Title:	A serious case review: 'Child L': a domestic homicide review: 'Adult L': the executive summary.
LSCB:	Lancashire Local Safeguarding Children Board
Author:	Peter Maddocks
Date of publication:	2015

Lancashire
Local Safeguarding Children Board

Lancaster District Community Safety Partnership

A Serious Case Review

'Child L'

A Domestic Homicide Review
'Adult L'

The Executive Summary

April 2015

Introduction

1. This is a combined domestic homicide and serious case review that was commissioned following the death in April 2013[1] of a 40 year old woman (the adult victim) and her six year old and only child (Child L and the child victim) and the attempted suicide of the 34 year old child's father (the perpetrator) who had killed them both and had then attempted to take his own life.

2. It is a tragic incident that has caused great distress and confusion for the family, friends and other people who knew the family, many of whom have contributed information to help inform the findings of the review to help understand what occurred and to support professional learning in regard to a very rare and unusual set of circumstances. It has also caused ongoing emotional and mental trauma for the perpetrator.

3. The taking of life is the most serious of crimes. This tragic incident occurred shortly after the perpetrator had first experienced symptoms of what was later diagnosed as a psychotic illness and he was due to participate in a mental health assessment just a few hours after he took the lives of his family and attempted to take his own. There had been no clear indication that the perpetrator had prior thoughts or any motivation to harm himself or to cause injury to anybody else.

4. The killings were entirely out of character and are difficult to comprehend for all who knew the family as well as for the perpetrator himself. Such deaths which are variously referred to in the relevant research and other literature as family annihilation or familicide are very rare within the UK as well as in other countries.

5. It was a late morning in early April 2013 when the police were summoned to a domestic property in the county. On arrival they had found the adult victim and Child L already deceased and the perpetrator suffering from multiple self inflicted and life threatening stab wounds in several locations on his body. He was arrested on suspicion of murder and was taken to hospital where he survived his self inflicted injuries. His general physical fitness combined with the speed and quality of the medical treatment including the paramedical care at the scene as well as at the hospital was a significant factor in saving his life. He subsequently appeared in court charged with two counts of murder and was remanded in custody although was transferred to a secure hospital to receive ongoing assessment and treatment.

6. The perpetrator subsequently pleaded guilty to manslaughter on grounds of diminished responsibility. He has been diagnosed with a psychotic mental illness, a delusional

[1] The review was completed and the findings presented to the Lancashire Safeguarding Children Board and the Lancaster District Community Safety Partnership in January 2014 although the report could not be finally published until the completion of all parallel processes in 2015.

disorder to which both the prosecution and the defence agreed on the diagnosis. The perpetrator is to remain in hospital indefinitely under S37 of the Mental Health Act 1983[2]. He will also be subject to a restriction order under section 41 of the same legislation.

7. Child L and the adult victim were not known to any of the specialist services in the county. They were both registered with the GP as was the perpetrator. Child L attended a local primary school.

8. Less than 24 hours before the deaths, the perpetrator had consulted his GP about feeling low in mood and had reported hearing voices in his head. He had been accompanied by the adult victim to the surgery who was concerned about her partner's behaviour. There had been no previous mental health difficulties.

9. The GP who had recent experience of working in psychiatric services took a detailed history and contacted the single point of access to mental health services requesting a prompt assessment of the perpetrator's symptoms. An initial assessment was conducted by telephone the same day and a follow up face-to-face meeting was arranged for the following day with a mental health practitioner (MHP1)[3]. The mental health practitioner is a mental health specialist who with their other colleagues has undertaken specific training and has several years experience before working in the team.

10. This appointment with the mental health practitioner was not kept due to the events already described in the first paragraph.

11. The deaths were reported to the Lancashire Safeguarding Children Board on the 10th April 2013 and was considered by the serious case review group on the 7th May 2013 who recommended to the independent chair of the local safeguarding children board that the circumstances of Child L's death met the criteria for a mandatory serious case review. The Chair of the Lancaster Community Safety Partnership was notified on the 11th April 2013 and community safety partnership was notified on the 13th April 2013.

12. The serious case review was commissioned by Nigel Burke, the independent chair of the Lancashire Local Safeguarding Children Board on the 7th May 2013. The domestic homicide review was commissioned by City Councillor David Smith, the Chair of the Lancaster District Community Safety Partnership on the 7th May 2013.

[2] This is a court order imposed instead of a prison sentence, if the offender is sufficiently mentally unwell at the time of sentencing to require hospitalisation. The psychotic illness was diagnosed several weeks after the killings.

[3] The single point of access is through telephone, fax or post. The referral was triaged by a mental health practitioner (MHP1) who made contact with the service user the same day the referral was received.

13. The review panel at their first meeting on the 24th June 2013 confirmed the scope and terms of reference for the review. The scope and terms of reference of the review was routinely discussed and updated at subsequent panel meetings to take account of any new or emerging information and reflection.

