Dorset Community Safety Partnership
&
Bournemouth Poole & Dorset Safeguarding Adults Board

Domestic Homicide Review

Overview Report

Executive Summary

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1. INTRODUCTION

1.1 This domestic homicide review relates to the death of a female adult (A) killed by her son (B) age sixteen, who was arrested and charged with her murder. B was convicted of and was sentenced to Detention at her Majesty's Pleasure with a minimum tariff of fifteen years.

1.2 Domestic homicide reviews take place under section 9 of the Domestic Violence, Crime and Victims Act (2004). The statutory guidance[1] states that a domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by -

a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
b) A member of the same household as himself, held with a view to identifying the lessons to be learned from the death.

1.3 Following the death of A Dorset Community Safety Partnership agreed that the criteria for a Domestic Homicide Review were met and a panel was appointed to oversee the process. The panel consisted of:

Independent	Panel Chair
	Safeguarding Partnership Officer, Dorset County Council
	Safeguarding Manager, Children's Services Dorset County Council
	Service Director, Adult and Community Support, Bournemouth Borough Council
	Detective Inspector , Dorset Police
	Domestic Violence Strategic Co-ordinator, Dorset County Council
	Partnership Co-ordinator, Dorset Police
	Interim Director of Quality and Lead Director of Safeguarding, NHS Bournemouth, Poole and Dorset

[1] Home Office (2011) *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.* www.homeoffice.gov.uk

South West Ambulance Service NHS Trust
Community Safety Manager, Community Safety Partnership, Dorset County Council

1.4 Agencies were asked to give chronological accounts of their contact with the victim prior to her death and where there was no involvement or insignificant involvement, agencies advised accordingly. Since the perpetrator in this review was under eighteen and the son of the victim, it was agreed with Dorset Safeguarding Children Board that the Domestic Homicide Review would consider the involvement of agencies with the perpetrator. The review recommendations relevant to Children's Services would be received and acted upon by Dorset Safeguarding Children Board.

1.5 The following agencies were found to have had significant involvement with either the victim or her son. Individual management reviews were requested and received from:

- Dorset Police
- Dorset Children's Services (including Youth Offending Team, Children's Social Care and Education, Early Intervention Service and Specialist Prevention Service)
- A Housing Association
- NHS Bournemouth Poole and Dorset.
- South Western Ambulance Service NHS Foundation Trust. (Including Urgent Care Service and GP Out of Hours)

1.6 Initial consideration of the individual management reviews revealed that a Children's Society Project had provided services to the family. Records were obtained in order to understand the process of their work.

1.7 It was also apparent that B had previously been sentenced by the local Youth Court. No pre sentence reports had been requested and in order to understand whether this was usual procedure in such cases, a letter requesting information was sent to the Court. The reply informed the final overview report.

1.8 In addition, the overview author has had sight of the pre sentence report and Asset assessment completed by the Youth Offending Team (YOT) after the arrest and conviction

of B. The panel recognises that there had been limited time to undertake a full assessment and that the information was primarily based on self-report by B.

1.9 Records revealed that A and B had spent time in a different local authority area and that B had family in the area. Children's Services from this area were contacted no reference to B was found on their system. However, B spoke to the overview author about the primary school he attended in the area and a children's centre he went to for help with anger problems when he was about seven years of age. Every effort was made by Dorset Children's Services to trace any relevant information and contact was made with primary schools and a children's centre in the area where he lived. No records have been found and it is possible that school records were destroyed in a flood.

1.10 Panel meetings to consider the information within the individual management reviews and discuss the overview report were held on:

- 19th October 2012
- 11th December 2012
- 12th February 2013

Family Involvement

1.11 Significant family members were invited to contribute to the review. A's father and B both expressed a willingness to contribute and were seen by the overview author, who recorded the discussion and shared the record with both parties via letter. The panel would like to thank them both for their contribution; their information and views were used throughout the overview report.

1.12 A's father had the opportunity to discuss the findings of the review with the overview report author and the panel chair. He expressed serious concerns about the possibility of the executive summary being published as, in his view, the case is very identifiable and he was concerned about the detrimental effect of further press interest on the emotional wellbeing of his family.

2. SUMMARY OF KEY EVENTS

2.1 A and B moved to Dorset when B was aged eleven; A having family in the area. B's siblings remained in the previous area with their father. It is suggested that A experienced domestic violence whilst living with the father which may have been witnessed by her children. There was no information in the health records received from the previous area which raised any significant concerns about the family circumstances.

2.2 Soon after arrival in Dorset A was finding it hard to control B's behaviour and there were also behaviour problems, (including an assault on another pupil) within school. The Youth Inclusion and Support Panel (YISP) became involved, a Common Assessment Framework was completed and a plan put in place to provide practical help and support of A in setting boundaries. A YOT worker was also engaged to look at ways that B could manage his anger. Following perceived improvements the case was closed by YISP and notes from the YISP panel sent to Children's Social Care.

