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**DOMESTIC HOMICIDE REVIEW
INTO THE DEATH OF 'Sarah'/2016**

Executive Summary compiled by Kath Albiston

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Executive Summary

1. BACKGROUND

1.1 Background to the Review

1.1.1 This Domestic Homicide review related to the death of 'Sarah' (aged 45), who was killed in November 2015, by her sixteen year old son 'Michael'.

1.2 Terms of Reference

1.2.1 As well as the general terms of reference outlined within Appendix 1 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, the following specific terms of reference were agreed by the Panel for this review:

- Where any mental health diagnosis was made in relation to the perpetrator, did this influence the response to any domestic abuse or risk issues; the decision making in addressing wider complex family issues; or the making of referrals to other support services?
- Was the age of the perpetrator and the relationship with his mother a significant factor in responses and decision making, and how did this impact in terms of recognising and addressing risk?
- What influence did the age of the perpetrator have on his behaviour due to adolescence and the related potential behaviour of young people in this age group?
- Did your agency treat this as a complex case and was there an appropriate level of understanding of complex family need? What level of supervision was in place for those professionals dealing with the complex family needs.
- Did the gender of either the victim or the perpetrator influence or impact on the response of agencies? If so, in what way and what was the result of this? Consider responses to concerns, assessments undertaken and risk management actions.
- Did full and relevant information sharing take place? Was there evidence of a multi-agency and coordinated approach to assessment and management of risk? If not, why did this not occur and what were the implications of this as regards effective management of the case?
- Did your agency hold any information provided by broader family networks or informal networks? Was this information responded to and acted upon appropriately?
- Was your agency aware of any influence from social networking or web based sites which may have/did impact on the behaviour of the perpetrator?

1.2.2 The timescale of the review was set from January 2013 to November 2015. In addition, each IMR considered any relevant events prior to this period, relating to the risk of harm posed by the alleged perpetrator or the vulnerability of either the victim or perpetrator.

1.4 The Review Panel and Process

1.4.1 The review Panel membership was as follows:

NCC Strategic Community Safety
Northumberland Fire & Rescue Service
NCC Adult Services
NCC Children's Services
NCC Strategic Community Safety
NHS England
Northumbria Police
Northumbria Community Rehabilitation Company
NCC Adult Social Care
NCC Children's Services
NTW NHS Foundation Trust
Northumberland Fire & Rescue Service
Northumbria Probation
NHS Adult Safeguarding Clinical Commissioning Group [CCG]
North East Ambulance Service
Northumbria Healthcare Foundation Trust [NHCFT]
Northumberland Clinical Commissioning Group [CCG]
Northumberland Clinical Commissioning Group
NCC Strategic Housing
Independent Report Author

1.4.2 The review consisted of the following key meetings:

11/12/15	Meeting of the Northumberland Domestic Homicide Review Core Panel – agreement that case met criteria for a formal review to be conducted.
20/01/16	Initial Panel Meeting – terms of reference finalised.
10/02/16	Initial Individual Management Review (IMR) authors meeting.
25/04/16	Deadline for submission of Agency IMRs.
25/05/16	Panel and IMR authors meeting – presentation of IMRs.
04/07/16	Circulation of the Overview Report.
28/07/16	Final panel meeting
29/09/16	Presentation of report to family
19/10/16	Presentation to the Safer Northumberland Partnership Board.

1.4.3 Individual Management Review (IMR) reports were completed by the following agencies:

- Northumberland Tyne and Wear NHS Foundation Trust (NTW)

- Northumberland County Council (NCC) Children's Social Care (CSC)
- Northumberland County Council (NCC) Education & Skills (Wellbeing and Community Health Services Group),
- NHS Northumberland Clinical Commissioning Group (CCG)
- Northumbria Healthcare NHS Foundation Trust (NHCFT)
- Northumbria Police
- Northumberland County Council (NCC) Housing Services
- North East Ambulance Service Foundation Trust (NEAS)

1.4.4 The review process was not completed within six months due to the complex nature of the review, the time needed to complete fully comprehensive IMRs, and a number of ongoing parallel reviews.

1.5 Family Input into the Review

1.5.1 Sarah's parents kindly agreed to meet with the Chair of this review and provided valuable insight into the family situation and their family's contact with agencies. Within this meeting they also identified a friend of Sarah's who also contributed to the review process.

1.6 Criminal Proceedings

1.6.1 The criminal investigation concluded in April 2016 and Michael pleaded guilty to Manslaughter. It was accepted that Michael was not fit to stand trial due to his mental health, but that he was competent to enter a plea. The Judge sentenced Michael on the basis of two Psychiatric Reports and a Hospital Order under Section 37 of the Mental Health Act was imposed, with Restrictions but no specified time limit. This means that Michael will be detained for an indefinite / unspecified period, until he is no longer deemed to be dangerous.

1.7 Other Reviews

1.7.1 Parallel to this review process, Northumbria Police also undertook a Quick Time Review regarding their management of this case.

1.7.2 In addition, NTW undertook a Serious Incident (SI) Investigation in line with Department of Health requirements when a serious incident occurs.

1.7.3 Finally, NHS England commissioned an Independent Investigator to meet the requirements of a Domestic Homicide Review and Independent Investigation, in accordance with the wider scope of the Serious Incident Framework 2015.

