REPORT OF THE SERIOUS CASE REVIEW REGARDING

Child H

CONTENTS

1 INTRODUCTION

1.1 Background to the Review

1.1.1 This review was commissioned by Kent Safeguarding Children Board as a Serious Case Review (SCR) following recommendations to the Board's Independent Chair that the circumstances met the statutory criteria for an SCR because a child had died, and the circumstances of the death indicated it to be the result of abuse or neglect. The criteria being:

(a) abuse or neglect of a child is known or suspected; and
(b) (i) the child has died[1]

This recommendation was confirmed by the Chair on 19th July 2018 and was reported to the National Panel on 23rd July 2018; who confirmed their agreement to the decision on the 26th July 2018.

1.2 The Terms of Reference

1.2.1 Under specific terms of reference, all agencies were asked to report on their work under the following headings: -

- What was life like for the child in this family?
- What was the impact of single-agency and multi-agency working?
- How were assessments, including risk assessments, undertaken?
- What support was provided to the mother regarding her mental health problems, what consideration was given to how they might impinge on her capacity/role as a counsellor, what impact did the mother's role have on how agencies responded to concerns within the family?
- Did the fact that the father was the victim in the domestic abuse impact on how agencies dealt with the family?

1.2.2 The time frame of the review was from 1st June 2017 to 17th June 2018. In addition, agencies were asked to provide a brief background of any significant events and safeguarding issues in respect of Child H's immediate family that fell outside the timeframe if agencies considered that it would add value and learning to the serious case review.

1.3 Review Process

1.3.1 The review was conducted using a systems methodology that: -

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

[1] Working Together to Safeguard Children, 2015 4:18 p 76

- makes use of relevant research and case evidence to inform the findings. [2]

1.3.2 Individual agency reports were received from the following sources: -

- Kent Police
- Kent County Council (KCC) Children's Social Work Services (CSWS), Early Help, and Local Authority Designated Officer (LADO)
- Education Safeguarding: The Education People commissioned by KCC – including School and Childminding
- Kent Community Health Foundation Trust (KCHFT)
- District council
- A Kent NHS Trust
- Primary Care – General Practitioner (GP) services
- A third sector counselling service based in Kent where mother was employed
- Children and Family Court Advisory and Support Service (CAFCASS)

1.3.3 A key part of the methodology was contact with frontline professionals who had been involved with the family. There were two meetings: a workshop where frontline practitioners and their managers examined inter-agency working; and a recall day, where the same professionals discussed the first draft of the report.

1.3.4 The Lead Reviewer was Fiona Johnson, an independent Social Work consultant who was Head of Children's Safeguards and Quality Assurance in East Sussex County Council between 2004 and 2010. Fiona qualified as a social worker in 1982 and has been a senior manager in children's services since 1997, contributing to the development of strategy and operational services with a focus on safeguarding and child protection. She is independent of Kent SCB and its partner agencies, although she previously worked for Kent County Council as the Independent Chair of one of their foster panels.

1.4 Parallel Processes

1.4.1 There were no ongoing criminal proceedings during the review, however, the coronial process was ongoing and had not been completed at the time of writing this report.

1.5 Family Input to the Review

The father and adult half-siblings of Child H were invited to contribute to the review and the Lead Reviewer and LSCB Board Manager met with them all, together. Their input to the review is detailed in section 3 of the report.

2 SUMMARY OF FACTS

2.1 Family composition

Family member	Age at the time of the child's death
Child H	5 years
Half-Sibling 1	22 years
Half-Sibling 2	21 years
Mother	42 years
Father	45 years

[2] HM Government, (2015) *Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children*. London: Crown copyright 2015. [accessed 15/6/2015]

This was a white British family who were living in owner-occupied accommodation, both parents were in employment (albeit mother had been off work sick for some time), the Half Siblings were also in employment or further education.

2.2 Background History

2.2.1 A significant feature of this review was that agencies had limited information about the family history and until April 2018, the only professionals in contact with the family were the GP, the childminder and school staff. The GP had a full history of mother having mental health problems from 1998; this included her having a paracetamol overdose in 1998, being deemed a high risk for a further overdose in 2004, having a history of sexual abuse by her father and experiencing domestic abuse in her relationship with the father of half-sibling 1 and half-sibling 2. Mother was referred to a psychiatrist in 2004, and in 2005 reported having a car accident, suggesting it was intentional. Following this she was treated for depression with anti-depressants and received psychotherapy; she ceased to take medication for depression in 2014.

2.2.2 Mother became pregnant with Child H in 2012. This was an unplanned pregnancy and did not progress smoothly as Child H was found to be a Cystic Fibrosis carrier[3] and mother was treated for probable Idiopathic Thrombocytopenia Purpura[4]. Midwifery had full access to the GP records and midwives were aware of mother's past mental health history; there is no evidence of anything untoward regarding this during the pregnancy. After the birth there was routine contact with mother and Child H by GP and midwife, and no concerns were noted.

2.2.3 The health visitor also had minimal contact with Child H. The child was seen for the new-birth visit but did not attend the 2-year developmental assessment. The health visitor was unaware of mother's history of mental health problems, sexual abuse and domestic abuse as mother did not report any issues and it does not appear that the information was shared by the midwife. Mother did not present as having any problems and so there was no requirement for the health visitor to contact her when she did not bring Child H for the assessment.

2.2.4 Mother was known to the Police because of an alleged historical indecent assault by her father. They also were involved in two further investigations prior to the birth of Child H; one a harassment incident where it was alleged that mother was stealing from a charity, another domestic incident involving her sister; neither allegations resulted in prosecution.

2.2.5 Children's Social Work Service (CSWS) had only one contact with mother which was a request for respite support in caring for half-sibling 2 who was diagnosed with as having Autistic Spectrum Disorder (Asperger's)[5] and Attention Deficit Hyperactivity Disorder. This was resolved by recommending closer working with school support services.