2.3 At the age of thirteen, B was arrested for criminal damage to a window following a fight at school. B in interview with the police denied causing the damage and was not charged with any offence. Also at the age of thirteen B was arrested for burglary. He admitted the offence and a 'restorative justice' meeting with the victim was held, which resulted in an agreement that B would make good the damage.

2.4 Two months later, B (age 13 years 9 months) was taken to hospital having been found by the police suffering from alcohol intoxication. A referral was made to a school nurse who saw him two months later at the start of the school year; B declined any help with alcohol problems.

2.5 Soon after he was found intoxicated, B was arrested for assault. B admitted the offence and was given a Final Warning. The final warning process resulted in a notification to the YOT who completed an assessment which noted that B was a "low risk of serious harm to others".

2.6 A month after the arrest for assault, B was known to be often sleeping in a shed overnight

and it was noted by Dorset Police that his mother was not reporting him missing. A safeguarding referral was made to Children's Social Care and an initial assessment concluded that support was required to prevent further escalation of B's behaviour but that since YOT were involved there was no need for input from Children's Social Care. During this period there was an escalation of B's disruptive behaviour within school. A 'Pastoral Support Plan' was developed which included support in lessons and anger management sessions. B was placed on the Special Educational Needs Code of Practice (School Action Plus).

2.7 An assessment by a health worker in YOT recorded that B's mother thought that anger was B's "main problem at the moment" and identified emotional and mental health as the main cause for concern. B was referred by the YOT worker to a Children's Society project for help with anger and alcohol issues; both A and B attended the project for approximately two months after which time both declined further help. Soon after this referral B was arrested for shoplifting two CDs. B was charged with the offence and sentenced to a 4 month referral order by the local Youth Court. This is a mandatory order for a first time offence before the court.

2.8 B continued to show disruptive and abusive behaviour at school and a change of school was planned. Prior to the move B was given a five day exclusion for verbal abuse and threatening behaviour towards an adult. Two days after starting at the new school B was caught smoking, was verbally abusive and threatening to teachers, left the site and subsequently refused to attend. The head teacher was not willing for the planned move to continue.

2.9 A YOT Initial Panel Meeting proposed community reparation for the shoplifting offence, and that work with B would explore the effects of peer pressure, thinking about his behaviour and developing his victim awareness. Anger management sessions with The Children's Society Project were noted as part of the plan although it was at about this time that B declined further help from that service.

2.10 At this time B, now age fourteen was considered to be at the point of permanent exclusion due to disruptive and abusive behaviour in school. This resulted in dual registration

between the school and an out of school centre. B rejected the reduced Year nine time table proposed for him, only attended the out of school centre on three occasions and was referred to the Education Social Work and Attendance Service (ESWAS). During this period, the Housing Association received information about noise from B's flat. No action was taken possibly due to previous unfounded complaints by the same informant.

2.11 The involvement of YOT continued and the YOT final panel (when he was fourteen and half years old) recorded positive progress although a significant ongoing issue at this time was noted to be B's reluctance to engage in education. In respect of attendance, the education social worker encouraged B to attend the out of school centre; this resulted in B attending four times. No formal action was instigated as it was felt that the imposition of an Educational Supervision Order was punitive, unlikely to result in increased attendance, and that a fine would place A in increased debt.

2.12 A telephoned Children's Social Care asking for help with B's behaviour. An initial assessment was instigated and concluded that there was significant evidence of B being the perpetrator of domestic abuse towards A. The social worker identified that the situation required an immediate response to prevent family breakdown.

2.13 A referral was made by the social worker to the Specialist Prevention Service (also known as Adolescent Support) highlighting concerns that B could become physically violent towards his mother. During the next four months Adolescent Support worked with the family to develop positive parenting strategies, encourage clear boundary setting, work with B on anger management and work on communication. By the time that the work undertaken by Adolescent Support concluded the situation was deemed to be 'calmer' with a 'considerable reduction in conflict'.

2.14 During this period, B was arrested for criminal damage in the home whilst he was drunk. B admitted to an alcohol and an anger problem. B was interviewed by Police (YOT provided an Appropriate Adult) and charged with the offence. B was sentenced to a 12 month conditional discharge by the Youth Court.

2.15 Approximately two weeks after B's arrest for criminal damage B was once more drunk in

public and was verbally abusive to an ambulance crew. The Police were called, and they took B to his home address. The attending officers' recorded that in their opinion A was not concerned for his welfare or about the fact that emergency services had had to bring B home. The next day B (age 14 years 8 months) was again seen by police drinking alcohol in public. The alcohol was confiscated and poured away and a safeguarding referral form was completed.