2 AGENCY INVOLVEMENT WITH SARAH AND MICHAEL

2.1 Northumberland, Tyne and Wear NHS Foundation Trust (NTW)

2.1.1 Michael had significant involvement with NTW from a young age, with his first referral being at the age of five. Within the years considered by this review his contact was with a number of services within NTW in relation to assessment and ongoing treatment. He was diagnosed as having, ADHD, Autistic Spectrum Disorder (ASD), Moderate Learning Difficulties and Psychosis. Information provided throughout the chronology highlighted that there were often delays in assessment taking place to inform a diagnosis and the associated care provision.

2.1.2 From January 2015, there were also documented indicators that Michael was displaying symptoms of a psychosis, and in October 2015 he was still presenting with aggression towards Sarah. On reviewing Michael's clinical presentation as part of the NTW review, the Clinical Advisor indicated that it was a possibility that Michael developed a psychosis whilst being treated with stimulant medication (for his ADHD) above the licensed maximum dose.

2.1.3 Within the timeline for this report many risk issues and concerning behaviour were reported by the family and other paediatrician to NTW staff. As well as demonstrating the extent to which the family alerted professionals to increasing concerns around Michael's behaviour, this timeline also clearly indicates that his level of risk, including aggression and assaults, had markedly increased in both frequency and severity in 2015, with 23 incidents/concerns in 11 months. This correlates with the emerging clinical picture over 2015 that indicated a deterioration in Michael's mental health.

2.1.4

Conclusions regarding NTW's involvement

A number of omissions and failings were identified within the NTW IMR and these were summarised into four key areas of practice:

- **Care and Treatment**

In respect of Michael's presentation, he met the criteria within NTW's policy for an enhanced level of care but was not classified at such a level, reflecting a poor judgement of the level of need. The lack of exposure to appropriate challenge and support offered through the mental health clinical network, in addition to a lack of understanding and recognition of the significance of clinical symptoms, restricted access to clinically effective intervention and monitoring. Therefore, Michael's full presentation not being explored in the mental health clinical network was a significant omission.

No one was clear on accountability regarding Michael's overall care and its coordination. A weakness in the system was identified that allowed Michael, who had been identified as requiring additional support, to be allowed to 'drift' as a result of staff sickness.

In respect of Michael's deteriorating presentation there was also a failure to recognise and actively treat the emergence of psychotic features that were possibly caused by the prescribing of high doses of a stimulant medication. A referral to the EIP (Early Intervention Programme) service (as had been advised) would have facilitated a greater level of expertise to consider any diagnostic uncertainty and medication issues. More widely, prescribing practice and monitoring was identified by the IMR author as weak, and it was also noted that at no point was consideration given to undertaking a full mental health assessment on an inpatient basis.

- **Risk assessment and multi-agency risk management plans**

Limited risk assessments were undertaken, as well as no continuity of clinicians involved to understand the changing risk. There was no evidence that any immediate risks disclosed were fully explored or shared, and risk assessments and formulations undertaken failed to identify the requirement for referrals/notifications to other agencies in order to develop a robust multi agency risk management plan to safeguard Sarah. A comprehensive understanding of the potential underlying psychotic nature of any presenting risk was also absent. The risk assessment was therefore below an expected standard of psychotic aetiology and the associated risks.

There was also a failure to recognise Sarah as a victim of domestic abuse and the risk posed by Michael in this context was not understood. There was an overreliance on Sarah reporting to the Police, even after this had not resulted in a response, and little understanding of the increasing risk to Sarah of such a strategy. There was also no evidence that staff understood why it would be difficult for the family to raise concerns of Michael's risks in his presence due to them being fearful of reprisals.

- **Safeguarding/Incident reporting**

There was evidence of silo working in this case, with no due consideration of the need to protect the wider family. There was limited contact with NTW's Safeguarding team to raise concerns around increasing violence and aggression concerns, and to assist and inform decision making for referrals/signposting to other agencies. When the Safeguarding team were contacted, the clinicians failed to describe or articulate the risk. No incident reports were completed despite multiple disclosures.

- **Carers assessment and Think Family**

There was no evidence of a carer's assessment being offered or considered for a

family who were understandably struggling to care for Michael. The impact Michael's deteriorating mental health and associated violence was having on the family was also not considered. Sarah and maternal grandmother were not seen as victims.

2.2 **NCC Children's Social Care (CSC)**

2.2.1 Michael became known to CSC following contact by Sarah in June 2014 to say that she was struggling to cope with his behaviour. The duty Social Worker recommended a referral to the Early Intervention Hub (EIH) and Michael was allocated to the Children's Support Team (CST) for an Early Help Assessment to be undertaken; a CST worker was allocated and remained the CST Lead Professional throughout the review period. The case was finally closed to CST in September 2015.