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[3] *Cystic fibrosis* (CF) is a genetic condition affecting more than 10,400 people in the UK. You are born with CF and cannot catch it later in life, but one in 25 of us carries the faulty gene that causes it, usually without knowing. 'Carriers' of a faulty cystic fibrosis gene are **not** affected by the condition. The gene affected by CF controls the movement of salt and water in and out of cells. https://www.cysticfibrosis.org.uk/what-is-cystic-fibrosis

[4] Immune thrombocytopenic purpura (ITP) is a condition which causes the number of platelets in your blood to be reduced. ... If you do not have enough platelets in your blood, you are likely to bruise very easily or may be unable to stop bleeding if you cut yourself. https://www.ouh.nhs.uk/patient-guide/leflets/files/12388Pitp.pdf

[5] Autism spectrum disorder (ASD) is the name for a range of similar conditions, including Asperger syndrome, that affect a person's social interaction, communication, interests and behaviour. https://www.nhs.uk/conditions/autism/ Attention deficit hyperactivity disorder (ADHD) is a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness. Symptoms of ADHD tend to be noticed at an early age and may become more noticeable when a child's circumstances change, such as when they start school https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

2.2.6 In September 2017, mother started a new job as a children's counsellor with a voluntary sector provider. In October 2017, mother was on a family holiday abroad and had an accident where she damaged her knee and was off sick from work. From 1st November 2017, there were seven sick notes issued by the GP for mother, and from February 2018 mention was also made of back-ache. From March 2018 mother was treated with amitriptyline (an anti-depressant) for pain relief.

2.2.7 Child H started attending school in September 2017. Mother and father also utilised wraparound childcare through access to a breakfast club, delivered as part of the school's extended school provision, and with a local childminder. Initially there were problems with Child H's school attendance (which was 83%). The mother's explanation was that the absences were due to illness, Child H had a diagnosis of asthma and mother advised that Child H take paracetamol everyday (previously prescribed) due to the child having asthma, however, school staff did not consider this to be appropriate and asked that this be discussed with a health professional. A school health care plan was drawn up and the child's school attendance improved (remaining above 90%). Child H's name was also added to the Special Educational Needs Register[6], at the parents' request, but by April 2018 the school had not observed any special educational needs so after informing the parents the name was removed from the register.

2.2.8 Child H had a Ventolin inhaler and the childminder was aware of it, but never used it, as there were no asthma attacks observed. In February 2018, mother responded to a health needs questionnaire sent by the school nursing service requesting support and describing Child H as having autism. In this response, mother said she was in contact with the GP about an assessment, however, there is no evidence that this was requested. In March 2018 Child H was seen by a staff nurse at the GP practice because mother reported that the asthma was poorly controlled, and the child was using an inhaler daily. This was not a positive consultation as mother was very resistant to the advice being given.

2.3 Key episode 1: Domestic abuse incidents (10/4/18 - 12/4/18)

2.3.1 On 10th April 2018, Kent Police were called to the family home by half-sibling 1. There had been a dispute between half-sibling 1 and mother. Mother was wanting respite away from the family home and intended to take Child H with her, but the family would not agree to this. There was also a dispute about the dog (which was owned by half-sibling 2) as mother was attempting to re-home the dog without the agreement of the family. Half-Sibling 1 had attempted to remove the dog and Child H from the argument, and at that point mother punched half-sibling 1 in the back. The Police Officers attending spoke to all family members present and after some negotiation it was agreed that they would escort mother to the hospital (with a neighbour) as the family felt that she needed professional help because she was stressed. The family agreed they did not want mother to be charged but wanted her to receive help for her mental health problems. The Police Officers completed a Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) assessment checklist[7] with family members and half-sibling 1 and 2 disclosed some past abuse by their mother. Father also reported that mother would threaten 'to kick the [older] children out of the home' but said that he would never allow that to happen.

[6] Special Educational Needs (**SEN**) is a legal term. It describes the needs of a child who has a difficulty or disability which makes learning harder for them than for other children their age. Around one in five children has **SEN** at some point during their school years. http://www.bbc.co.uk/schools/parents/identifying_sen/

[7] A Dash checklist is a risk identification tool that is aimed at enabling front line professionals to identify the risk of serious harm in cases of domestic abuse.

2.3.2 Mother was taken to the hospital by the Police but there was no direct handover of information from the Police Officers to hospital clinical staff and mother was left in Accident & Emergency with the neighbour. Mother waited for three hours at the hospital, and when she was seen by the Doctor, she reported that there had been an argument at home and half-sibling 1, who was upset by this, had called the Police. Mother was very tearful and said that she did not feel that she required any mental health services. The Doctor undertook a comprehensive assessment; however, he did not contact the Police as this would not routinely be expected. His assessment was that mother seemed very capable and clear about what had happened. The Doctor did ask about Child H and gained the impression that the child was with father and safe. The Doctors were not aware that mother was potentially a perpetrator of domestic abuse.

2.3.3 On 11th April 2018, father told the GP about the domestic incident the previous day and also contacted CSWS who advised that he seek legal advice regarding 'custody' arrangements where Child H would live. Later that day Kent Police were again called to the family home because of a family dispute. On this occasion father called the Police because mother was being verbally abusive and was trying to take Child H from the family home. On this occasion the Police Officers were told that during the dispute mother had said 'all my kids are dead to me' the family also said that Child H did not want to leave with mother. The family were clear that they did not want mother to be criminalised but wanted her to leave the property and seek help. The Officers advised mother to leave the property and seek GP help and she complied. A DASH assessment checklist was undertaken and assessed as medium risk; the Officers were informed about two historic incidences, one six months prior where she had thrown a wooden toy at father and another more historic where she threw a laptop at one of the half-siblings causing an injury to the leg. The Officers spoke to father and provided safety advice and signposted him to the relevant resources.

2.3.4 On 12th April 2018, father again contacted Kent Police as mother was refusing to leave the family home. Mother had returned to the home to remove property but would not leave; the couple had decided the previous weekend to dissolve their relationship. The Police Officers who attended that incident advised her to leave and not return and their stance was much stronger and less supportive to the mother than previously, eventually she left.

2.4 Key episode 2: Father takes actions to protect Child H (13/4/18 –16/4/18)

2.4.1 On 13th April 2018, father made an ex-parte[8] application to the family court for a Child Arrangements Order (for Child H to live with him) and a Prohibited Steps Order (PSO), to prevent mother removing Child H from the family home or collecting the child from school or the childminder; the court granted a PSO on 16th April. As a result of this application, on 17th April 2018 the case was allocated in CAFCASS[9], screened and information was requested from Kent CSWS. From the screening of the application Child H was safe, as the child was in the care of father, who had acted appropriately through seeking protective measures.