14. The purpose of the review is to establish what lessons are learned from the case through a detailed examination of events, decision-making and action. In identifying what those lessons are, to improve inter-agency working and better safeguard and promote the welfare of children in Lancashire and reduce the incidents of domestic abuse (although this is not a case that involved domestic abuse).

Position	**Organisation**
Annie Dodd	Independent reviewer and chair
Peter Maddocks	Independent reviewer and author of the overview report
Early Years Lead	Quality and Continuous Improvement Service (LCC)
Named Nurse Safeguarding Children	University Hospital Morecombe Bay
Assistant Director of Nursing – Safeguarding Adults	Lancashire Care Foundation Trust
Review Officer	Lancashire Constabulary
Quality and Review Manager Safeguarding Unit	Schools Safeguarding and Children's Social Care (CSC), LCC
Safeguarding Manager	Fylde and Wyre and Lancashire North Clinical Commissioning Groups
Acting Principal Social Worker	Children's social care services (LCC)
Designated Doctor Safeguarding and Children Looked After	NHS North and East Lancashire
County Head of Active Intervention and Safeguarding	Adult Social Care, LCC
Named Nurse Safeguarding Children	Blackpool Teaching Hospital NHS Foundation Trust (health visiting and school nursing)
Safeguarding Practitioner	Blackpool Teaching Hospital NHS Foundation Trust (Acute)
Named Nurse Safeguarding Children	Southport and Ormskirk Hospital
Panel Observers/Support	
Business Manager	Lancashire Safeguarding Children Board
Community Safety Officer	Lancaster City Council
Community Safety & Justice Coordinator	Lancashire Community Safety Partnership

15. The perpetrator and other members of the extended families were made aware of this review when it was commissioned. A letter was initially sent by the lead reviewer who

chaired the review panel, who in consultation with the police ensured that the relevant national guidance was complied with[4].

16. The perpetrator's mental health deteriorated following the killings. He was initially judged to be unfit to enter a plea for the purpose of the criminal proceedings. In view of his mental health it was considered inappropriate to seek any direct contact with him. This decision was taken in consultation with the medical team providing care and treatment.

17. After the completion of the criminal proceedings further contact was made with the perpetrator through the consultant supervising his ongoing treatment and care and the perpetrator confirmed that he was willing to participate in a discussion with one of the lead reviewers.

18. That discussion took place in late 2013 and included one other professional member of the review panel along with a member of the professional team working with the perpetrator.

19. During that meeting the perpetrator talked about his relationship with the adult victim and Child L and his recollection of events and circumstances leading up to the deaths. He was not asked about the reasons or for details about the killing of the adult victim and Child L.

20. The perpetrator recalled feeling very down and depressed. The perpetrator was very distressed by events and still could not believe what had happened. The perpetrator said that the house move had been very stressful. It had coincided with him being unable to work in his landscape gardening business because of the severe weather at the time. The perpetrator acknowledged that he had always been a bit of a worrier and could get anxious about 'nothing'; for example dealing with the routine tax returns, ensuring that they had enough money (which they did). He did not know why he began to feel paranoid and that people were after him. He felt generally closed in, lost and scared and when he began to hear voices he sought advice from the GP.

21. The perpetrator had felt fine about talking with the GP and about the referral to psychiatric services. He had become anxious when the meeting did not happen the same day as seeing the GP and because the hospital was located close to a prison the perpetrator had begun to have feelings of being sent away and possibly locked up. These can now be seen and understood as symptoms of his illness that was at an early stage of developing.

---

[4] *A Guide for the Police and the Crown Prosecution Service and Local Safeguarding Children Boards to assist with liaison and the exchange of information when there are simultaneous chapter 8 serious case reviews and criminal proceedings*; April 2011

22. Almost all of the relatives and friends who were contacted contributed information. All were consistent in describing the family as being apparently happy and were all deeply shocked by the incident.

23. The paternal family had thought that the perpetrator had a medical problem when it was noticed that he was showing unusual symptoms such as drinking an excessive amount of water a few days before the killings. They thought that he possibly had developed diabetes for example. They had also become aware that other aspects of his behaviour had become unusual. For example, he thought people were being 'funny' with him. Initially this was not severe but increased over a period of several days. The perpetrator knew he had some sort of problem but could not identify what it was. The appointment with the GP was made on the expectation that the perpetrator had developed a physical condition such as diabetes and this was having an impact on him along with the usual stress of going through a house purchase and the house move that had been completed three weeks previously.

