications be reviewed between agencies, in order to identify if there were issues of concern that were not shared?	**There was a good level of information sharing between the agencies involved throughout the case history. Section 3.5 identifies difficulties in information sharing that may arise when a victim of domestic abuse moves across local authority boundaries**
7. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments? If appropriate actions did not take place, what was obstructing this?	**There are no concerns about the services offered to the family, though the report recognises that the mother of Child P did not always view them as positive**
8. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?	**No**
9. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability to the child and family, and were they explored and recorded?	**Services were very sensitive to the disability of Child P's half brother. Sensitivity to issues of religion and culture are addressed in section 3.6 of the report**
10. Were other organisations, professionals, or multi-agency arrangements, involved at points in the case where they should have been?	**Yes. The review has considered in detail the working arrangements between agencies when high risk victims of domestic abuse move across local authority boundaries**
11. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children,	**Work was consistent with policies and procedures**

and with wider professional standards? If this was not the case, what was preventing this from happening?	
12. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?	**The only difficulty identified was that for a period of some months East Sussex County Council could not allocate a social worker to the case. However the work was covered by a senior social worker and there is not evidence that this had a negative effect as this was a period during which there would in any event have been little activity**
13. Was there sufficient management accountability for decision making, including the appropriate involvement of senior managers?	**Senior staff were appropriately involved (for example when Child P was taken out of the UK). At other points this was not perceived as being a high risk case that required senior management input**
14. Include any other information that would be relevant to the SCR Panel.	

How the review was undertaken

1. The review compiled a chronology of key events based on the written and electronic agency records.
2. Agencies which had had involvement with the family prepared management reviews in line with the terms of reference, during the course of which staff and managers who were involved were interviewed and offered the opportunity to discuss their role in the case and views of the services that had been provided.
3. The Serious Case Review Panel had discussions with authors of a number of the individual management reviews and met with the senior investigating officer with responsibility for the investigation into the death of Child P.
4. Members of the Serious Case Review Panel met with the Coroner for East Sussex to discuss how the SCR and the Coroner's Inquest should proceed in parallel.
5. The Serious Case Review Panel discussed and agreed drafts of the report and recommendations.

Appendix IV

SCR REVIEW TEAM MEMBERSHIP

Independent members	
Andrea Saunders	National Probation Service, Independent Panel Chair
Keith Ibbetson	Independent Lead Reviewer
East Sussex Safeguarding Children Board	Business Manager
Agency	**Designation**
Clinical Commissioning Group	Designated Nurse
	Designated Doctor
East Sussex County Council	Head of Children's Safeguards & Quality Assurance
	SLES Manager
Brighton & Hove City Council and East Sussex County Council	Strategic Commissioner Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit
Sussex Police	Child Protection and Safeguarding Manager

Appendix V

Documents and material considered by the Serious Case Review panel

Management reviews provided by agencies based or providing services in East Sussex

Sussex Police (covers all the local authorities concerned)
East Sussex County Council Legal Services, Children's Social Care and Adult Services
East Sussex Healthcare NHS Trust
District Council area where the family was resident
Local authority social care
Sussex Partnership NHS Foundation Trust
Crime Reduction Initiative (CRI) Domestic Abuse Service (a charity which provides a range of services, including the Independent Domestic Violence Advisor (IDVA) service in East Sussex)
Primary care health services

Management reviews provided by agencies based or providing services in Brighton & Hove

Brighton & Hove City Council Children's Social Work
Sussex Partnership NHS Foundation Trust (covers all the local authorities concerned)
Sussex Community NHS Trust
RISE (a domestic abuse charity which provides a range of services in Brighton & Hove, including the Independent Domestic Violence Advisor (IDVA) service)
Brighton Multi-Agency Risk Assessment and Coordination Panel (MARAC)
Western Sussex Hospitals NHS Foundation Trust
Primary care health services

A management review was requested from Brighton & Hove City Council Legal Services, but not received

Management reviews provided by agencies based or providing services in West Sussex

NHS West Sussex Coastal
Primary Care Services

National organisations

Management review by Child and Family Court Advisory and Support Service (Cafcass)

Others

Background information from another local authority area in relation to the mother's history prior to moving to Brighton & Hove

Papers disclosed by the family court

Original records of child protection conferences and core group meetings

Appendix VI

References

HM Government, (2015) *Working Together to Safeguard Children*

Research and reports on domestic abuse and violence

Hilary Saunders (2004) *Twenty-nine child homicides: Lessons still to be learnt on domestic violence and child protection,* Women's Aid

Liz Kelly, Nicola Sharp and Renate Klein (2014) *Costs of Freedom: How women and children rebuild their lives after domestic violence*, Women's Aid / SOLACE

Family Court

Practice Directions on domestic abuse https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12j

Claire Sturge and Danya Glaser, 'Contact and domestic violence – the experts court report', *Family Law* (September 2000).