Conclusions regarding NCC Children's Social Care's involvement

- Whilst support was being provided under an Early Help Assessment (EHA) and Early Help (EH) Plan, the CST worker provided regular and consistent support to Sarah.
- While this was initially an appropriate framework for supporting the family, it quickly became apparent that this was not the most appropriate framework, however such concerns were not acknowledged and escalated to the social care locality team to provide assessment and support under a statutory framework. A number of missed opportunities to do so were identified.
- The undertaking of assessment, such as the EHA and Disabled Children's Team's (DCT) Child and Family Assessment, and the triage of referrals and decision making, did not always seek and consider full information that was available, resulting in little evidence of a holistic picture that would have highlighted the increasing concerns and the need to escalate the case.
- There was limited direct contact with Michael and his views and experience of the situation remained largely unknown.
- Sarah and her family's reports of increasingly aggressive and violent behaviour by Michael were not fully explored and it was not considered as domestic abuse. Within this no risk assessments were undertaken regarding the risk to the family, information was often not shared with other agencies, and no multi agency risk management measures were considered to protect Sarah and her family.
- There was no evidence that the Team Around Family (TAF) and other professionals had a shared understanding of what was behind B's presentation.
- On one occasion, a worker from the DCT attended a school meeting but the Lead Professional (CST worker) was not invited. This indicated a lack of understanding of the central role of the Lead Professional in coordinating the TAF and other professionals.
- Although there had been three TAF meetings, there was not good multi-agency representation, either through lack of invites or lack of attendance. This resulted

in key information being missing from education and Children and Young People's Service (CYPS). There was no strong evidence of planned and coordinated multi-agency work to support the family, which should have been led by the Lead Professional.

- Whilst TAF meetings did take place, the initial EHA and EH Plan had not been updated throughout the CST worker's involvement and there did not seem to be any evaluation of impact.
- Michael's self-harming behaviour appeared to be minimised and the deliberate Self Harm and Suicide Care Pathway had not been considered. This could have been a further opportunity to consider the risks within a formal multi-agency strategy meeting forum.

2.3 **NCC Education & Skills (Wellbeing and Community Health Services Group)**

2.3.1 During the period of the review, known concerns regarding Michael's behaviour within school were recorded as first occurring in February 2014, when he threatened to stab another pupil in a cookery class. Following this, in June 2014, he drew a picture at school depicting people having been stabbed, legs removed, and eyes cut out; then in December, he goaded another student saying 'shoot yourself, slit your throat'.

2.3.2 In February 2015 a number of further presentations in Michael's behaviour were noted, in which he spoke to different members of school staff regarding hearing voices, wanting to inflict serious harm onto others. Shortly after this, in early March 2015, the concerns escalated further with Michael graphically describing scenes of violence.

2.3.3 From the perspective of the school the risk Michael posed seemed to diminish from mid-2015, as his behaviour and application in lessons improved. Such improvement meant that staff were happy that their interventions, and those of other agencies, were having a positive effect.

Conclusions regarding NCC Education and Skills' involvement

- Michael's behaviour within school was not considered to be a concern until March 2015. Prior to this the three incidents identified in February, June and December 2014, and a further three incidents in February 2015, were not considered serious enough to warrant sharing outside of the school. This was a missed opportunity to contribute to building a more complete picture of Michael's behaviour.
- When significant concerns presented in March 2015, these were appropriately shared with CSC, the Police and Sarah. It is not clear if the reports of Michael having thoughts he had killed people would alone have prompted such sharing.
- There were no further incidents of concern within school following March

2015, and Michael's behaviour within this setting was reported to have improved.

- It is not clear to what extent the school were aware of ongoing concerns and, when they were made of these at multi-agency meetings, to what extent they were considered and Michael and his family engaged to address these.

2.4 **Northumberland Clinical Commissioning Group**

2.4.1 The GP's contact was primarily with Sarah and her mother, and the GP identified having known Sarah for 'years and years', and of her being 'devoted to' Michael.

2.4.2 Sarah was diabetic and had associated weight problems, exacerbated by 'comfort eating'. As a result of this, she was seen regularly and received extensive support from the Practice Nurse, the diabetic secondary care team and Health Psychology. Sarah also presented with depression to the GP, who prescribed anti-depressants.

2.4.3 In relation to contact with Michael, the GP reported having seen the family when Michael was young in order to get a referral to the mental health team. After this point however, once CYPS were involved, the GP's input with Michael diminished and he was not seen by the GP over the full period of the review.

2.4.4 Throughout this time Michael's mental health and behaviour issues were identified by a number of agencies, and was shared with his GP in the form of correspondence from various professionals.

Conclusions regarding Northumberland CCG's involvement

- Sarah was seen regularly and was well supported in the management of her diabetes and weight problems. However, there was little exploration of the underlying causes of both her overeating and depression and how these may be linked to stresses at home.
- Correspondence to the GP practice, as well as behaviour noted by the mother and grandmother, showed a clear escalation in Michael's disturbing behaviour but did not prompt the GP to take any active steps to address this with the family.
- Michael was not seen during the time period of the review. The GP in this case assumed everything 'was in hand' due to CYPS being actively involved. Given the escalating concerns attempts should have been made to establish contact.
- There is little evidence of a 'Think Family' approach, with the links between Michael's escalating behaviour and Sarah's health concerns not having been made, and no assessment of the risk posed by Michael to Sarah undertaken.

- The GPs failed to recognise the concerns as domestic abuse, despite reports of assaults by Michael against Sarah and her expressed fear of him. This appears to have been influenced by Michael being seen as a child with ADHD/ASD and associated behavioural problems. This appears to have led to the 'acceptance' of certain behaviour and a failure to consider them as domestic abuse and thus identify, and take steps to manage the risk to Sarah.
- The family were never discussed at the weekly Supporting Families meeting. Families identified as being vulnerable or having complex needs, and where children have challenging and aggressive behaviours which parents are unable to cope with, should always be included in these meetings.
- Coding and record keeping of the GP records did not mirror what was happening with the family.