24. Some of the family felt that the visit to the GP had inadvertently exacerbated the feelings of paranoia (and this was subsequently confirmed when the perpetrator spoke with the reviewers). The GP had asked lots of questions and completed a physical assessment which had not identified any physical problems. The perpetrator was advised that a referral had been made to a local psychiatric hospital service. It is the family's perception that this appeared to have shocked the perpetrator and the adult victim with the suggestion that the perpetrator was mentally ill and a possible expectation that he was to be admitted to a psychiatric hospital.

25. The family felt that the perpetrator had developed a fixation that there was a plan to keep him in the psychiatric hospital. He could not understand why he should be going there otherwise. He had talked a lot about the scheduled appointment.

1.1 The methodology of the serious case review

26. This review was completed using the methodology and requirements set out in the government national guidance in respect of serious case reviews and domestic homicide reviews.

27. A case review panel was convened of senior and specialist agency representatives to oversee the conduct and outcomes of the combined review.

28. Work began on compiling a chronology in June 2013, which coincided with the appointment of the lead reviewers.

29. The panel established terms of reference, identified key lines of enquiry for the review and set a timetable for submission of reports and other evidence and information. This included seeking appropriate contributions from family and friends.

30. The panel established the identity of services in contact with the family during the time frame agreed for the review. For services that had significant involvement they were required to provide an independent management review in accordance with Home Office requirements[5] (and are listed in section 1.4). These reports were completed by senior people who had no direct involvement or responsibility for the services provided to the child or adults.

31. The local safeguarding children board in Lancashire was already working on how future serious case reviews in the county could be developed in order to provide a more productive window into the local systems for safeguarding and protecting children[6] and have participated in regional and national pilot work on using system learning within serious case reviews developed by SCIE (Social Care Institute for Excellence).

32. The review panel decided to build on the learning that had been developed from two previous serious case reviews in the county; one of those had been wholly conducted using the SCIE framework and another serious case review had used the framework to present the findings from the review.

33. The analysis in the final chapter of this report uses some of the framework developed by SCIE to present the key learning within the context of the local systems. This also takes account of recent work that suggests that an approach of developing over prescriptive and SMART recommendations have limited impact and value in complex work such as safeguarding children[7]. The final chapter of the review for example explores the influence of professional self confidence and calibration of risk and the tools that are used by professionals to help inform their judgments and decisions.

34. The panel agreed case specific terms of reference that provided the key lines of enquiry for the review and were additional to the terms of reference described in national guidance.

---

[5] The revised *Working Together* published in 2013 removed this as a prescribed requirement for SCRs.

[6] Analysis of clinical incidents; providing a window on the system not a search for root causes. CA Vincent; *Quality and Safety in Health Care*, 2004; The article argues that incident reports by themselves tell comparatively little about causes and prevention, a fact which has long been understood in aviation for example and is the basis of developing a systems learning approach to serious case reviews in England.

[7] Department of Education, September 2011, *A study of recommendations arising from serious case reviews 2009-2010*, Brandon, M et al, Current research about how the learning from serious case reviews can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation through over complex action plans

a) What knowledge or information did agencies have that indicated the adult victim might be a victim of domestic abuse, or that child L might be at risk of significant harm?

b) What services were offered to the adult victim, the perpetrator and child L and were they accessible and sympathetic?

c) What information did family and friends have that might have indicated the adult victim and/or child L were at risk of abuse?

d) What knowledge did agencies have that the perpetrator might be a perpetrator of abuse and pose a risk of significant harm to child L or the adult victim?

e) Were there any risks in relation to resources or capacity that had an impact on how services were provided to the victims or to the alleged perpetrator, or that impacted on agencies' ability to work effectively with other services?

35. The panel established the identity of services in contact with the family during the time frame agreed for the review. For services that had significant involvement they were required to provide an independent management review. These reports were completed by senior people who had no direct involvement or responsibility for the services provided to the children and their parents.

36. The following agencies have provided an individual management review that was completed in accordance with *Multi-agency statutory guidance for the conduct of domestic homicide reviews* (it is no longer a national requirement in *Working Together to Safeguard Children 2013)*.

a) Blackpool Teaching Hospital NHS Foundation Trust (provided health visiting and school nursing services)
b) NHS England (GP services for the whole family)
c) Lancashire Care NHS Foundation Trust (provided the single point of access to mental health services)
d) Lancashire Constabulary (historical information and investigated the circumstances of the killings and the subsequent attempted suicide)
e) Southport and Ormskirk Hospitals NHS Trust (services provided in July 2010 by the accident and emergency department at Southport and Formby District General Hospital to the adult victim and Child L and the services provided by the paediatric

accident and emergency department at Ormskirk District General Hospital to Child L in regard to scald injuries that occurred during a camping holiday)[8].

f) The independent kindergarten service where Child L attended a nursery until he began school
g) Two primary schools attended by Child L (second primary school because of the house purchase and move)
h) University Hospital Morecambe Bay (provided midwifery and accident and emergency services)

37. Information that was sought from other services at the outset of the review is described in the appendix to this report. Written information was received from a Walk In Centre that provided treatment for Child L when had a scald injury.