2.16 Educational attendance continued to be problematic and records at the Out of School Centre show that at age fifteen he had a 14% attendance record.

2.17 Children's Social Care closed the case as A was deemed to be able to meet B's needs, and did not want to engage with services. Information from B obtained following the murder of A now indicates that he spent most of his time from this point on until he was arrested not attending school and watching horror DVDs in the flat. B told his grandfather that he did not leave the flat, as when he went out he got into trouble.

2.18 During this period when B was age fifteen Dorset Police recorded concerns that a sex offender might be having contact with B as there was intelligence that A was visiting the sex offender's home. A disclosure was made to A regarding the previous convictions of the sex offender and A agreed that whilst she intended to continue to see the sex offender she would protect B. This incident prompted a referral to Children's Social Care by the Police Offender Management Unit. A letter was sent by Children's Social Care to A advising there was to be no contact between her son and the sex offender. The referral was closed as a contact.

2.19 Around this time there were a number of visits by A to her GP with medical symptoms. These were not however linked with any stress she may be experiencing due to ongoing concerns about B.

2.20 B was offered a college course at the local College; however, this was not taken up and there was some confusion as to whether A and B were leaving the area as A had indicated that they intended to move away from Dorset. There were two visits to the home by the worker from the Early Intervention Service and the possibility of virtual learning was

discussed. B did not attend any education provision throughout the academic year prior to the murder of A. Dual registration between the out of school centre and the secondary school was ended by the school and B remained on the role of the out of school centre until one month before the murder when B was removed due to his age.

3. EVALUATION OF THE QUALITY OF SERVICES

Services to A

3.1 The services delivered to A in Dorset were primarily in relation her role as the mother of B. A was described as one of the GP's most frequent attendees and treatment by the GP of her presenting problems was appropriate. A did not volunteer any information to the GP about the problems she was experiencing with B however; her symptoms may have been seen in context if a link had been made between A and B's records. The current GP self-assessment tool issued by NHS Dorset does advise GP Practices to ensure that they "link family members in medical records especially if they have different surnames so they can be flagged". This case confirms the importance of this approach.

3.2 A was appropriately provided with information on the Dorset Women's Outreach Project, (DWOP) a specialist domestic violence support organisation but she declined the offer of support.

Services to A in her role as mother of B

3.3 This work with A as a parent was characterised by short periods of involvement by specialist services and closure of the case following some apparent improvements. Three periods of specialist provision are identified within the case history. These were; involvement with the YISP, YOT and Adolescent Support Service.

Intervention by the Youth Inclusion and Support Panel (YISP) soon after A and B arrived in Dorset.

3.4 B was eleven years old at this point, and it is important to note that at this early stage A was asking for support, since later it appears that A became defined as a mother who did not wish to engage with services.

3.5 YISP worked with the family for nine months, and it seems that the service was successful in working alongside A and B, providing a range of interventions. There were fifty five contacts with the family in total, indicating a high degree of engagement. The outcomes stated at the point of closure were, however, not necessarily indicative of long term change. For example, the stated outcome that work was undertaken with B to manage anger does not explore how successful this work was. It is noted that B had stayed out of trouble but, in the light of B's past behaviour and family circumstances, there should have been more consideration given to sustainability at this point.

Intervention by the Youth Offending Team

3.6 This period involved intervention by the YOT as a result of a Final Warning following an assault. The Final Warning Profile noted low risk of serious harm to others; however, there is no indication that this was revised when a further YOT assessment contained information indicating concern about B's emotional and mental health. However, the context for this was a view that the assessment was "unremarkable" and that B did not stand out from many of the young people YOT were working with.

3.7 It was a reasonable decision for Children's Social Care to close the case as YOT were involved but this meant that they were unaware of the additional issues that had emerged as a result of the YOT assessment regarding B's emotional and mental health. Although the YOT worker informed this review that the information would have been available to any other professional, a more proactive approach by YOT should have been taken and consideration given to whether the information needed to be shared and with whom.

3.8 By the time YOT involvement finished, the focus of the work was on a Referral Order which had been instigated following a shoplifting incident. It would have been helpful if, at this point, information known to YOT had been shared with Children's Social Care since there were clearly serious concerns about B's access to full time education.

Work with Children's Social Care and the Adolescent Support Service

3.9 This period involved focused intervention by the Adolescent Support Service following the self-referral to Children's Social Care by A, concerned that A could no longer control B.