2.5 **Northumbria Healthcare NHS Foundation Trust (NHCFT)**

- 2.5.1 In relation to NHCFT's contact, Sarah was known to Diabetic services, where records suggest she had been seen regularly since 2009. Commencing in November 2014, she was also being seen by a Psychologist from the Health Psychology Service on a monthly basis.
- 2.5.2 Michael was under review by a Paediatrician. He was referred to the service in 2012 and, although the initial referral issues had resolved, he remained on six monthly review to monitor his weight and growth.

Conclusions regarding NHCFT's involvement

- Sarah shared concerns regarding Michael's behaviour in both her own appointments with the Health Psychologist, and Michael's appointments with the Paediatrician.
- Michael's Paediatrician was proactive in assessing need at each appointment and was actively trying to engage the appropriate support for the family. When concerns were raised in relation to Michael she shared them appropriately and in a timely manner.
- Michael's increasingly concerning behaviour was not seen as a Safeguarding issue by the Psychologist and therefore no sharing of information took place, including no notifications or referrals to CSC.
- During the family's contact with NHCFT Michael's behaviours were escalating and a number of key contacts have been identified where NHCFT staff could have been more inquisitive in their questioning around Michael's behaviour and explored disclosures made by Sarah further.
- Despite Michael's documented behaviour within the home, the situation was not identified as one of domestic abuse. It appeared that Michael's age and the nature of the mother/son relationship may have influenced this lack of recognition.

- No risk assessments were completed or considered in relation to Michael's reported behaviour and the potential risk to Sarah. In addition, no consideration was given to further referral for support, or to multi agency risk management processes such as Safeguarding by the psychologist involved in Sarah's care.
- There was evidence of good practice by the paediatrician involved in Michael's care, who following routine appointments repeatedly escalated concerns and requested support from specialist agencies with regard to Michael's violent behaviour and deteriorating mental health.

2.6 **Northumbria Police**

2.6.1 Northumbria Police's contact with Sarah and Michael was primarily in relation to concerns expressed by Sarah regarding her neighbours. This was dealt with as Anti-Social Behaviour and managed by the Neighbourhood Policing Team with a harm reduction plan.

2.6.2 In relation to Police contact around Michael himself, there was one occasion in October 2014 in which an incomplete 999 call was made after Michael had become upset. There was also an incident in October 2015, when Sarah contacted police reporting that Michael had been verbally aggressive towards her and was, in her words, 'out of control', describing him as screaming, shouting and banging his head off the wall. Whilst he was not physically aggressive towards her, Sarah felt overpowered and at the end of her tether.

Conclusions regarding Northumbria Police's involvement

- There was evidence of good practice in the level of contact and action taken from the allocated Neighbourhood Policing Team Officer in relation to the issues of Anti-Social Behaviour. There was also good liaison around this with Homes for Northumberland.
- The ASB incidents should have also been considered as a potential hate crime and as a result this raises questions about awareness, knowledge and training of identification of Hate Incidents & Hate Crime; particularly in cases where the incident/crime is not immediately apparent as such and involves Officers viewing the incidents within a wider context.
- There was a missed opportunity to submit a CCN after the 999 call in October 2014.
- The incident in October 2015 should have been recognised as a Domestic Abuse incident. The failure to do so, led to it inappropriately resulting in Resolution Without Deployment. This meant that Sarah was not seen and there was a missed opportunity for further enquiry and the Domestic Abuse Stalking and Harassment (DASH) risk assessment to be undertaken which may also have led to further support and/or multi agency referral such as Multi – Agency Risk Assessment Conference (MARAC).

2.7 **NCC Housing Services**

- 2.7.1 Sarah's contact with Housing Services was limited and solely in relation to her Homefinder application. Within this contact she was not identified as experiencing domestic abuse.

Conclusions regarding NCC Housing Services involvement

- Housing Services had extremely limited involvement with Sarah and her family during the period of the review.
- No information was known about domestic abuse or the risk posed to her by Michael, as Sarah did not identify this on her housing application form.
- Sarah had requested a move based on the problems she was experiencing with her neighbours.
- As Sarah identified the involvement of the Police and Community Safety, more information could have been sought from them which would have contributed to the assessment of risk relating to the neighbours.

2.8 **North East Ambulance Service (NEAS)**

- 2.8.1 The only relevant involvement NEAS had was on the date of the homicide.

2.9 **Equality and diversity issues**

- 2.9.1 As part of the review process, consideration was also given throughout to issues of equality and diversity. In the case of Michael and his family, no specific issues were identified in relation to religion or sexual orientation. It was noted however that Michael's age and gender may to some extent have impacted in the way in which the case was responded to by agencies, primarily by nature of the relationship between perpetrator and victim, and him having been a child at the time of his contact. In addition, the vulnerability of both Sarah and Michael has been significantly demonstrated. These issues have been discussed where relevant throughout the report.

- 2.9.2 It was also noted that Michael was of dual heritage, with information from the GP indicating that his father was black Zimbabwean. None of the IMRs identified that Michael's race or ethnicity was seen to have impacted in relation to either his vulnerability. There were no occasions on which it was identified that this was, or should have been, actively considered in relation to agency contact and responses. This was however considered further within Panel discussion, to ensure that all agencies were confident that any issues of race were given full consideration and that this in no way impacted in

relation to agency responses. All Panel members confirmed that this had been actively considered in their review of practice.