The summary of findings from the review

38. Familicide is defined as "a multiple-victim homicide incident in which the killer's spouse or ex-spouse and one or more children are slain[9]". It remains a relatively understudied phenomenon and there is very limited information or research in regard to family annihilation or familicide.

39. In domestic abuse there is more usually some prior indication of potential harm and a pattern of escalating behaviour. In regard to domestic and child abuse there is a considerable range of information and research evidence to inform the analysis and development of learning. Because familicide is a rare event there is relatively little data and limited research that can help professionals identify factors that might indicate a heightened risk of it occurring and therefore preventing it.

40. The review considered relevant research which is summarised in the overview report; the research indicates there are numerous motivations for the crime of familicide.

41. The research that is available in the UK draws a distinction between groups of killings. These are described by Yardley, Wilson and Lynes[10] as revenge killings and a second group that is 'altruistic' where the killing serves 'a necessary even if distasteful means towards a desired outcome' or from 'a warped sense of love and loyalty'. Within the group the same researchers go on to describe four categories that are anomic,

[8] The adult victim's foot was dressed for a scald injury and the parents were advised to attend the paediatric accident and emergency department with Child L who had a blister on the abdomen as there are no paediatric emergency facilities at Southport Hospital; the paediatric accident and emergency department is based at Ormskirk Hospital.

[9] Wilson, M., Daly, M., & Daniele, A. (1995). Familicide: The Killing of Spouse and Children. *Aggressive Behavior,*

[10] Elizabeth Yardley, David Wilson and Adam Lynes (2013). *A Taxonomy of Male British Family Annihilators, 1980–2012*; The Howard Journal.

disappointed, paranoid or self righteous. This case appears to have the characteristics of an anomic killing described in more detail in the overview report.

42. Anomic suicide which is also described in the UK study published in the Howard Journal and by other academics including Professor Gelles reflects an individual's moral confusion and lack of social direction, which is related to dramatic social and economic upheaval. Social norms become unclear during times of change. Individual behaviour is less susceptible to social norms and can induce feelings of threatened masculinity. In this case for example the perpetrator had developed concerns that other people might think he was gay (the perpetrator explained that he did not have a girl friend until relatively late adolescence that had been the source of some teasing by family members but had surfaced in his memory when he became unwell).

43. People (and men in particular) may develop feelings about not knowing where they fit in within their communities or societies. This can occur when an individual goes through extreme changes in wealth; while this includes economic ruin, and it can also include windfall gains. In both cases, previous expectations from life are pushed aside and new expectations are needed before an individual can judge their new situation in relation to the new frameworks.

44. In this case the family had moved into a new area having purchased their home with a bequest from the death of the maternal grandmother a month before the killings. The perpetrator had set up a gardening business. The police investigation following the killings has not identified any significant financial difficulties although a colleague of the adult victim's has mentioned feeling that the family did have financial worries perhaps associated with the seasonal nature of the perpetrator's business and the adult victim working only part time. The perpetrator confirmed that he had worried at times about business and the house move had been very stressful for him.

45. On the evening the perpetrator had expressed his concerns that Child L would be bullied and that other people would think he was a paedophile (which has no substantiation but reflected the perpetrator's mental and psychological distress at the time). In a statement to the police after the killings the perpetrator also described his concern about the possibility of becoming a hospital in-patient as result of the mental health assessment and that he would be unable to care for his family.

46. Very little if any of this information was known to any of the services that have participated in this review. Even if they had known all of the information, there was little to indicate from the perpetrator's behaviour or conversation or from his partner to indicate a risk of significant or immediate harm.

47. The review has examined the onset of mental health symptoms for the perpetrator just before the killings. There was no opportunity for either family and friends or the

professional services that were in contact with the family to have predicted and therefore prevented what happened to Child L and the adult victim.

48. Until the untimely and tragic deaths this was a family who were living quietly and without any exceptional or unusual incidents or the involvement of any specialist services or from the police. The perpetrator and his family had become aware that he was not feeling well and had sought advice and help and he was co-operating with the assistance and support being offered.

49. The information for the review describes how the adult victim moved to Lancashire after she and the perpetrator had developed a relationship in 2003 and had quickly planned to have a child. The information provided to the review and analysed in later sections of the overview report includes reflection about how the potential social and economic isolation of women is not part of routine health screening for example when registering as a new patient. The adult victim had become a welcomed member of the perpetrator's family.

50. The review reinforces the importance of routine checking for potential indication of domestic abuse especially when any injuries are observed in or outside clinical settings. For example, both the adult victim and Child L had treatment for different injuries that were described as accidents although there were shortcomings in the level of detail that was checked at the time. There were also gaps in how some of this information was then passed to services such as the GP.