3.10 There is evidence of a reasonably thorough initial assessment being undertaken by

Children's Social Care which gathered information from the Police and GP. However, the social work assessment did not make reference to the previous involvement of Children's Social Care, nor gather information from YOT. The assessment identified the family's complex history and that A could become physically violent towards B. Had information been gathered from YOT, the information regarding his emotional and mental health and A's concern about his anger might have been given greater significance. In addition the emerging pattern of intervention, followed by short term improvement which was not then sustained, might have been identified. Instead, the work with the family perpetuated this problem, with a short term intervention followed by indications that the situation was calmer and case closure, due partly to the reluctance of both A and B to engage in further work.

3.11 Following on from the initial assessment the strengths based assessment completed by the Adolescent Support Service did helpfully highlight significant issues relating to family history and dynamics. However, since no core assessment was completed by Children's Social Care this was another lost opportunity to bring together all known information from across the professional network, including that known to YOT, identify gaps in information and analyse the situation in relation to the likelihood of change. In fact, there is no evidence at any time that assessments and plans fully considered whether change was likely to be sustained. The case was closed when there were self-reported improvements or a withdrawal from the services being offered by A, B or both. This is a pattern repeated across organisations and was not understood as indicative of increased risk for either B or A.

3.12 It seems that two key issues hampered an understanding of the significance of the family situation and the implementation of more constructive approach to the work with the family:
1. an understanding of the research relating to children's violence towards parents and established frameworks for response, including services for B;
2. a lack of a holistic approach to intervention with B which included a gathering together of all known information, particularly taking account of the impact of poor attendance at school and work alongside schools and the Education Social Work and Welfare Service to address this.

3.13 Intervention may have also been strengthened if the Youth Court had requested a report

from YOT prior to giving a Conditional Discharge, although requesting reports for minor offences is not usual practice. Such a report would have enabled the court to understand the behaviour within the overall context of B's history and may have resulted in a more structured approach to the prevention of re offending.

3.14 Following case closure by Children's Social Care there was no further involvement until they received the notification from Dorset Police that A was spending time with a known sex offender. Given the previous history, simply sending a letter advising A that there should be no contact was insufficient. Consideration of previous records would have revealed that A who was fearful of violence from B, had difficulty in setting boundaries and was therefore unlikely to be able to implement the request to keep B away from the address. An assessment should have been completed in order to understand the current situation and had this been done at this point, it would have revealed continuing problems with educational attendance: a situation which increased risks in respect of B.

The role of Education

3.15 The time period of this review covers the period when B was aged eleven to sixteen, a time when B should have been in full time education. It is now clear that problems with behaviour in school were apparent at the primary stage and worsened as B moved to secondary education. It was not good practice that a pastoral support plan was only put in place when B had been at the school for two years and was at risk of permanent exclusion and there is no evidence that early preventative strategies within the secondary school paid sufficient attention to the development of B's mental health problems. Despite serious violent incidents there is no evidence that a possible referral to Child and Adolescent Mental Health Services (CAMHS) was considered.

3.16 Psychological testing after B's arrest revealed that B is within the category of borderline learning disability. The lack of referral for psychological testing at school meant that there was insufficient attention paid to meeting his specific learning needs. The focus appears to have been mainly on his behavioural problems rather than exploring ways in which he could be appropriately supported to achieve at school. The result appears to be increasing frustration on the part of B, who ultimately opted out of education.

3.17 An additional concern in relation to B's education is apparent confusion over who had overall responsibility for B's education once B was in alternative provision. The joint responsibility between the out of school centre and the secondary school appears to have led to no one assuming overall responsibility for ensuring that the curriculum met his needs, or working together with the Education Welfare Service when B did not attend. The year when B did not attend any educational facility was a crucial period as we are now aware that much of it was spent in the flat watching horror DVDs. It is unacceptable that B's lack of school attendance was not picked up and addressed by any individual or organisation.

Dorset Police's involvement with the family

3.18 Dorset Police had periodic involvement with the family, mainly due to B's behavioural problems. The process of referral to Children's Social Care was inconsistent; at times a safeguarding notice was completed and sent, and on other occasions it was completed but not forwarded. The explanation for this inconsistent approach given within the Police individual management review is:

1. There was a time period when anti-social behaviour problems were recorded locally; a decision on referral was made locally and not forwarded to Headquarters.
2. There was a time period when Children's Social Care asked that incidents of anti-social behaviour were not forwarded to them.
3. Different individuals who did not necessarily have safeguarding children skills were making the decisions.

3.19 The Police individual management review makes it clear that information sharing arrangements have changed since 2010 and that Dorset Police has put in place the Safeguarding Referral Unit with dedicated sergeants who are the decision-makers for referrals.