3 LESSONS LEARNED AND CONCLUSIONS

3.1 In undertaking this review of the events and actions that occurred leading up to the tragic death of Sarah, a devastating picture emerged of a woman, and her family, trying to support and protect her young son as his mental health, and associated behaviour, deteriorated.

3.2 Sarah's contact with agencies demonstrated a mother devoted to her son, who, with the help of her own parents, fought hard to provide a safe environment for him, whilst also managing her own health difficulties and maintaining two jobs. As Michael's behaviour worsened, the increasing despair of the family can be seen as they tried to make agencies understand the depth of their concerns and the difficulties they were having in managing these. Despite these attempts, focus was often placed by agencies on Sarah's parenting and the need to control Michael's behaviour, even when his presentation clearly demonstrated increasing risk, and indicated that the interventions needed were beyond those of behaviour management.

3.3 Michael's difficulties had presented from an early age and it has been highlighted that, prior to the period of this review, there were delays and often a lack of consensus or clarity regarding diagnosis. As Michael grew, his behavioural difficulties escalated, with signs of psychosis becoming apparent throughout 2015. This may also have been exacerbated by his obsession with 'dark' internet websites.

3.4 As the situation deteriorated, both Michael's self-harm and the increasing risk to Sarah can be seen. Reports of abuse and assaults by Michael increased and included him swearing at his mother, hitting her, throwing things at her, grabbing her by the throat, threatening her with a knife, and stating that he was going to kill her. This culminated in the tragic events of November 2015, in which Sarah's parents lost their child at the hands of their mentally unwell grandson; who, once he is well, will also have to come to terms the devastating impact of his own actions.

3.5 In reviewing agencies contact with Michael and Sarah, what emerged was a picture in which there were a number of failings and inadequacies that left Sarah and her family vulnerable, and without a coordinated and robust plan by agencies to manage the risks posed by Michael. As a result, a number of lessons to be learned have been identified throughout this report and are summarised below.

3.6 **Inadequate assessment and treatment of Michael's mental health.**

- 3.7 As has already been outlined in detail, NTW's response to Michael's mental health was identified as inadequate in relation to his assessment, care and treatment. This included delays in early assessment of presenting concerns, lack of care coordination, and a failure to recognise and actively treat the emergence of psychotic features. Within this there was also a lack of adequate risk assessment and management, although NTW and the Paediatrician were the only agencies to have carried out any risk assessment.
- 3.8 **Failure to identify domestic abuse, specifically Adolescent to Parent Violence and Abuse, and to fully recognise the risk posed by Michael.**
- 3.8.1 Throughout the review period, and particularly in 2015 as Michael's mental health deteriorated, it has been identified that there were numerous incidents of concerns or disclosures regarding Michael's aggressive, threatening and violent behaviour, primarily towards Sarah. Not only was this behaviour described, but also the family's fear of Michael directly expressed. Few of the disclosures made were actioned by the undertaking or updating of risk assessments and risk management plans, alerting other agencies to the concerns, or the making of Safeguarding referrals. In addition, within CSC, when referrals were made or concerns expressed directly by Sarah, decisions were not taken to escalate management of the case to statutory involvement. While some information sharing was seen, this was often sporadic and left an overall incomplete picture.
- 3.8.2 This failure to fully recognise the risk has been identified by agencies to have been influenced by a number of potential factors. Firstly, it was seen that there was at times a 'medicalisation' of Michael's behavioural problems, seeing them as a result of his ADHD, and resulting in a focus upon behaviour management.
- 3.8.3 Secondly, the impact of Michael's age and his relationship with the primary target of his abusive behaviour can be seen, and is demonstrated by the fact that no agency recognised the context as one of domestic abuse. The nationally used definition of domestic abuse is 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'. While this definition does highlight familial violence, it nevertheless focuses on those aged 16 or over and perhaps does not therefore prompt practitioners to consider the wider implications of child to parent violence.
- 3.8.4 In relation to this, the first large scale study of Adolescent to Parent Violence and abuse (APVA) in the UK was conducted by the University of Oxford between 2010 and 2013 (Condry and Miles). Practitioners and parents

interviewed in this study described the abuse as often involving a pattern of aggressive, abusive and violent acts across a prolonged period of time. A new Home office document: 'Information guide: adolescent to parent violence and abuse (APVA)' recognises the complexities of these cases and provides guidance for all agencies. The guide recognises that there is currently no legal definition of adolescent to parent violence and abuse, although sites research indicating that this is an increasingly recognised as a form of domestic violence.

3.8.5 This case has highlighted the need across all agencies for an increased awareness of Adolescent to Parent Violence and Abuse, and for it be considered as a form of domestic abuse. In addition, it highlighted the lack of clear referral pathways and a lack of understanding of pathways in such cases, for the MARAC process. Nonetheless, it was apparent throughout that even with this understanding there had been no recognition of the relationship and issues between Sarah and Michael as domestic violence / abuse. there was no multi agency referral pathway for child to adolescent to parent violence in place for any agency to refer to, therefore silo single agency working was apparent in the absence of same. As such a number of both local and national recommendations were identified.

3.8.6

3.9 **Lack of care coordination, full information sharing and a robust multi agency approach to risk management.**

3.9.1 It has been seen that multiple agencies were involved with Michael and Sarah and information sharing between them did take place. However, this was often sporadic and resulted in no one agency holding the full picture.