51. This is not to suggest that abuse or violence was confirmed or missed as a feature in this family but it does reinforce the importance of professionals maintaining an appropriate level of sceptical curiosity when treating injuries that may not be accidental.

52. The review has examined the referral to mental health services on the day before the killings. Although there was a prompt response and practitioners complied with the relevant protocol for the initial and immediate response and contact with the patient there is learning and improvement identified, for example in regard to risk assessment and management in new cases with active and untreated psychosis.

53. The review panel agrees with the IMR provided on behalf of the mental health service that a face-to-face mental health assessment should have been given even higher priority with the perpetrator if it had been correctly understood that he was experiencing a first and untreated episode of psychosis; there was a difference of professional opinion between the GP and the mental health practitioner (MHP1).

54. The risks associated with the first episode of untreated psychosis had been a factor identified in a regional domestic homicide review that had led to implementation of clinical guidance in the health service in the county. The protocol was not implemented in this case because although the GP thought that the perpetrator might have been

showing symptoms of psychosis the subsequent assessment by the specialist mental health practitioner did not identify symptoms to confirm such a diagnosis.

55. This is not a criticism of either professional who both had relevant training and experience and can both be expected to make a professional judgment of their own. The review explores some of the factors and influences that contributed to how judgments were made for the purpose of identifying learning.

56. The perpetrator had been the subject of a face-to-face assessment by the GP who made the referral to the mental health service and there was a telephone consultation between the GP and MHP1 and a telephone triage assessment by the mental health practitioner on the same day that he had first disclosed his symptoms.

57. There was a differential diagnosis as to what specific mental health symptoms the perpetrator was experiencing which is described and analysed in later sections of the overview report. Not unreasonably some of the relatives have queried whether the killings could have been prevented if the perpetrator had been seen by a psychiatrist. Regrettably, even if the face-to-face assessment had occurred the same day, this would not have necessarily prevented the killings and the perpetrator's attempted suicide. This would have only been prevented if there had been a decision that the perpetrator required in patient treatment either as a voluntary patient or if the legal thresholds had been met for detention under the mental health legislation or the perpetrator had felt less anxious about no longer being able to care for his family.

58. This would have required evidence that the perpetrator posed a risk of harm to himself or to others. No evidence has been found to indicate that any professional had grounds for such a concern and there was never an indication from the adult victim or from Child L that they had ever felt threatened by the perpetrator at any time.

59. It is impossible and unwise to second guess what symptoms would have been diagnosed in a face-to-face assessment for example with a consultant psychiatrist or what treatment plan might have been identified. There was agreement in the panel and with the benefit of expert advice and opinion that in the presentation of symptoms to the GP and the MHP1 there was no basis to think that in-patient treatment would have been a likely outcome.

The summary of events examined by the review

60. The family had recently moved house that had involved relocation to another part of the county and a change of school for Child L. Child L was settling well. Shortly after that move the adult victim had begun to have the first symptoms of what later developed into a serious psychotic mental illness although this was only diagnosed after he had been arrested and subsequently placed in a secure hospital following the tragic deaths of Child L and the adult victim.

61. Less than 24 hours before the killings, the perpetrator had consulted his GP about his low mood and symptoms. The GP provided an extended consultation with the perpetrator and the adult victim during which a physical examination and history was taken. This resulted in the GP making an immediate referral to the local mental health services while the perpetrator and the adult victim were still at the surgery.

62. The referral had a prompt response from the duty mental health practitioner (MHP1) who made contact with the perpetrator the same morning by telephone although this was after they had left the surgery and were walking in a local park. The telephone call allowed the mental health practitioner to undertake an initial assessment of the perpetrator'symptoms in line with expected standards and procedures. The mental health practitioner was not as persuaded as the GP that the perpetrator was experiencing a psychotic episode; if the mental health practitioner had believed that this was a psychotic episode there would have been a referral for a face-to-face assessment the same day in compliance with the local protocols for responding to first episodes of untreated psychosis.

63. The face-to-face assessment was scheduled to take place at a mental health service at a hospital that is located close to a prison. Following the telephone contact and before the planned appointment the perpetrator became more anxious about his symptoms and had begun to believe that he was about to be locked up. This was symptomatic of his state of mind at the time rather than being based on anything else.

64. The overview report provides more detail about events as well as the relevant research evidence that has been considered for this review. The tragic deaths of the adult victim and Child L were a product of the psychotic mental illness that was just developing. Neither the perpetrator nor the adult victim had indicated any concern about thoughts of harm.

Key themes from the review

65. The response that was made by the GP and the mental health service was consistent with professional knowledge and relevant local protocols. An initial assessment of the perpetrator's symptoms had not identified a risk of harm from the perpetrator or from the adult victim.