3.20 An issue which needs further exploration is the extent to which Police Officers (and other professionals) become de-sensitised to the significance of adolescent behaviour. Since so called "normal" adolescent behaviour is likely to put young people at some degree of risk, distinguishing those for whom this risk is heightened due to their family circumstances becomes an important task. In this case information indicates that B's behaviour was

placing both himself and others at risk and this was combined with family circumstances which indicated neglect including A being unconcerned about his whereabouts and failing to report him missing. There was good practice on the part of Dorset Police in making a safeguarding referral to Children's Social Care but the inconsistencies in the responses to B's behaviour over time highlights the importance of the changes in procedures outlined in the paragraph above. Current safeguarding training programmes will also continue to be delivered to all front line police staff and supervisors and will include early identification of risk and measures to mitigate and deal with risk in all domestic violence situations.

The role of Health Services

3.21 One significant issue linked to general responses to adolescents is the response when it became clear that B age thirteen was sexually active and informed health staff that B had a regular partner. The lack of evidence of any exploration of the circumstances surrounding this is worrying and, as highlighted by recent reviews into situations of sexual exploitation[2], professionals need to guard against the tendency to accept too readily the early onset of sexual activity.

3.22 The school nursing service could have potentially played a more proactive role in services to the family and there is little indication that they were actively engaged with the plans for work with B. This may have been more likely had the school nurse read B's records prior to contact, since B's current alcohol issue would have been understood within a broader context including B's angry and abusive behaviour towards A.

The role of the Housing Association

3.23 Although there was little information that would have alerted Housing Providers to major issues within the family there was a lost opportunity to identify potential concerns when they were informed about noises in A's flat. The officer appears to have been deflected by the fact the person raising the concern previously made an unfair complaint.

4. KEY ISSUES ARISING FROM THE REVIEW

[2] Torbay Safeguarding Children Board (2013) *Executive Summary Case 26.* *http://www.torbay.gov.uk/c26executivesummary.pdf*

4.1 Although in many ways the final outcome of this case may be considered to be extreme and rare, analysis of professional contact with the family does provide some important opportunities for learning and practice development. In particular:

1. The recognition of parent abuse.
2. Current knowledge regarding the risk of adolescent parricide.
3. Understanding and availability of appropriate responses where a parent is at risk of harm from their child.
4. Working in the most effective way possible with young people with behavioural problems, including recognising and working with adolescent neglect.
5. Recognising the impact of non attendance at school and responding appropriately.

Recognition of risks associated with violence towards parents by their children

4.2 It is striking that throughout the records there are frequent references to B's anger, and particularly anger directed towards his mother. The clearest articulation of the potential abuse of A was in the Children's Social Care assessment; however, without a clear framework for defining and responding to such circumstances, subsequent services to the family did not adequately address the issue.

4.3 Our current state of knowledge in relation to the abuse of parents is acknowledged to be in its infancy[3] with research showing that social workers may be unfamiliar with the term 'parent abuse'. Practitioners in the field of domestic violence are more ready to acknowledge parent abuse as a form of family violence but are also aware that due to the stigma associated with this form of family violence, it is particularly difficult to identify.[4] The emotional responses of parents to their abuse by their child may be complicated, including feeling that they will be judged as bad parents, fearing the consequences of their child becoming embroiled in the criminal justice system or guilt that they yearned for the child to leave home.[5]

4.4 Self-blame and shame on the part of the abused parent have been shown to be associated with a parental reluctance to seek help and be particularly likely when the abuse seems

[3] Holt, A. (2013) *Adolescent-to-parent abuse.* Bristol: The Policy Press. Page 13.
[4] Nixon. J. (2012) 'Practitioners' constructions of parent abuse' *Social Policy and Society.* Vol 11 Issue 2, pp229-239.
[5] Holt, A. (2013) *Adolescent-to-parent abuse.* Bristol: The Policy Press. Page 51.

targeted only at them.[6] Reluctance to engage with professionals on the part of A, or withdrawing at the first indication of improvement, can possibly now be understood as part of a complex pattern of emotional responses. Awareness needs to be raised across the whole professional network about parent abuse and findings from up to date research in order that the complexity can be understood and effective help given.

4.5 Knowledge in relation to risk factors associated with parent abuse points to the significance of having witnessed domestic violence themselves as a child. In the case of B there is little indication that his early childhood experiences were explored in sufficient depth in order for his current behaviour to have been interpreted in the light of this understanding. Had this been done there may have been more of a focus on his mental health and the need to move beyond short term approaches towards sustained change over time.

Current knowledge regarding the risk of adolescent parricide

4.6 The literature in respect of parent abuse distinguishes between parent abuse and parricide (the killing of a parent by their child), describing parricide as an extremely rare phenomenon that is distinct from parent abuse in terms of its case characteristics.[7] The rarity of such events points to the fact that even if parent abuse had been more clearly recognised it may have been very unlikely that practitioners could have predicted that B would go on to kill his mother.