3.9.2 The lack of appropriate risk management and response to concerns can be seen, in part, as a direct result of the lack of recognition and assessment of the risk and therefore failure to consider the need for risk management actions including Safeguarding referrals, or referral to other risk management processes for Michael or Sarah. However, in addition to the lack of recognition of the risk in relation to violence to Sarah, it would also appear that there were occasions when agencies presumed that others agencies were already aware of that risk, or that such agencies were managing it. As a result, further or repeated concerns were not always shared or raised as potential Safeguarding issues. Had this occurred however the extent of the concerns would have been more starkly highlighted, and may have contributed to an escalation of responses by all agencies.

3.9.3 A further area impacting upon the lack of robust risk management was the lack of care coordination. As the primary agency engaged with Michael, NTW had identified the need for a care coordinator. However as has been demonstrated, due to staff sickness and a lack of response to this, he was left for five months with no active care coordinator. Similarly, within CSC, whilst a Lead Professional was allocated, they were not always recognised or responded to as such, and this was demonstrated through the fact that they

were not always consulted for information in the decision making process, including not being invited to meetings.

3.9.4 Such a lack of coordination may also have contributed to the fact that when information sharing did take place, it was often haphazard and limited.

3.10 **Lack of full exploration of concerns being raised by the family, and lack of consideration given to further support that they may have needed.**

3.10.1 A significant feature revealed by this review was the wealth of information provided by Sarah and maternal grandmother. As has been outlined such concerns were not always appropriately acted upon, and there appears to have been limited attempts to explore them further. During interview for this review, Sarah's parents also expressed how during Michael's appointments with health services, they often did not have time to talk to health staff alone, thus resulting in limited opportunities for an even fuller picture of the risk to be shared. In addition, there is little evidence of any attempts by agencies to consider further support that Sarah or her mother may have benefitted from, outside of contact with agencies whose primary role was in relation to Michael. There was also a great emphasis given to Sarah exerting parental control and putting boundaries in place, despite the information she was provided that clearly demonstrated her to be a victim of abuse at the hands of her son. These issues were highlighted by the absence of any form of carers' assessments being offered, or signposting to third sector support agencies.

3.11 **Michael's 'invisibility'**

3.11.1 Throughout this review a lot of information emerged regarding the circumstances leading up to Sarah's death, however much of this relates to Sarah, her family, and professionals' perspectives. What is noticeably absent is Michael himself. It has been identified that he was not seen by his GP during the period of the review, and no proactive attempt was made to bring him in despite much information from other health services being shared with the GP. In addition, throughout CSC's contact Michael was present at only 30 out of 58 visits. Even in those agencies where Michael was seen directly, such as NTW, there is little evidence within recordings of Michael's perspective or views having been sought to inform assessments and interventions.

3.11.2 While it is recognised that Michael may not have been easy to engage it is critical that any assessments relating to the well-being and/or behaviour of a child, seek that child's view and make them central to the assessment process.

3.12 **Lack of consideration given to the interplay between Michael's behaviour and his internet use.**

- 3.12.1 Within a number of agencies involvement reference was made to Michael's use of the internet, in particular his use of the CreepyPasta website. Research undertaken for this review, revealed this to be a website associated with previous tragedies in America.
- 3.12.2 While much discussion took place about the impact of this website on Michael, it was recognised that despite the reports to a number of agencies, no specific exploration took place as to what exactly the website was in order to understand the potential impact on Michael's behaviour. In particular, NTW identified that this resulted in no consideration of the potential interplay between the website and his psychosis.
- 3.12.3 Within the above it can be seen that, despite concerning presentation in which Michael made reference to his use of this website, little consideration seems to have been given to the potential impact of this.

3.13 **Could Sarah's homicide have been predicted or prevented.**

- 3.13.1 Much evidence was revealed to this review to suggest that in the year leading up to Sarah's death there was a steady escalation in Michael's aggressive and violent behaviour, particularly towards Sarah, and a concurrent worsening in his mental health, including increasing indicators of psychosis. This included ideation around killing and death, and reported threats that he would kill Sarah. In addition, Sarah and her family expressed their fear of Michael. A number of agencies, particularly NTW, had sufficient information to indicate an increasing and very real risk. Had full and robust risk assessments been carried out, including the gathering of information from other sources, it is likely that the potential for serious harm or death could have been predicted, and Sarah identified as a potential victim.
- 3.13.2 It has also been identified that there were a number of missed opportunities in which risk was not recognised, full assessments were not taken, full information sharing did not take place, and referrals were not made. As a result, no sufficiently robust multi agency risk management plans were put in place. Had these opportunities been taken and more robust intervention occurred, while the exact impact cannot be known, it is reasonable to conclude that death of Sarah may have been preventable, particularly had Michael received appropriate interventions for his psychosis.

4 **RECOMMENDATIONS**

- 4.1 A number of specific agency recommendation have arisen either through completion of IMRs or as a result of the overall review process; these are summarised below. In addition however, the key learning points that have arisen are relevant for all agencies working with potential victims and

perpetrators. In light of this it is recommended that all agencies consider existing procedures and staff training to ensure that the key lessons learned from this review are fully incorporated and embedded in practice.