66. If there had been a face-to-face assessment rather than the telephone based triage there is no evidence that the perpetrator would have been admitted as an in-patient.

67. The review has highlighted that GP referrals to the Single Point of Access are routinely categorised by GP's as urgent. The Single Point of Access through the duty mental health practitioner has to prioritise those and other referrals which are about 25 a day. The mental health practitioner have to make a judgment about the information from non

specialist health professionals along with the self reported information that the mental health practitioner receives from the patient.

68. The mental health practitioner also have to take account of the thresholds and clinical demand that have to be managed by the Crisis Resolution Home Treatment Team (CRHTT) who have the resource and responsibility to provide same day assessments.

69. The review has identified that at present there is no consistent use of a patient health questionnaire (PHQ-9) that gathers information about mood and thoughts of harm over a preceding two week period rather than just being focussed on symptoms during the consultation.

70. The review also highlighted a need to improve the awareness and knowledge of health personnel providing emergency and routine medical care in regard to signs and symptoms of domestic or child abuse. Although this case did not involve either form of abuse, there was insufficient inquiry and recording about presentations for example at emergency departments following an accident.

Priorities for learning and change as a result of the review

71. A statutory review that requires a detailed examination of professional interaction and decision making will inevitably highlight opportunities, often with the benefit of hindsight, where improvements can be achieved in systems and human judgments. It is for this reason that although the deaths were not predictable this serious case review has resulted in 31 recommendations being made by the agencies and action plans have been developed to implement those actions.

72. The review panel have focussed on identifying lessons that help to continue with the development of effective systems and practice rather than trying to address the unique features of one particular and highly unusual case.

73. The most important points of learning from the review are set in further detail out in the overview report. Although the review has examined an exceptional and tragic set of circumstances that could not have been foreseen or predicted by anybody and therefore could not have been prevented, the services have used the review as an opportunity to analyse and evaluate practice and agency arrangements. A detailed exercise such as this will inevitably highlight opportunities for making further improvements in the spirit of learning and improvement.

74. It is because of that thoroughness required by the review process that all of the IMRs have identified recommendations for their own agency and service.

75. The overview report has not made any other recommendations for a single agency or in respect of multi agency arrangements. The overview report discusses the findings from

the review as they relate for example to the cognitive conditions in which referrals and assessment are made, the processing of information and the tools for supporting professional judgment and decision making.

76. The Lancashire Local Safeguarding Children Board and the Lancaster District Community Safety Partnership are invited to consider the following:

    1. Are there any specific issues to be addressed by local organisations in the development of referral, risk assessment and information sharing between the specialist mental health services and other professionals in the county?

    2. Are the local safeguarding children board and community safety partnership sufficiently confident that current arrangements for recognition and responding to indicators of child or domestic abuse in emergency health settings?

    3. How can the learning from the review be transferred into professional risk assessment and practice?

    4. Are the local safeguarding children board and/or the community safety partnership satisfied with current arrangements described in this review for the identification, assessment and management of risk associated with the onset of psychotic or mental health crisis?

77. A formal response and action plan will be published by the local safeguarding children board and community safety partnership. Progress will be overseen by the Lancashire Safeguarding Children Board and Lancaster District Community Safety Partnership. The serious case review has been submitted to the Department of Education and the Home Office.

78. The review was not the subject of a formal evaluation by Ofsted; that arrangement was ended in July 2012. The Home Office evaluate domestic homicide reviews as being either adequate or inadequate. This review was evaluated as adequate.

79. The serious case review and the associated action plans will be examined as part of the unannounced inspection of arrangements to protect children that takes place in all English local authority areas with children's social care responsibilities.

Signed

Chair of the Lancashire Safeguarding Children Board and Chair of the Lancaster District Community Safety Partnership

DATE

Appendix 1: Single Agency Recommendations

a) Education: No recommendations

b) General Practitioners:

1. Screening for domestic violence

Currently the practice does not screen for domestic violence. The guidance for conducting Domestic Homicide Reviews states that "murder is often not the first attack and is likely to have been preceded by psychological and emotional abuse" and it is recognised that most of those experiencing abuse are not identified by their GP (Richardson et al. BMJ 2002). One study conducted in primary care in the USA put the figure of those identified at fewer than 10%. Questions on domestic violence are now incorporated into antenatal care but as yet there is no consensus on the benefits of routine screening for all. The National Screening Committee found that it did not meet the criteria for a national screening programme, one reason being that there is a lack of evidence on effective interventions for those who do identify themselves. Nevertheless routine reviews such as new patient and post-natal checks may represent the only chances a victim of abuse has to attend the surgery without arousing the partner's suspicion and safeguarding concerns should be borne in mind.