2.4.2 On 16th April 2018, a senior practitioner from CSWS contacted both parents to discuss the domestic abuse incidents. The CSWS worker offered to mediate within the family, however,

[8] Latin meaning "for one party," referring to motions, hearings or orders granted on the request of and for the benefit of one party only. ... Ex parte matters are usually temporary orders (like a restraining order or temporary custody) pending a formal hearing or an emergency request for a continuance http://dictionary.law.com/Default.aspx?selected=696

[9] Children and Family Court Advisory and Support Service.
CAFCASS represents children in family court cases in England. Their duty is to safeguard and promote the welfare of children going through the family justice system. CAFCASS Family Court Advisers may be asked by the court to work with families and then advise the court on what is considered to be the best interests of the children – they are involved in three main areas:

- divorce and separation, sometimes called 'private law', where parents or carers can't agree on arrangements for their children
- care proceedings, sometimes called 'public law', where Social Services have serious concerns about the safety or welfare of a child
- adoption, which can be either public or private law.

father declined as he felt he was managing the situation and monitoring and supervising the contact. At this stage CSWS became aware of mother's job and advised her that they would be making a referral to the LADO[10] service. The CSWS discussed the matter with a LADO but did not make a written referral as that was not the system at the time. The LADO determined there was no need to take action as mother had not been charged or cautioned by the Police. This conversation was recorded on the CSWS database, but the LADO did not record it on their system. The CSWS worker also offered mother support via Early Help Services which she refused. Social work staff undertook checks with Police but there was no contact with health or education professionals and the case was closed on 27th April 2018.

2.4.3 On 16th April 2018, father talked to school staff about the domestic abuse incidents and the PSO. He had emailed them earlier, but the school was closed because of the Easter holidays. They agreed arrangements for collection of Child H from school and childminder.

2.5 Key episode 3: Mother makes homeless application (25/4/18 – 9/5/18)

2.5.1 On 25th April 2018, mother made a homeless application to the local District Council. She alleged emotional abuse by father and said that Child H was living with her and that they were both staying with a friend, she also said she cannot work because of health issues. The same day the GP wrote a letter for mother requesting re-housing because she was homeless.

2.5.2 On the 3rd May 2018, mother met with her line-manager at the counselling service and phased return to work was discussed but mother not able to commit as she felt her health was still too poor. Mother was advised that her statutory sick pay ended on 9th May 2018.

2.5.3 On 9th May 2018, the Housing Officer met with mother at her friend's house and during the interview identified that Child H was living with father and that there was a court process ongoing regarding where the child should live.

2.6 Key episode 4: CAFCASS and court assessment (8/5/18 - 7/6/18)

2.6.1 The CAFCASS risk assessment was progressed in May 2018. On 8th May Police National Computer (PNC) checks were requested and a further request was made to Kent CSWS for information, as no response had been received to the initial request. On 13th May 2018 Information was received from Kent CSWS stating there had been "Contact from Step-father (father) with concerns regarding mother's behaviour during contact. Mother advised to seek legal advice. No Further Action." On 21st May PNC information was returned stating no record in respect of either party.

2.6.2 On 31st May 2018, the CAFCASS worker undertook a telephone interview with father. He advised that the application had been issued as mother had attempted to remove Child H from his care. Child H was distressed by this episode, during which father advised that mother assaulted one of her adult children. The Police had been called and he understood they had taken mother to hospital for a mental health assessment. He made allegations that Child H had witnessed domestic abuse perpetrated by mother against himself and her adult child. He noted that he did not know where mother was living and that she had used social media for family pets to be rehomed. Following the making of the PSO he had supported and facilitated contact between Child H and mother.

[10] A Local Authority Designated Officer (LADO) works within each Local Authority area and is there to support staff across all organisations who work with children and young people if any concerns arise regarding any practitioner who works with children and young people.

2.6.3 On 4th June 2018, the same CAFCASS worker interviewed mother. She advised that she had medical evidence that she did not have mental health difficulties, and that she had regular treatment for physical injuries sustained in an accident in 2017. There was, she said, no domestic abuse between herself and Child H's father. She did not believe that father would place Child H at risk of significant harm but expressed concerns about his ability to meet Child H's medical and dietary needs. Between April and May half term her time with Child H had been supervised by father; in the half term it had been unsupervised. Mother wanted Child H to live with her. A follow up call made by the worker later that day clarified mother's account of the incident on 11/04/18. Mother denied assaulting her adult child but acknowledged that it was sad Child H had witnessed the incident.

2.6.4 On 7th June 2018, there was a Child Arrangements Order hearing in the Family Court. A different CAFCASS worker met with father prior to the hearing. Father repeated much of the information he shared in the telephone interview; he had legal representation. He had been facilitating supervised contact and had recently agreed to unsupervised day time contact. Father shared new information that mother was a psychotherapist employed by a local community sector organisation providing services to children; that the school informed him that mother had requested they administer paracetamol to Child H on a regular basis and that mother presented with worrying behaviours and narcissistic tendencies. Mother initially declined to meet with the CAFCASS worker, as her solicitor was not present. Her solicitor did not attend court and mother later agreed to speak with another CAFCASS worker. Mother denied the allegations raised by father. She did not share the letter of discharge from hospital but did share two letters, one confirming she was a patient at her GP's practice, the other she indicated was proof of accommodation. This was not evident from the correspondence which read as if Child H was living in her care. On 7th June, mother was offered temporary accommodation by the Housing Department, however, following discussion with her friend she chose to remain living with her as she said she was in too much pain to move to a new house at that time.

2.6.5 The outcome of the court hearing was that CAFCASS should complete a Section 7 report[11]. The court also ordered that Child H would continue to spend unsupervised time with mother each Saturday or Sunday and the parents were to attend a Separated Parents Information Programme (SPIP). Mother was unhappy with this outcome as she had expected to leave court with Child H on the day of the court case. She found it difficult to accept that the court would not make a decision that day and was aggressive with the CAFCASS worker who reported that mother expected to have at least overnight contact.

2.7 Key episode 5: Mother meets employer to discuss employment (8/6/18 -13/6/18)

2.7.1 On 8th June 2018, there was further contact between mother and her employer to discuss the results of MRI scans. A meeting was arranged for the 13th June and following discussion about the length of time full recovery could require mother was advised that termination of employment was an option to be discussed. On the 13th June no plan for return to work could be agreed so termination of contract was discussed.

2.7.2 On 17th June 2018, Child H had planned contact with mother. When she failed to return Child H by the agreed time father contacted the Police. Later that evening mother killed herself and Child H.

[11] This is a report produced by Cafcass to assist the court making decisions about what is in the best interests of a child – see glossary for more detail

3. VIEWS OF FAMILY

3.1 The surviving half-siblings describe mother as a 'narcissist'[12] who was only happy when she was the centre of attention. They said that she had isolated them as children from their wider family. They described an early childhood of physical and emotional abuse. The half-siblings did not appear to be aware of mother's reported suicide attempts but instead referred to her attention seeking behaviour; they were clear that they did not consider mother's injury to her knee to be as significant as she reported. They described the domestic incident with their aunt and said that this isolated them further. From discussion it did not appear that the half-siblings had discussed in detail their early childhood with Child H's father prior to the Child H's death.