4.2 **Summary of recommendations arising from this review**

National Recommendation

Home Office/Safelives to consider the current definition of domestic abuse and the age criteria for referral into MARAC, in light of the learning from this review, and identify whether this can be amended to reflect issues in relation to APVA.

Local recommendation 1 (for all agencies involved in the review):

All agencies to ensure that the Home Office document relating to APVA is disseminated to all relevant staff, and that the key learning and guidance within this is incorporated into relevant existing training around domestic abuse, Safeguarding, risk assessment and management.

Local recommendation 2:

Safer Northumberland Partnership to coordinate a piece of work to identify the most appropriate referral pathways in future cases of APVA, and for this information to be disseminated to staff within all agencies.

Local recommendation 3 (for all agencies involved in the review):

All agencies to ensure that all relevant staff are aware of the need to make Safeguarding referrals, even when other agencies are already involved or it is believed concerns have already been raised.

Local recommendation 4 (for all agencies involved in the review):

All agencies to ensure that where other agencies are identified as part of a strategy to manage risk, full and appropriate information is shared to the relevant agency to ensure an appropriate response.

Local recommendation 5 (for all agencies involved in the review):

All agencies to review current practice to ensure that parent's views, and those of other relevant family members or carers, are taken into account within assessments, that they are being offered the opportunity to be seen alone, and that carers' assessments and/or signposting or referral to support services are being offered.

Local recommendation 6 (for all agencies involved in the review):

All agencies working directly with children to ensure that workers are equipped with skills and tools to actively seek and record the views of children and to incorporate these into assessments and accompanying plans. To ensure also that those providing supervision for staff robustly challenge whether children's views have been sought and recorded.

Local recommendation 7 (for all agencies involved in the review):

All agencies to ensure appropriate training is provided to staff regarding the potential risks associated with internet use, particularly in relation to the interplay with mental health issues, vulnerability and issues of radicalisation. To ensure that such consideration of such issues are prompted in any risk assessments undertaken.

NTW

Recommendations identified by the Independent Investigator will be further developed with NTW and detailed in a robust action plan. In summary, recommendations are as follows:

Care Coordination, multi-agency working and care planning.

- NTW re-acquaint staff with the existing policy on Care Coordination in order to understand the organisation's and their own professional responsibilities in the assessment, planning and implementation of an appropriate package of care. An essential pre-requisite of this recommendation is an assurance that all staff fully understand what the policy advises with regards to Multi-agency assessment, specialist interventions and the practice of Care Coordination.
- Agreed interventions within care plans are evidence based and fulfil SMART criteria. For this to be inclusive it is imperative that all professionals are aware of the importance of involving the family / Carers at all stages of the process.
- NTW provide assurance that recording and communication practices are adhered to most notably in the context of updating records, developing and communicating formulations, care plans, risk management plans and review processes.

Risk Assessment and Risk Management planning

- At the very least staff are reacquainted / re-trained in the various elements of the Clinical Risk Assessment and Management Strategy with particular reference to understanding the principles of a structured clinical approach to risk behaviours.
- NTW plan how they intend to provide staff with the knowledge to practice in the area of Risk assessment and management with special regard to not only the processes but the current evidence base related to Assessment, Management and mitigation of risk behaviours.
- In line with the above recommendations, communication practices reflect the need to constantly reassess and re-evaluate risk management practices and that professionals practice should reflect these. This, it is recommended would contribute to reviewing and improving the quality of care provided.

Prescribing practices, Diagnosis and Mental Health Assessment.

- There was clear evidence, especially from the assessment and implementation information available that questions were raised with regard

to developing a diagnosis and the effect on care packages, the potential implications of prescribing practices and monitoring, and Mental State examination and review. At this stage the Investigator had not had the opportunity to have the views of a psychiatrist on this, but this process was planned to occur in the months following the report.

NCC Children's Social Care

- Within the review of training, outlined with the IMR recommendations, CSC should ensure that staff are aware of the need to act upon reported incidents of violence and abuse through the undertaking of appropriate risk assessments, referral to appropriate risk management procedures, and consideration of the need to share such information with other agencies.
- To review procedures relating to the feedback of information following multi-agency meetings, including TAF, to ensure that feedback is disseminated to all those actively working with the case.

NCC Education & Skills (Wellbeing and Community Health Services Group)

- Where concerns are known regarding the home environment, the school should identify how this can be addressed within the school environment and attempts made to engage the young person and his family.

4.3 **Individual agency recommendation identified within IMRs**

NTW

- The CYPS service will review their safeguarding responsibilities to assure themselves that they are fulfilling their requirements within trust safeguarding and public protection policies and are receiving advice supervision and support when required.
- Review current practice with regard to the Early Help agenda.
- A clinical review of a sample of x cases of children, who are seen within the ADHD clinic and have additional needs that require Care Co-ordination have a care co-ordinator who has the skills to meet their needs.
- Specialist Care Triumvirate Management Team should further review the clinical practice of those individuals identified by the Investigating Officer and clinical advisors to ensure that the early interventions already initiated in the process of undertaken the review are sufficiently robust to ensure patient safety.
- All community CYPS practitioners will be offered a specific workshop with a focus on assessing and managing risk to others and factors impacting on decision making.
- The CYPS service will review their responsibilities to support parents in their caring role to assure themselves that parents' needs are met and that staff responsibilities to report acts of domestic violence are understood.