There are a number of screening tools for domestic violence. These include some general, well phrased questions which could be incorporated into routine checks. I would recommend that the practice considers incorporating these into its computer templates. This should be preceded by general training on identification and management of disclosures of domestic violence so that the questions would only be asked in the appropriate setting and manner. Mother's possible social isolation following her move from Lincolnshire may have increased her vulnerability. Such risk factors may be picked up if enquiries are made about wider social circumstances at routine checks and again I would recommend that consideration is given to the incorporation of this.

2. Depression screening for all chronic diseases

Currently screening for depression is only performed for patients with Coronary Heart Disease and Diabetes as part of the Quality and Outcomes Framework. As shown in the critical analysis other chronic diseases (including epilepsy and asthma as suffered by mother and father respectively) are linked to varying degrees with depression and I would recommend that consideration is given to incorporating the two screening questions into all chronic disease reviews.

3. GP Practice/Health Visitor communication

When Child L was discharged from hospital a copy of the discharge letter was sent to his health visitor recommending that his weight gain be monitored. There is no further record of his weight until 2011. It may be that this information is contained in Child L's Red Book but I do not have a copy of this. There is no record of any communication about Child L's weight gain

between the surgery and Health Visitors. Currently the practice has neither a formal nor informal arrangement for regular information sharing with the attached Health Visitors. Consideration should be given to implementing regular two way communication

4. Further exploration of psychological symptoms

Father presented on 29/3/10 with chest pain. During the consultation he disclosed that he was under some stress due to the poor weather as he worked as a self-employed gardener. This is the only mention in the medical records of any psychological symptom prior to 8/4/13. The focus was, as is appropriate, on the perpetrators symptom of chest pain but there does not appear to have been any further exploration of his stress. This may have been due to time constraints or it may have been done but simply not documented. It may have been appropriate to explore this further, perhaps at a separate appointment and I would recommend that consideration is given as to whether disclosures such as this should prompt any further enquiries. I am well aware that I have the considerable benefit of hindsight when making this recommendation and I would again stress that in my opinion this would in no way have prevented the tragic events that took place three years hence.

5. Emergency Department attendances

I feel that the circumstances surrounding the scald to mother and Child L should have been explored in greater detail. It is unclear whether this was not performed due to time constraints, a training issue or requires a change in practice policy. It may be that it had been done but not documented. This case shows us the importance of recording such discussions. Emergency attendances for certain types of injury or frequent attendances may indicate abuse and NICE guideline 89 (2009) recommends we seek an explanation for any injury in an open and non-judgemental manner. Currently the urgent care dashboard will flag up frequent attendees but presumably this would only cover a single hospital trust and an abused child may be taken to a number of different locations for treatment in an effort to allay suspicion. I discussed this with the practice's nurse team leader who felt that the urgent care dashboard could be configured to flag up multiple attendances at different locations. I would recommend that practitioners when they receive an Emergency Department discharge for a child or adult ask themselves whether there may be safeguarding concerns. In the case of injury to an adult which arouses suspicion of domestic violence the "child behind the adult" should be considered and an appropriate risk assessment made.

6. Assessment of risk to others and recording thereof in Mental Health consultations

There is no mention in the records as to whether the GP made an assessment of the risk father posed to others. GP 1 felt it was not necessary to specifically question father on his intent to harm others as his mental state examination and observation of father did not give any indication that this was at all likely. As discussed below there is evidence to support this approach. However he did not document it.

As GPs we are trained to always ask about thoughts of self-harm when a patient presents with a Mental Health issue but under normal circumstances we would not usually ask about intent to harm others. No assessment tool was used in the consultation as this was an episode of

psychosis for which no general practice assessment tool exists. In consultations for depression without psychosis there are a number of possible assessment tools - the Patient Health Questionnaire (PHQ 9), Hospital Anxiety and Depression scale (HAD) and the Beck Depression Inventory being the most commonly used. None of these includes a question on intent to harm others. GP 1 did not ask mother about her feelings in relation to the risk of self-harm or harm to others posed by father. He had already ascertained whether father had any intent to self-harm and it would not have been appropriate to put these questions to mother in his presence. Vinestock (1996) states that when assessing risk to others "the patient's own statements tend to be less reliable and the emphasis is more on behaviour and collateral information".

I reviewed a number of mental state examination templates. Some asked questions about thoughts or intent of harming others and some did not. Although not qualified to comment on whether specific questions should be asked to assess risk to others, I would recommend that risk to others is not only considered but specifically documented in Mental Health consultations as we already do for risk of self-harm. It is important to remember that risk cannot be completely eliminated and accurate prediction is never possible for individual patients (RCPsych 2008). Information regarding more advanced risk assessment tools can be found in the documents listed in the reference section.