4.7 However, a review of the limited research into parricide does highlight that this case does have some similarities to a number of the factors known to be associated with a higher level of risk. Whilst this indicates that there were a number of risk factors present this should not suggest that such a violent act could have been predicted. They do, however, point to the need for a more sophisticated understanding of the meaning of adolescent behaviour, access to mental health assessments and taking seriously situations where adolescents appear to withdraw from contact with others, particularly their peers. In fact in this case a reduction in antisocial /offending behaviour was possibly indicative of an increased risk that B's mental health was deteriorating.

[6] Ibid Page 50.
[7] Holt, A. (2013) *Adolescent-to-parent abuse.* Bristol: The Policy Press. Page 3

Understanding and availability of appropriate responses where a parent is at risk of harm from their child.

4.8 The review has raised questions as to how far B should have been seen as a victim of domestic violence and responded to accordingly. Whether such processes were used depends upon whether or not the experience of A was seen as constituting domestic violence. The Police individual management review highlights the issue of how domestic violence is defined and how this definition affects responses; for example, when B was arrested and charged with criminal damage within the home appropriate action was taken in respect of the criminal damage, and the offence would have been placed within the context of understanding parent-child disagreement as common within adolescence. This was not defined as a domestic violence incident since at the time the Association of Chief Police Officers/Home Office definition of domestic violence was an incident between adults aged eighteen and over.

4.9 However, from April 2013 this definition has been amended and now defines domestic violence as: *"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality".* In addition, Dorset Police have confirmed that they will consider reports where under 16s are presenting a risk in relation to domestic violence. Risks will be identified on the appropriate form and dealt with by the Safeguarding Referral Unit officers in liaison with Children's Social Care.

4.10 Whilst the new definition may have prompted consideration of the incident as falling within the realm of domestic violence, the issue of what is viewed as "normal" in families with adolescents may still have inhibited a response which included services to A as a victim. Organisations should therefore be wary of being lulled into a false sense of security that changing definitions will automatically change responses.

4.11 The experience of A was more likely to be understood if the current situation with B was assessed in relation to A's previous experiences. As identified above, there are many psychological and emotional barriers preventing parents from admitting that they are being abused by their children. In the case of A her own experiences may have increased her tolerance to abuse within the home and the likelihood that A would not consistently bring

this to the attention of others. The fact that A did from time to time speak of her fear of B should have been seen as an alert, and understood within this context.

4.12 Our current legal framework for managing such situations has limitations. The existing criminal law constructs the child as a criminal and the parent as responsible for the behaviour whilst child care legislation is based on the principle of protecting the child from harm and is not equipped to deal with situations where the child may be harming the parent. In view of the limitations of the current legal framework, it is important for organisations to work together and consider how to most effectively develop clear pathways for response using domestic violence processes.

Responding to "problematic" adolescent behaviour

4.13 The impact of beliefs and values regarding adolescent behaviour on professional responses has been highlighted by recent reviews into sexual exploitation[8] as well as research into adolescent neglect[9] and other reviews of practice. Dealing with the presenting behaviour and regarding it as "normal" for young people in this age group may become a feature of practice, particularly when professionals are dealing with large numbers of challenging or vulnerable young people on a day to day basis.

4.14 In this case is notable that, when it was clear that B was sexually active he was dealt with within Fraser guidelines[10]; but there was little consideration of the context which might be driving this behaviour, nor the potential risks to others involved. There was also a high tolerance of alcohol misuse at a very young age by all concerned and little curiosity shown by the school nurse regarding B's social circumstances or reasons for his behaviour.

4.15 The Police individual management review notes that B's behaviour would not have been seen by police officers as outside the normal range of adolescent behaviour and the YOT report is clear that B would not stood out within their service. In addition when B went before the youth court they did not feel that a social report was required prior to making a

[8] See for example: Rochdale Safeguarding Children Board (2012) *Review of Multi-agency Responses to the Sexual Exploitation of Children* Page 10

[9] Rees, G., Stein M., Hicks L., & Gorin, S. (2011) *Adolescent Neglect: Research. Policy and Practice.* London: JKP.

[10] The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice

decision in his case. The issue must therefore be how to assist professionals in distinguishing between adolescent behaviour that is within an expected range and that which is indicative of deeper underlying problems. Making this distinction will require very robust multi agency information sharing and assessment across schools, YOT, Children's Social Care and the Police, which was not always apparent in this case.