3.2 The half-siblings and father reported that their major concern about mother was the emotional abuse that she would cause Child H. They did not see mother as someone who would deliberately cause Child H physical harm and they did not consider her a risk of suicide.

3.3 The family saw the first incident involving the Police as very significant as they felt mother needed help and that this should have been provided at this point. They were very upset that mother was trying to dispose of the family dog behind their back. They were also upset at the level of physical violence and felt that this was a change and was different from before. The half-siblings felt that their disclosure of previous abuse by mother was very significant for them as they had not previously told anyone. They were concerned that mother should receive help for her problems.

3.4 Once father had applied for the PSO and custody of Child H, he felt he had to do what the court ordered, but he did not see mother as a risk of physical harm to Child H so did not have concerns about the unsupervised contact. His major anxiety was about emotional harm in the longer term.

4 ANALYSIS

4.1 What was life like for the child in this family?

4.1.1 Child H was described by both the school and the childminder as being the "centre of the parents world" and "a very loved child", almost to a point where parents could at times appear "overprotective". Child H was clearly a happy child, and until the parents' relationship deteriorated there were no concerns about the parents' care from any agency. It is, however, clear that the child had been distressed by witnessing the arguments between mother and father and the childminder reported that the child talked to her about these events and was upset. That the child was able to show this distress, and share it with a known carer, would indicate that this was an unusual event and was not representative of usual behaviour by the parents. The school also reported that once mother had left the household, Child H settled and was seen to be happy in school and progressing well.

4.1.2 The only agencies who had significant contact with Child H in the early years were the school, childminder and GP. With hindsight it is possible there were some concerning aspects to mother's anxiety about Child H's health. She seemed very anxious for the child to be identified as having significant health problems including asthma (for which she asked

[12] Narcissistic personality disorder involves a distorted **self**-image. Emotions can be unstable and intense, and there is excessive concern with vanity, prestige, power, and personal adequacy. There also tends to be a lack of **empathy** and an exaggerated sense of superiority https://www.medicalnewstoday.com/articles/9741.php

staff to give the child daily doses of paracetamol) and autism; she also asked the school to put the child's name on the Special Educational Needs (SEN) register. It is noteworthy that neither the school nor the childminder who had regular contact with the child ever observed an asthma attack nor considered the child to be showing signs of autism. These concerns also do not seem to have been shared by father, and it is possible that mother was using these issues to gain attention from professionals. Whilst this may have been her intention, there is no evidence that there was inappropriate responses by professionals, in fact the school did not give the child paracetamol for the asthma and whilst they added the name to the SEN register this was for a short period and once it was clear that Child H did not have special educational needs the name was removed.

4.2 What was the impact of single-agency and multi-agency working?

4.2.1 There were two main periods of multi-agency working; the first was the immediate response to the domestic incidents between 10th and 12th April 2018 and the second was around the application to the family court by father for a child arrangement order regarding where Child H should live.

4.2.2 The main agency involved with the domestic abuse incidents was the Police and the staff involved on these three occasions worked hard to resolve the disputes between the parents in a way that safeguarded Child H but also addressed the concerns for mother that were being raised by her family. When they attended on the first occasion, on 10th April 2018, they were successful in enabling Child H's immediate safety. They used the prescribed tools (DASH assessment forms) to gather background information about the family circumstances, and the level of risk posed by mother, which was deemed to be low. This information was shared with CSWS and Health, in a timely manner, in accordance with local protocols. It was not shared with the school as this was not the agreed process at that time.

4.2.3 The Police Officers acted proportionately, and in accordance with the family's wishes, when they did not pursue prosecution of mother, but instead took her to the hospital in order that she could access mental health support services. Whilst they took her into the hospital, the officers did not talk directly to a health clinician about the reasons they had become involved; this meant that mother was able to present a very one-sided perspective of events when seen by the Doctors and she denied having any mental health problems. The Police Officers involved were clear that when they took mother to hospital it was in order to assist her to access support with her mental health and that if she had been unwilling to go there or leave the family home, they would have considered arresting her. They were also clear that her mental health needs did not warrant Police intervention under the Mental Health Act 1983 (Section 136)[13] and it was only under such circumstances they would remain at the hospital and formally handover a patient to the mental health team. Clearly, given that mother waited three hours to be seen at the hospital, this would have added significantly to the time they would be committed, in the event the Police Officers were involved with the family for over six hours.

4.2.4 The Police Officers spoke to the hospital receptionist when leaving mother at the hospital, and the Doctor who saw mother was aware that she had been brought by the Police, and if there was concern contact could have been made to gain more information. As it was mother's explanation was taken at face value, in part, because she presented in a calm and reasonable manner and did not show any signs of distress or impaired mental health. An assumption was made that as the Police had "dropped her off", they had no acute concern or information to share. Within the reported information from mother she stated that half-

[13] **Section 136** is an emergency power which allows a person to be taken to a place of safety from a public place, if a Police Officer considers that they are suffering from **mental illness** and in need of immediate care. https://www.rethink.org/living-with-mental-illness/police-courts-prison/section-136-police-taking-you-to-a-place-of-safety-from-a-public-place

sibling 1 called the Police because of distress about the reports of mother wishing to leave the family home.

4.2.5 The DASH assessment form was used again when the Police were called by father on 11th April because mother was being verbally abusive and was trying to take Child H from the family home. On that occasion the risk assessment was deemed medium indicating that there was increased concern about mother's behaviour. This information was again shared in a timely manner with CSWS and health professionals in accordance with the protocols in place at the time. When the Police were called for a third occasion on 12th April 2018 the DASH assessment tool was not completed, however, it is noteworthy that the Police Officers were firm in advising mother to leave the property and were clear that if she did not do so she would be arrested.