Richard Green, Holly Rodger, Sophie Cappleman and Rebecca Dale, (November 2014) *Learning from Cafcass Submissions to SCRs, https://www.cafcass.gov.uk/media/224016/learning_from_cafcass_submissions_to_scrs.pdf*

Cabinet Office, HM Government (2011) Call to End Violence Against Women and Girls: Action Plan, https://www.gov.uk/government/publications/call-to-end-violence-against-women-and-girls-action-plan

Guidance and definitions in relation to MARAC (Multi-Agency-Risk-Assessment-Conference)

http://www.safelives.org.uk/practice-support/resources-marac-meetings

http://www.standingtogether.org.uk/standingtogetherlocal/standingtogethermarac/

http://www.safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

http://www.safelives.org.uk/practice-support/resources-marac-meetings/resources-people-attending

Others

Oxfordshire LSCB (2014) *Serious case review into the death of Child N: overview report*.

CRI (formerly Crime Reduction Initiative) http://www.cri.org.uk/

Claire Sturge and Danya Glaser, 'Contact and domestic violence – the experts court report', *Family Law* (September 2000)

For the cases Re L (Contact: Domestic Violence); Re V (Contact: Domestic Violence); Re M (Contact: Domestic Violence); Re (Contact: Domestic Violence) [2000] 2 FLR 334 we were asked, by the Official Solicitor, to prepare a report giving a child and adolescent opinion on, amongst other matters, the implications of domestic violence for contact.

SECTION 4

IN WHAT CIRCUMSTANCES SHOULD THE COURT GIVE CONSIDERATION TO A CHILD HAVING NO DIRECT CONTACT WITH THE NON- RESIDENTIAL PARENT?

The core question

In our experience the judiciary takes careful account of all the relevant factors and comes to decisions based on the individual needs of the child in question.

From all that is written above, it will be clear that we consider that there should be no automatic assumption that contact to a previously or currently violent parent is in the child's interests; if anything the assumption should be in the opposite direction and the case of the non-residential parent one of proving why he can offer something of such benefit not only to the child but to the child's situation (ie act in a way that is supportive to the child's situation with his or her resident parent and able to be sensitive to and respond appropriately to the child's needs), that contact should be considered. We would go as far as to suggest, acknowledging our limited knowledge of the law, a position in which a father (or mother in certain circumstances) who has been found to have been domestically violent to the child's carer should need to show positive grounds as to why, despite this, contact is in the child's interests in order for an application to be even considered. There could be a requirement that that parent sets out how he proposes to help the child heal and recover from the damage done.

In these situations, it is unlikely that the conditions outlined in (2)(i) above will be met and that contact will be in the child's interests. Domestic violence involves a very serious and significant failure in parenting - failure to protect the child's carer and failure to protect the child emotionally (and in some cases physically - which meets any definition of child abuse).
Without the following we would see the balance of advantage and disadvantage as tipping against contact:

(a) some (preferably full) acknowledgment of the violence;
(b) some acceptance (preferably full if appropriate, ie the sole instigator of violence) of responsibility for that violence;
(c) full acceptance of the inappropriateness of the violence particularly in respect of the domestic and parenting context and of the likely ill-effects on the child;
(d) a genuine interest in the child's welfare and full commitment to the child, ie a wish for contact in which he is not making the conditions;
(e) a wish to make reparation to the child and work towards the child recognising the inappropriateness of the violence and the attitude to and treatment of the mother and helping the child to develop appropriate values and attitudes;
(f) an expression of regret and the showing of some understanding of the impact of their behaviour on their ex-partner in the past and currently;
(g) indications that the parent seeking contact can reliably sustain contact in all senses.

Without the above we cannot see how the non-resident parent can fully support the child, play a part in undoing some of the harm caused to the child and his or her whole situation, help the child understand the reality of past events and experiences and fully support the child's current situation and need to move on and develop healthily.

Without (a)-(f) above we see there as being a significant risk to the child's general well-being and his or her emotional development. Without these we also see contact as potentially raising the likelihood of the most serious of the sequelae of children's exposure, directly or indirectly, to domestic violence, namely the increased risk of aggression and violence in the child generally, the increased risk of the child becoming the perpetrator of domestic violence or becoming involved in domestically violent relationships and of increased risk of having disturbed inter-personal relationships themselves.

(h) Respecting the child's wishes: while this needs to be assessed within the whole context of such wishes,

the older the child the more seriously they should be viewed and the more insulting and discrediting to the child to have them ignored. As a rough rule we would see these as needing to be taken account of at any age; above 10 we see these as carrying considerable weight with 6-10 as an intermediate stage and at under 6 as often indistinguishable in many ways from the wishes of the main carer (assuming normal development). In domestic violence, where the child has memories of that violence we would see their wishes as warranting much more weight than in situations where no real reason for the child's resistance appears to exist.

In addition to the above, which are specific but by no means exclusive to domestic violence, the other evaluations of how the contact will benefit the child need to be made. In particular, the question of its purpose needs answering as there is a great difference between contact, direct or indirect, designed to provide information and, in the case of direct contact, direct knowledge of the parent and contact designed to re-establish, continue or develop a meaningful father-child relationship.