4.16 There are also clear indications that a fuller assessment of parenting capacity would have assisted decision making, particularly in relation to engagement with services and capacity to change. There were aspects of parenting behaviour that could be described as neglectful, the most apparent being when A failed to report B missing when B was found sleeping in a shed. The response to this episode appears to have focused on B's problematic behaviour rather than identifying the behaviour of A as neglectful and working with the case from a child protection perspective. This could have included further exploration with A about her feelings towards B and their relationship, and might provide further opportunities for understanding the meaning of B's behaviour. The picture presented to this review is of a mother who was struggling to cope, was feeling increasingly powerless and distanced herself from B as a coping mechanism.

4.17 Such a professional response to potential neglect of adolescents is not uncommon and research into serious case reviews in respect of children has identified that young people may be labelled as "hard to help" and professionals fail to explore the underlying *causes* of their behaviour.[11] It should, however, be acknowledged that in some instances defining adolescent neglect may be challenging and there are gaps in our knowledge base regarding whether there are causal links between neglectful parenting and young people's behaviour[12]. However, in this case there appears to have been too high a tolerance of a parental behaviour which could be defined as neglectful.

4.18 There was also a tolerance of what was seen to be low level violence by B which could have been understood as part of a pattern which included an increased risk of violence within the home. Parent abuse has been found to be part of a broader pattern of violent

[11] Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R. Dodsworth, J. Black, J., (2008) *Analysing Child Deaths and Serious Injury Through Abuse and Neglect: What Can We learn?* London DCSF Research report DCSF-RR023

[12] Rees, G., Stein M., Hicks L., & Gorin, S. (2011) *Adolescent Neglect: Research. Policy and Practice.* London: JKP. Page 111

behaviour, with one study identifying that in 63% of cases where a young person abused a parent they were also violent to others outside the family.[13]

4.19 This framing of B's behaviour as within the normal range appears to have precluded a referral to Child and Adolescent Mental Health Services (CAMHS) although this was spoken about on one occasion. With hindsight, the combination of factors known across the network, particularly the potential impact of early family experiences should have prompted consideration that B's behaviour, although apparently not unusual, could be linked to issues that required specialist help.

4.20 Supervision is one forum where staff can be given the opportunity to explore their intuitive responses or biases that may be impacting on their practice. There is little evidence contained within the individual management reviews that supervision in any organisation promoted critical reflective practice and enabled staff to explore the factors that were driving their decision making. Good, effective supervision within Children's Social Care, for example, would have questioned whether sufficient capacity to change had been demonstrated, and questioned the advisability of simply sending a letter to mother when she was known to be in contact with a known sex offender. Instead records suggest that the focus on management oversight was on closing cases.

The provision of alternative education following school exclusion

4.21 B was excluded from school on five occasions; three were due to a physical assault on a pupil, one was drug and alcohol related and another due to persistent disruptive behaviour. Whilst there are clear lessons regarding the effectiveness of assessment planning within the school environment, one of the key questions raised by this review is how B managed to be absent from education for the best part of two years.

4.22 The problem stems from the point at which he transferred to out of school service and dual registration was agreed. In his report into The Edlington Case[14], Lord Carlile recommends

[13] Biehal, N. (2012)" Parent Abuse by Young People on the Edge of Care: A Child Welfare Perspective." *Social Policy and Society.* Vol. 11 Issue 2 pp251-263

[14] Carlile (2012) *The Edlington Case: A review by Lord Carlile of Berriew CBE QC.* https://www.education.gov.uk/publications/eOrderingDownload/The%20Edlington%20case.pdf

that when a child is excluded, the excluding school should retain the responsibility for the education of the child and that there should be an underlying assumption that special provision should be provided on the same campus of the school itself. In this case if the school had retained responsibility for B it is less likely that B would have been at home for the extensive period prior to the homicide. The cultural shift in Dorset resulting in schools taking responsibility for attendance is noted by the panel, but more work should be done to ensure that lines of responsibility are absolutely clear so that young people do not fall between the net. This is a national as well as a local issue.

5. CONCLUSIONS

5.1 This is an extremely tragic case for all concerned and it is important that all possible steps are taken to learn lessons and improve practice in the future. The overarching conclusion must be that it would have been impossible to predict accurately that A was at risk of being murdered by B, and that practitioners generally acted in good faith within their current knowledge base and work environment. However, there were lost opportunities to act differently and lessons that can be learnt which should improve the response to similar situations in the future.

5.2 Specific opportunities to intervene differently were:

1. The GP practice linking A's and B's records and assessing A's presentation with physical symptoms within her family context.
2. Referral to domestic violence services once A spoke of being scared of B and his anger towards her.
3. Recognition of the potential impact on B of his early childhood experiences and deeper consideration of the causes of B's behaviour.
4. A more coordinated approach to assessment and intervention across YOT and Children's Social Care.
5. Recognition of adolescent neglect.
6. B being referred for psychological testing by the school in order to establish the

precise degree of his learning difficulty.