4.2.6 In 'Everyone's business: Improving the Police response to domestic abuse'[14] it is stated that the '*duty of Police Officers when attending the scene of domestic abuse is to protect the victim and any children from further harm. Where a power of arrest exists, the alleged offender should normally be arrested. Police officers should not base a decision to arrest or not to arrest on the willingness of a victim to testify in subsequent proceedings*.' It goes on to state that '*Here, as in all other areas of Police work, the focus should be on investigating and prosecuting offences (and preventing further offences against persons or property) in the public interest*' and says that ACPO[15] guidance '*that where an offence has been committed in a domestic abuse case, arrest will normally be necessary'*. This approach is clarified further in the local Kent Police guidance which states '*Where a substantive offence has been committed, or is suspected to have been committed, there will be a presumption in favour of arrest; the decision to arrest is for the attending Police Officers. Officers must be able to justify the decision* ***not*** *to arrest where the grounds exist, and it would be a necessary and proportionate response. In some situations, other positive approaches may be more appropriate, i.e. when the behaviour does not amount to criminal conduct'*.[16] The Police Officers who attended the workshop (who had been present on the 10th April 2018) were clear that they could have used the power of arrest with regards to mother if she had refused to leave the property, but also felt that she was presenting with some mental health difficulties which were best resolved by her receiving medical help, their decision to take her to hospital therefore, appears eminently reasonable. It is not clear that the threshold for arrest would have been met on the two subsequent days despite there being some escalation in the perceived risk of domestic abuse.

4.2.7 The application by father for a child arrangement order immediately triggered a CAFCASS safeguarding assessment which is a multi-agency process in that it requires CAFCASS officers to gather information from other agencies to inform their risk assessment. CAFCASS requested information from CSWS immediately and when this was not received made a follow-up request on 8th May 2018. CSWS confirm that they received two requests for support from CAFCASS, the first on the 19th April 2018 and the second on the 8th May 2018 and report that CSWS responded to these requests on the 3rd May 2018 and 10th May 2018 respectively. However, neither response was loaded onto the databases until 27th and 28th June 2018 due to administrative delays in the team at that time. CSWS confirm that their first response to CAFCASS included the detailed discussions with father about the incidents in April, however, at this time CSWS had also received two Domestic Abuse Notifications (DANs) from the Police that were not shared. The DANs did not, however, hold any additional information beyond that which the father had already shared. Regarding the second response to CAFCASS, this comprised a short summary which did not fully reflect the history held by the CSWS. CSWS was not able to explain why the second response did not include the full detail, apart from to say that that they would not consider the additional

[14] Everyone's business: Improving the police response to domestic abuse ISBN: 978-1-78246-381-8 www.hmic.gov.uk © HMIC 2014
[15] Association of Chief Police Officers (UK)
[16] Duty of Positive Action (excerpt from DA Policy N07a) Kent Police Procedures

information pertinent as the relevant information had already been shared. This was surprising, as the second request from CAFCASS clearly indicated that they had not received a response to their first application for information.

4.2.8 The information from CSWS was particularly important because CAFCASS when requesting information from the Police have a two-stage process. The first is a PNC check which was requested on 8th May and for which a nil return was received on the 21st May 2018. When CAFCASS are aware that there may be information held by the local Police that is not on the PNC, (such as involvement with domestic disputes where no charges are pressed) they make contact direct with the local Police, but this is not done routinely. In this case when the CAFCASS worker became aware (from the telephone interview with father at the end of May) that the Police had been involved she requested Level 2 checks with Kent Police. At that stage the PNC check had shown a nil return, and CAFCASS' knowledge of Police involvement was based upon father's disclosure.

4.3 How were assessments, including risk assessments, undertaken?

4.3.1 Routine assessments were undertaken by midwifery, health visiting and the school. None of these assessments highlighted anything of concern and therefore, there were no further risk assessments regarding Child H. It is probable that if the health visitor had been aware of mother's full mental health history there would have been a further visit and greater consideration of the risk of post-natal depression, however, there is no evidence, even with hindsight, that mother was suffering depression and certainly nothing to suggest concerns about the care provided to Child H during the early years.

4.3.2 The Police Officers involved with the family in April 2018 appropriately completed DASH assessments using the risk assessment tool. They assessed the first incident as low -risk and the second medium reflecting both an escalation in mother's behaviour but also additional information that was provided by family members. The officers involved were clear about the need to protect Child H and intervened as necessary to support father in achieving this. Good advice was given to him and other family members about how to make the house secure and it was clear that the family were assisted by this which is why father called the Police again when mother continued to cause problems at the family home.

4.3.3 The CAFCASS safeguarding risk assessment, started on 17th April, was significantly undermined by the absence of clear information from partner agencies about the events between 10th and 12th April 2018. The purpose of the safeguarding assessment is to ascertain immediate risk as it is known that relationship breakdown and separation is a time when children are at greatest risk; it is, therefore, crucial that partner agencies share information speedily and in full detail. Parents frequently provide CAFCASS officers with contradictory information and are often critical of each other's parenting; their task, therefore, is to identify those children who are at greatest risk. In this case neither parent identified risks to Child H of immediate significant harm meaning that in the absence of any contradictory information from other agencies it seemed reasonable to defer further intervention until the completion of the Section 7[17] report. The CAFCASS officer who

[17] Section 7 report by CAFCASS
The court will often ask CAFCASS to prepare a report which will assist in determining the outcome of a family court dispute. A CAFCASS officer will prepare this report after meeting with both parties and the child (alone where possible and only If the child has sufficient maturity and understanding). When writing a report, the CAFCASS officer will have specific regard to what is known as the 'welfare checklist'. The CAFCASS officer, and eventually the Judge, will have considered the following when forming their conclusions:

- the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding)
- his physical, emotional and educational needs
- the likely effect on him of any change in his circumstances
- his age, sex, background and any characteristics of his which the court considers relevant
- any harm which he has suffered or is at risk of suffering
- how capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs

interviewed mother in court on 7th June, attended the workshop, and was clear that her assessment may have been different if she had received a fuller picture of events in April. At this point father reported that mother was working with children and the CAFCASS officer noted that the Local Authority Designated Officer (LADO) needed to be informed of the domestic abuse incidents, however, this was a matter left to be completed as part of the Section 7 report.

4.3.4 One area of risk assessment that was relevant in this case was the need to advise the LADO that a person who worked with children had:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child, or
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children

4.3.5 The procedures are clear that if the concern is not connected to the person's employment or work activity, these procedures may also apply:

- Where concerns arise about the person's behaviour towards his/her own children or any other child. The Police and/or CSWS should consider if they need to inform the person's employer and/or the LADO in order to assess whether there maybe implications for children with whom the person has contact at work
- If an allegation relating to a child is made about a person who also undertakes paid or unpaid care of vulnerable adults, Safeguarding Adults' procedures should be followed.[18]

4.3.6 A range of professionals were aware that mother had been involved in a domestic abuse incident that had been observed by Child H and that would have caused the child emotional distress. There was also some knowledge of allegations made by the child's half-siblings of previous abuse when they were children. Two agencies were aware that mother's employment involved her with contact with children, CSWS and CAFCASS. Professionals in both agencies noted the need to inform the LADO, however, in CAFCASS this was left as an action to be completed as part of the Section 7 report. The CSWS referral was an informal discussion that was not recorded on the LADO system and the LADO decided that they did not need to become involved as the Police had not charged or cautioned mother. The GP and Police were also aware that mother worked as a counsellor (and therefore, with vulnerable people) but not that she had contact with children. None of these professionals involved considered whether a referral to the LADO should be made, or whether Safeguarding Adults' procedures should be followed. One reason for professionals' decisions was that mother was known to be absent from work because of her health problems, however, it was also apparent that professionals were less aware of the LADO responsibilities where the behaviour of concern was outside of work. It is possible that this also underpinned the LADO decision although it has not been possible to check this as they have no record of the discussion.