7. Consider whether there is a child safeguarding issue when a parent presents with a Mental Health problem

Quite correctly the focus of the consultation was on father who was presenting with a serious mental health problem. However, parental mental health problems are well known to be a significant factor in child abuse, being one-third of the "toxic trio" of major risk factors. We need to be aware when dealing with an adult patient that there may be a "child behind the adult" and ensure that the needs of the child are not overshadowed by the needs of the parents (Keep Me Safe RCGP, 2005). The RCGP Curriculum recommends that physical, psychological, social, cultural and spiritual issues should be considered in the assessment and management of mental health problems.

In the case of Child L the GP was not aware that a child lived with father and mother. In my opinion it would be good practice to make inquiries as to who lives in the household as this may raise safeguarding issues. I must stress that in my opinion GP 1's management of the case remains appropriate despite not being in possession of this information and having this knowledge would have made no difference to the tragic outcome.

All practice staff should have the relevant safeguarding training as recommended by the Intercollegiate Guidance for Safeguarding Competencies (2010). Staff should have training commensurate with their responsibilities - level 1 for all practice staff, level 2 for practice nurses and although GPs only require level 2 training for revalidation it is recommended that they undergo level 3 training as this includes multi-agency working relevant to their everyday practice.

8. Communication between Primary Care and Mental Health practitioners

GP 1 made an urgent referral to the Mental Health team via the single point of access. This was done immediately after father and mother left the consulting room. He was told that father would be assessed that same day but as we know father was actually given an appointment for assessment the following day. In my opinion where there is a change in the original care plan such as this, then that information should be communicated back to the referrer to ascertain whether this is acceptable as the referrer is the person who has actually seen the patient. I do not believe this is the responsibility of the GP and therefore this recommendation would apply more to the Mental Health service. I do feel that communication in general between the practice and Mental Health team should be looked at to enable any other potential problems to be identified.

9. Support for GPs and practice staff
During my interviews at the surgery it became clear that although GP 1 had had significant support from his colleagues in the practice, there was no formal support structure in place at a higher level to help surgeries when affected by such a tragedy. This could perhaps involve a debriefing exercise or counselling support. I would recommend that the responsible CCG considers implementing this as a matter of urgency.

c) Blackpool Teaching Hospital NHS Foundation Trust

1. If bruising is noted that indicated a suspicion or potential domestic abuse, questioning of the adult victim should happen as soon as possible.

2. Domestic abuse training that will address the importance of providing contact details of Women's Aid when domestic abuse is suspected but denied.

3. Ensure all health visitors and school nurses aware of the most recent guidance from DOH 2013 health visiting and school nursing programmes, no.5 Domestic Violence and Abuse Professional Guidance

4. Record keeping training - looking at basic entry details such as time of visits/contacts and also completion of the record regarding information about fathers/significant males living in a household.

d) Southport and Ormskirk Hospitals NHS Trust

1. Continue to raise awareness of signs of domestic abuse via safeguarding training
2. Ensure information is available regarding domestic abuse for patients in the accident and emergency departments.
3. Staff are aware of the importance of documentation and the need for a full history and details of attendance.

4. To develop the Domestic Violence Link Nurse at Southport Accident and Emergency Department
5. Review the Accident and Emergency Domestic Violence protocol to include routine questioning

e) Lancashire Care NHS Foundation Trust

1. The referral form is in need of review to ensure areas of identified risk are focussed and of an assured standard. This will include recording and training aspects.
2. That triage information is recorded on the clinical record system (rather than added to referral form). Citing who has provided the information.
3. That consideration should be given to the use of multi-disciplinary working, increased access to clinical discussion.
4. To review the potential for isolation in the current environment of the Single Point of Access team in Lancaster and Morecambe – small office, lone working
5. To review the interface with CRHT re referrals for urgent assessments.
6. To understand the capacity of urgent referrals and the use of telephone triage
7. Consider whether the Blue Light 71 needs to be revised to ensure risks and vulnerabilities are understood.
8. To review stepped care model and the concept of resources influencing pathways.

f) Kindergarten

1. Awareness raising session for staff on Domestic Abuse and the effects on children especially early years children and babies and the effects on women. (How to spot potential signs and gain support access for parents and children.)

2. E learning CP training for all staff annually rather than the 3 yearly updates at present this would go above and the current recommendations within the EYFS guidance

g) Constabulary

Third party reporting of Domestic Abuse to be written into the new DASH Policy and Supporting Procedures currently under review.

h) University Hospitals of Morecambe Bay NHS Foundation Trust

1. To set up archive evidence index for safeguarding.
2. Specific training from Woman's Aid on domestic abuse to continue to support A+E staff and Midwives and develop skills in the issue of Domestic Violence.
3. UHMBFT A+E to work with Lancaster Women's Aid to raise the awareness of the support available to victims of Domestic abuse.

4. UHMBFT clinical service team to work with the local MAPPA coordinator to strengthen information sharing of individuals who pose a risk to the others who may access care from UHMBFT.