7. Involvement of mental health services with B: i.e. referral by YOT, Children's Social Care or school.
8. The education system ensuring that one school had responsibility for monitoring B's attendance when B was referred to the special unit.

5.3 It is arguably the last factor above that had the potential to make the most difference in this case in the year leading up to the homicide. There are indications that B isolated himself in order to self-manage his behaviour and that through spending time alone in his room, watching horror movies, frustrations built up. Ensuring that B accessed some form of education outside the home would have prevented the isolation as well as providing further opportunity for assessment and understanding of any mental health problems that needed attention.

5.4 Would a better understanding of parent abuse and services for A as a victim have made a difference in this case or, was the act of violence so extreme and rare that nothing anyone could have done would have prevented her death? The evidence from the case, combined with current knowledge suggests that, whilst more effective responses to A as a potential victim of violence from B may have helped her to articulate what was happening and take steps to keep herself safe, this alone would not have been enough. In addition, work with B needed to move beyond a focus on anger management to a fundamental understanding of the causes of his behaviour and his likely mental health problems. Practitioners need skills in differentiating so called "normal" adolescent behaviour from that which is indicative of deeper problems, and greater access to mental health services to assist them in their work. Fundamental to this approach must be an education system which always fully assesses young people's learning needs, including where there may be a learning disability and crucially, takes full responsibility for identifying those young people who are not attending any education provision.

5.5 The review has identified that recognising and responding to situations where a parent may be being abused by a child is not easy. Our knowledge base in relation to this form of abuse is in its infancy and raises many complex issues which affect responses. Our child care system is understandably focused on the wellbeing of the child and naming what is

happening may be hard for parents due to fear that they will themselves be blamed for poor parenting. This, combined with the complexities of identifying the factors that may be associated with parents at risk of severe harm including death, means that if organisations are to be able to respond effectively in situations such as this a fundamental review is needed of policy and practice at both a national and local level. This should include:

1. Identification of parent abuse within the child protection guidance and awareness-raising amongst child care professionals.
2. Clarity regarding the use of the Multi Agency Risk Assessment Conference process in such situations.
3. Review of access to child mental health services

6. RECOMMENDATIONS

Understanding of parent abuse is in its infancy and practitioner awareness therefore needs to be developed alongside a strategy for service delivery.

6.1 Dorset Safeguarding Children Board and the Dorset Community Safety Partnership should work together to develop a strategy which provides a clear pathway for intervention, taking account of the needs of the parent and the child.

6.2 Practitioners working with children and adults should receive information about parent abuse and appropriate structures and tools to assist their practice.

Adolescent neglect and its impact was not fully recognised and understood.

6.3 Dorset Safeguarding Children Board should promote a greater understanding of the signs, indicators and impact of adolescent neglect, and the potential confusion between expected adolescent behaviour and behaviour resulting from compromised parenting.

6.4 Dorset Safeguarding Children Board should work with partner agencies to ensure that senior managers are clear with front line staff about the expected response to adolescent neglect and that this is taken into account when reviewing priorities and resources.

Throughout the history of this case there is no indication that children's mental health services (CAMHS) were considered as a possible source of help to B and A.

6.5 The strategy for the delivery of CAMHS services across Dorset should be reviewed in line with the recommendations of Lord Carlile's review of The Edlington case with a view to developing links between Children's Services and CAMHS to achieve the best possible assessment and response to conduct disorder.

There was a lack of curiosity by all those working with B regarding B's early childhood experiences, family relationships and the impact that these may be having on B's behaviour.

6.6 Schools should ensure that every effort is made to retrieve information from previous schools when pupils move into the Dorset area.

6.7 Children's Services should promote assessment practice within Children's Social Care and YOT that gathers information about family history and background from the young person themselves as well as significant family members.

Non school attendance for any school age pupil should be risk assessed taking account of all known information across Children's Services.

6.8 Children's Services should ensure that a full assessment that addresses risk issues is carried out for any pupil whom it has been impossible to engage in education. This should take account of any known information from Education, Social Care, YOT and health organisations.

There was a lost opportunity within the GP practice to link the records of B and his mother.

6.9 The importance of the current GP self-assessment tool implemented by NHS Dorset should be reinforced in respect of question 13, which focuses on linking family members within GP records.

There was a lack of clarity regarding the use of the MARAC system in cases of parent abuse

6.10 The Community Safety Partnership in Dorset should request that the MARAC Steering Group review the MARAC Operating Protocol in order to ensure that they address the use of MARAC in situations of parent abuse.

6.11 The Chair of the Community Safety Partnership should bring the findings of this review to the attention of the MARAC Steering Group who will liaise with CAADA (Co-ordinated Action Against Domestic Abuse) to inform national guidelines.