4.4 What support was provided to the mother regarding her mental health problems, what consideration was given to how they might impinge on her capacity/role as a counsellor, what impact did the mother's role have on how agencies responded to concerns within the family?

4.4.1 Both midwifery and Health Visiting undertook assessments of mother during and immediately after Child H's birth. The midwives were aware of her mental health history, but

- the range of powers available to the court under this Act in the proceedings in question.

[18] Kent LSCB Procedures Local Authority Designated Officer (LADO) https://www.kscb.org.uk/procedures/local-authority-designated-officer-lado derived from Working Together 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

this information was not known by the health visitor. No information was requested regarding the midwifery involvement as the birth of Child H occurred outside the terms of reference for this review therefore, there is no evidence to confirm whether the midwife shared the history and concerns relating to mother mental health with the health visitor. However, it is established from the health visitors records that they do not appear to be aware of her history which would have informed their assessment of her health needs. There is no suggestion that mother experienced any mental health difficulties during the pregnancy or after the birth, however, it was judged, with hindsight, that if mother's mental health history had been known there would have been greater consideration of the possible risks of post-natal depression and closer monitoring of the progress of mother and Child H.

4.4.2 The Police risk assessment was strongly informed by family members' perspective that mother had mental health difficulties and needed assistance in resolving her personal problems. They were aware of mother's role as a counsellor and did consider that this might be a contributory factor to her mental health problems along with other identified concerns such as a previous partner who had committed suicide and her inability to work at that time due to an injury. As previously stated, there was no consideration of any risks that might be posed by mother in her professional role and therefore, no referral made to the LADO.

4.4.3 The initial assessment of mother at the hospital was undertaken using a Safeguarding and Managing Risk Tool (SMaRT) which provided a picture of a patient who was communicating well, compliant and reporting stress secondary to relationship difficulties. When assessed by a Doctor three hours past initial registering, that picture appeared to continue to be reflected and the judgement was that there were no acute psychiatric issues so mother could be discharged to a local hotel. The hospital had no record of mother's employment and therefore, this was not considered in the assessment. Mother was also seen in an Orthopaedic Clinic and it was noted that she had "Finished course of physiotherapy but still struggling". It was also documented that mother reported she was "struggling", and the pain was "affecting her life". Again, there was no record of any discussion with mother about the nature of her employment and no further discussion of her mental health which would have been beneficial.

4.5 Did the fact that the father was the victim in the domestic abuse impact on how agencies dealt with the family?

4.5.1 In their reports all agencies reported that they were clear that their staff treated father in the same way that they would respond to any victim of domestic abuse. This response, however, did not address an issue that was debated in full at the workshop which was that the father did not see himself as a victim and it is probable that the only reason that he involved the Police was because of concerns about Child H. It was noted that the Police Officers in responding saw father as a victim, however, he downplayed his victimhood and the school staff did not feel that he saw himself in that way. At the workshop, school staff confirmed this was a learning point for them as they were not aware that he was a victim of domestic abuse because when they were discussing it with him, mother had left the home. It was noted at the workshop that half-sibling 1 had initially called the Police and without their involvement father may not have disclosed the abuse.

4.5.2 Men do not always see themselves as victims of domestic abuse, at the workshop it was recognised that this is not unique to this case as domestic abuse is not seen as something that men usually experience. This means there is an onus on agencies not only to treat men in the same way that they treat women but instead to acknowledge how difficult it can be for men to report domestic abuse and to take that into account when judging the level of risk associated with domestic abuse incidents.

4.6 Identified good practice

4.6.1 The Police Officers who attended the first domestic abuse incident (which was a low-level incident where no issues were clearly identified) provided robust and supportive input to the family. They went above and beyond minimum requirements in their interventions to safeguard Child H and find a resolution that suited the whole family who reported that they found the Police intervention helpful and supportive. They also referred the family to CSWS in a timely manner.

4.6.2 The father was very good at alerting professionals in a range of agencies (school, childminder and CSWS) and the responses to him were consistent and supportive. Child H and the family were also well supported by the school, the medical concerns were managed in a proportionate way and it was clear that Child H was at the centre of their practice.

4.6.3 The assessment that was started by CAFCASS was a strong piece of work and they attempted to gain as much information as possible with which to assess the risks to Child H.

5 LESSONS LEARNED FROM THE REVIEW

5.1 Information sharing between agencies

5.1.1 In this case the GP records included reference to mother's history and the midwife had direct access to GP records meaning the initial midwifery assessment was fully informed about the possible mental health risks. This information was not passed on to the health visitor meaning that her initial assessment did not take these matters into account. It is not clear why this information was not passed on. Health Visiting input to families is based on how a child and family present when seen but balanced with a knowledge of the family history meaning that it is important that all risk areas are shared by professionals.

5.1.2 An issue that was discussed at the workshop was information sharing with schools regarding domestic abuse incidents. In this case, in accordance with protocols in place at the time, the Police informed health professionals and CSWS about the domestic abuse incidents, but the school only heard about them from father, meaning they had a partial view and possibly were less aware of the risks posed by mother. It was noted that Operation Encompass[19] (a process where Kent safeguarding agencies share information about domestic abuse incidents to help protect any children who are involved) is being rolled out across Kent and this will ensure schools are updated about any domestic abuse incident within 24 hours.

5.1.3 A specific difficulty identified in this review was the challenge for Police Officers in passing on relevant information to hospital staff when taking people to hospital on an informal basis. Police Officers, when they detain a person under Section 136 of the Mental Health Act 1983, would escort that person to hospital and then wait until they are seen by a clinician and at that point would share any relevant information. If, however, the individual does not meet the threshold for Police detention but agrees to attend hospital, it is more difficult to arrange appropriate information sharing. The Police Officers involved did escort mother to the hospital and spoke to the receptionist, but it was not appropriate to share more information in a public place. Currently there are no systems in place to enable Police Officers in these circumstances to quickly pass on relevant information to a clinician so that their assessment of the patient can be fully informed.

5.1.4 Another area where information sharing systems need to be improved was the provision of local information between Kent Police and CAFCASS. CAFCASS reported that there can be

[19] https://www.kent.police.uk/advice/community-support/op-encompass/

a delay of up to 16 weeks for a return of Level 2 checks by Kent Police and that it was not uncommon for a court order to be needed to guarantee release of the information to ensure CAFCASS was able to complete safeguarding activity. It is apparent that the absence of clear information from CSWS and Kent Police meant that CAFCASS were significantly hampered in their safeguarding assessment.

5.2 LADO referral processes – triggers and recording systems

5.2.1 This review has identified that most professionals did not immediately consider the issue of the mother's employment when assessing the risks following the reports of the domestic abuse incident. One factor in this was that, whilst most professionals knew she was working as a counsellor, few knew she was working with children. A further issue was that at the time of the incident she was on sick-leave and therefore, it was not deemed an immediate matter of concern. It is noteworthy, however, that few professionals pursued the issue or inquired further as to the nature of the counselling work mother provided, even if not working with children it is probable that she would be working with vulnerable adults. It is also concerning that the LADO response to CSWS when they made contact was that there was no need for any action to be taken. Generally, there was little evidence that the LADO process was well-understood by professionals across agencies particularly when addressing concerns outside the workplace and it is probable that this could be an area for future development.

5.3 Effectiveness of DASH checklist as a risk assessment tool

5.3.1 The DASH risk assessment tool is known to have significant limitations which are identified in a range of research. In summary, it is considered that the DASH Checklist has insufficient focus on emotional abuse and mental health issues when assessing risk, it is too focussed on the risk of physical harm and does not sufficiently address risks associated with coercion and control. Research published by the College of Policing in 2016 concluded that it was '*not necessary to ask for all of the information contained currently in the 27-item DASH tool during the initial response. In its present form, the DASH is being circumvented in practice and is providing inconsistent data to secondary risk assessors. A more focused frontline tool could more effectively nudge officers out of an incident-driven mind set, towards identifying patterns of abusive behaviour, including coercive control*.' A further weakness identified in this review is that the tool does not ask where the perpetrator of domestic abuse works or if they work with children or vulnerable adults which means that Police Officers are not gathering key information required if they are to determine whether a referral should be made to the LADO.

5.4 Male victims of domestic abuse do not see themselves as victims

5.4.1 Domestic abuse by women against men has been the subject of much debate; one view is that domestic abuse is almost entirely committed by men against women. Another perspective is that domestic abuse is a human problem and that women, on occasion, may commit acts of domestic abuse. Evidence from analysis of data from the Crime Survey for England and Wales indicates that almost three-quarters (74 per cent) of domestic violent crime victims are female and 82 per cent of domestic violent crimes are committed against women. Over a million domestic violent crimes per year (on average) were committed against women, compared to just over 200,000 per year against men.[20] Research into 190 male callers to the 'Domestic Abuse Helpline for Men', however, shows that a small number of men are seriously abused by women. All callers experienced physical abuse from their female partners, a substantial minority feared their wives' violence and were stalked; over

[20] Untangling the concept of coercive control: Theorizing domestic violent crime, Sylvia Walby, Lancaster University, UK, Jude Towers, Lancaster University, UK, Criminology & Criminal Justice, 2018, Vol. 18(1) 7–28© The Author(s) 2018

90% experienced controlling behaviours and several men reported frustrating experiences with the domestic abuse system.[21] One explanation for this gender bias may be that men report their own victimisation less than females and furthermore many men do not view female violence against them as a crime. Hence, they differentially under-report being victimised by partners on crime victim surveys.

5.4.2 The relevance of better understanding of the nature of domestic abuse by women to men is twofold; firstly, in order to improve the response to the male victim; but also, to better understand the nature of the risk posed by the perpetrator of the abuse. In this case father felt well-supported by agencies and was acting to protect Child H. It is clear, however, that at least initially he did not see himself as a victim of domestic abuse. One impact of this may have been that professionals also under-estimated the risks and did not fully explore all safeguarding concerns regarding mother particularly in relation to her role as a counsellor.

5.5 How to identify suicidal ideation

5.5.1 Homicide–suicide[22] incidents occur mainly in family contexts with a parent killing a child followed by suicide being the second most common form of homicide–suicide after intimate partner murder. A major theme underlying homicide–suicide is one in which the mother views the child as being entirely dependent upon its mother, and therefore, unable to survive without her, even if other carers are available. This is described in research as '*The maternal protector role is thus threatened by loss of status, finance, health or personal support. This leads to feelings of hopelessness and frustration, making the mother believe she is unable to provide for the child or adequately care for her dependent, provoking a dependent-protective motivation for homicide–suicide. Thus, the intended suicide by the mother is the primary motivation, and the death of the child a secondary consequence*'[23]. Attachment theory would suggest that such cases reflect an enmeshed mother–child relationship, whereby the mother is unable to perceive her child could survive without her. In these cases, the main goal of mothers who commit homicide–suicide is their own deaths and, as such, the killing of their child can be understood as an extended suicide.

5.5.2 In this case there is some evidence that mother's relationship with Child H could be described as enmeshed. With hindsight her anxiety about Child H's health (unsupported by evidence of real difficulties) was unusual. Her older children's description of her as a 'narcissist' could also support an overprotective style of parenting. Typically, narcissistic parents are exclusively and possessively close to their children and may be especially envious of, and threatened by, their child's growing independence. This may result in the child being considered to exist solely to fulfil the parent's wishes and needs.

5.5.3 An alternative explanation for the homicide-suicide is that it was spousal revenge intended as a mechanism to hurt her ex-partner; a theory that could be supported by the death having occurred on Father's Day.

5.5.4 The reality is that mother's intention is still unknown and as there was no indication prior to the event of her intention to physically harm Child H it is impossible to be clear about her motivation. There was limited evidence that she was suffering from mental health problems prior to her death and, on the one occasion she was formally assessed, she denied any

[21] Characteristics of Callers to the Domestic Abuse Helpline for Men, Denise A. Hines Jan Brown Edward Dunning Journal of Family Violence ISSN: 0885-7482 (Print) 1573-2851 (Online) February 2007, Volume 22, Issue 2, pp 63–72 |

[22] Homicide: Includes murder and manslaughter, manslaughter defined as 'an unlawful killing that doesn't involve malice aforethought', for example manslaughter by gross negligence or by diminished responsibility. Within the workshop there was discussion about whether to use the term 'murder-suicide' or 'homicide-suicide' – it was agreed that there was insufficient information about Mother's motivation and therefore, the best term to use was 'homicide-suicide'.

[23] A case series of twenty one maternal filicides in the UK Amy McKee , Vincent Egan Child Abuse & Neglect xxx (2013) xxx– xxx https://www.sciencedirect.com/science/article/pii/S0145213413000367

major difficulties. The question of whether mother suffered with any mental health problems or whether there was any form of personality disorder, therefore, remains unanswered.

6 CONCLUSIONS

6.1 Even with the benefit of hindsight there was no evidence of significant abuse to Child H prior to the death. The major issue of concern identified by the father and half-siblings was a risk of emotional harm from mother and neither the family members, nor any professional in contact with the child, observed anything that would indicate the child was at risk of physical harm. As with any review there have been identified some areas where professional practice could be improved, however, there is no evidence that this would have led to a different outcome for Child H.

6.2 The review has highlighted that it is important that family history is given enough prominence by all agencies and is shared with all relevant professionals. This is particularly important at times of crisis and when family circumstances are changing such as when a new child is born. The birth of Child H occurred in 2012 and the mechanisms for sharing information between health professionals has changed. Once a pregnant woman has been booked with the midwifery service; a concerns and vulnerability form will be sent to that woman's registered GP and the health visitor. This form requests the GP to share and send back all relevant history including information that may impact on the health or care of the mother and baby which would include issues such as previous mental health concerns. This form would also prompt the health visitor to undertake an ante natal assessment. Should the midwife or the concerns and vulnerability form identify any issues that would need additional support then the case would be taken to the multi-agency maternity safeguarding hub. Information is shared in all cases of identified additional vulnerabilities and complex factors and a multiagency plan of support is identified. This ensures that concerns are known by all professionals, risks are identified, and support is given by all relevant agencies. The maternity safeguarding hub runs on a monthly basis and has representation from Health Visiting Services, Kent CSWS, the MIMHS (Mother and Infant Mental Health Service) and the midwifery safeguarding lead.

6.3 There were a number of areas where information sharing between professionals could be improved: The first was when the Police took mother to hospital but did not have a direct conversation with a clinician about the reasons for her coming to hospital because of the absence of systems for speedy confidential exchange of information between Police Officers and medical staff; the second was the delay in Kent Police providing CAFCASS with information when they were undertaking safeguarding checks; and the third was the lack of detailed information provided by CSWS to CAFCASS.

6.4 There are known difficulties with the current DASH checklist which is being reviewed nationally. This review has highlighted its limitations when addressing issues of emotional abuse and coercion and control rather than incidents of physical violence. It has also identified a further weakness in that it does not require professionals to identify the occupation of a perpetrator of domestic abuse, undermining professionals' capacity to advise the LADO where people working with children are involved in behaviour that is placing children at risk of emotional or physical harm. In the absence of immediate changes to the DASH checklist, which is already lengthy, Police Officers need to be reminded of the importance of obtaining information regarding perpetrators employment when attending domestic abuse incidents.

6.5 There is limited research available for professionals about working with male victims of domestic abuse and there is some debate about the levels of abuse of men by women. The research available, however, does show that men struggle, both with the stigma associated

with the concept of being a victim of domestic abuse, but also with the concept of being a 'victim'. In this case it seemed apparent that the father did not identify himself as a 'victim' which may have meant professionals under-estimated the relevance of mother's behaviour. For this reason, it is important that professionals when working with male victims of domestic abuse are aware that men may minimise its impact.

6.6 Finally the review has identified that there is limited awareness of the LADO process and particularly its relevance when responding to safeguarding issues within the home environment of people whose employment involves them with working with children and vulnerable adults.

7 RECOMMENDATIONS

Recommendation 1
That KSCB require Kent Police to resolve the difficulties causing the delays in providing CAFCASS with relevant information when they are undertaking safeguarding checks as part of their initial assessments.

Recommendation 2
That KSCB require Kent Police and the four Acute Hospital Trusts in Kent work together to ensure that when Police Officers take a person to hospital it is possible to pass on relevant information confidentially to a clinician within a speedy time-frame.

Recommendation 3
That KSCB require CSWS to work with CAFCASS to improve systems to share information effectively and speedily when requests are made as part of safeguarding inquiries.

Recommendation 4
That KSCB require Kent Police to work to ensure that when Police Officers are attending domestic abuse incidents, they ascertain a perpetrator's employment and consider LADO referral.

Recommendation 5
That KSCB and the Kent and Medway Domestic Abuse Executive Group develop an increased understanding of the needs of men as victims of domestic abuse and what this means about the nature of services that should be provided for them.

Recommendation 6
That KSCB require the LADO service to work with all agencies to improve knowledge and understanding of the LADO process particularly where it applies to incidents taking place outside of the workplace.

Fiona Johnson
1st April 2019

Appendix 1: BIBLIOGRAPHY

Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J. & Black, J., (2008) *Analysing Child Deaths and serious injury through abuse and negelct: what can we learn? A biennial analysis of serious case reviews 2003-2005*. Nottingham, UK: DCSF Publications

Characteristics of Callers to the Domestic Abuse Helpline for Men, Journal of Family Violence ISSN: 0885-7482 (Print) 1573-2851 (Online) February 2007, Volume 22, Issue 2, pp 63–72 |

Denise A. Hines, Jan Brown, Edward Dunning, Sylvia Walby, Jude Towers, Lancaster University, UK, Untangling the concept of coercive control: Theorizing domestic violent crime, Lancaster University, UK, Criminology & Criminal Justice, 2018, Vol. 18(1) 7–28© The Author(s) 2018

HM Government, (2015) Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children. London: Crown copyright 2015. [accessed 15/6/2015]

HMIC. (2014) Everyone's business: Improving the police response to domestic abuse ISBN: 978-1-78246-381-8 https://www.justiceinspectorates.gov.uk/hmicfrs/publications/improving-the-police-response-to-domestic-abuse/ [accessed 08/02/2019]

Amy McKee , Vincent Egan A case series of twenty one maternal filicides in the UK Child Abuse & Neglect (2013) https://www.sciencedirect.com/science/article/abs/pii/S0145213413000367

Eileen Munro 'Effective Child Protection' 2nd edition, Sage Publications 2008.ISBN 978-1-4129-4695-7

Amanda L. Robinson, Andy Myhill, Julia Wire, Jo Roberts and Nick Tilley, Risk-led policing of domestic abuse and the DASH risk model, © College of Policing, September 2016. https://www.college.police.uk/.../Risk-led_policing_of_domestic_abuse_and_the_DAS [accessed 08/02/2019]

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