- Review current practice with regard to prescribing within team and adherence to guidance.
- NTW should review their position relating to post incident contact with family members following homicide with immediate effect to ensure consideration and decisions on a case by case basis. This should have regard for the police support framework provided through Police liaison officers.
- The outcome of this investigation should be made available to the patient's grandparents and an apology offered regarding shortfalls in the provision of appropriate standards of care and treatment.
- To ensure that appropriate training is available and the systems for escalation are understood.

NCC Children's Services

- Children's social care and adult safeguarding to raise awareness and widely distribute the Home Office guidance regarding Adolescent to Parent Violence and Abuse (APVA) and request that this is disseminated within teams, discussed at team meetings, team briefs and referenced at relevant training. The Home office document will be available on the NSCB and Adult Safeguarding websites.
- Children's social care and adult safeguarding to implement a clear procedure and pathway to ensure that all referrals regarding adolescent to parent violence and abuse are responded to appropriately and consistently, identifying the risks around domestic violence, to ensure that the adult victim is safeguarded and protected and that the most appropriate assessment, intervention and multi-agency support is in place to safeguard, protect and support the child or young person and their family.
- The Home Office guidance regarding Adolescent to Parent Violence and Abuse (APVA) to be incorporated into the Single Point of Access (SPA) procedure and pathway to reflect the learning from this review and support a consistent, timely and appropriate response regarding adolescent to parent violence and abuse.
- The Disabled Children's Team should review the role of the Enquiry and Referral Administrator and duty Social Worker within the team, to include clarity and expectations around the duty Social Worker role in attending Team around the Family meetings and Transitional School Review meetings.
- To review the purpose of the Transitional Database held within the Disabled Children's Team.

NCC Children's Services Recommendations for NSCB

- The NSCB will review and revise the early help procedures and guidance to include the following key elements:
 - The threshold for undertaking an Early Help Assessment; to include an escalation policy, for all professionals, linked to the updated multi-agency Thresholds Document. The escalation policy should cover the

opening, stepping up/down and closing of the case and should include seeking guidance/supervision and exercising professional judgement.

- The role of the Lead Professional and the contribution and expectations of the Team Around the Family.
- Agreement that NTW, where appropriate, will take on the role of the Lead Professional.
- The visiting frequency of the Lead Professional and other relevant professionals, to include planned and meaningful direct work with the child or young person.
- The Early Help Assessment, plan and reviews, to include: the duration of the Early Help Assessment, linking with the escalation policy.
- The role of the Team Around the Family meeting, including multi-agency attendance, information sharing, professional contribution, timely and smart actions and the distribution of minutes.
- The formal supervision arrangements in place for the Lead Professional and members of the Team Around the Family to include: the frequency of formal supervision, reflection and professional challenge, the role of the Lead Professional's line manager in chairing Team Around the Family meetings, where progress is not being achieved or sustained within 6 months.
- The Early Help Module: to ensure that this is fully compatible with the statutory social care module, so information can to be accessed and reviewed between the Early Help and statutory social care elements of ICS. The Early Help Assessment template and Early Help module on ICS should incorporate a chronology that is used in order to capture and analyse the key events and the child's journey and experience.
- To review the single and multi-agency training that is available to Children's Services staff regarding domestic violence, to ensure that this includes adolescent to parent violence and abuse, mental health and self-harm to ensure that lessons learned from this case are incorporated.
- To explore multi-agency training with NTW to ensure a greater understanding of the role of professionals and interventions within NTW.
- Once the current review of the Suicide and Self Harm Pathway is complete, key messages from this DHR and for the Suicide and Self Harm pathway to be re-launched with training for all Children's Services staff.

NCC Education & Skills (Wellbeing and Community Health Services Group)

- It is not clear whether staff at the school were aware that domestic violence may have been taking place. Training staff in spotting the signs of domestic abuse (for victims and perpetrators) may mean that in future cases appropriate agencies can be informed more quickly and with greater certainty.
- Whilst the record-keeping of the school was very detailed the school should ensure that a single management system is used to collect all information regarding incidents linked to students, rather than in separate behaviour logs. This may aid the spotting of behaviour patterns in future.
- The school should also ensure that relevant information is shared systematically between staff within school and with outside agencies. A multi-agency approach to the most suitable way to achieve this is required. Consideration of who is responsible for collating such information is necessary.
- The school should consider a formal recording of conversations with parents/carers to aid the transfer of relevant and timely information between staff within school and outside agencies.
- On two occasions (10 December 2014 and 10 July 2015) the school did not receive any formal communication regarding outcomes from multi-agency meetings that had taken place. Whilst the responsibility for distributing those outcomes lies with the host of the meeting, the school may consider an internal process that follows up missing communications. This would ensure the school always has a full picture of activities undertaken by other agencies which may impact upon the school.
- The school may wish to instigate a process by which they ask parents for a summary of how each child has been during the summer holidays. This may flag up any changes in behaviour or attitude that may impact upon school performance.

Northumberland CCG

1. All GP's and practice nurses should have an increased awareness of Domestic Abuse (DA) and Adolescent to Parent Violence and Abuse (APVA)

All Single Agency Training (SAT) provided for primary care staff should include recognition of children as perpetrators of domestic abuse. This case should be discussed to illustrate this.

2. Improve GP awareness and understanding of children with mental health issues registered with the practice.

Circulate a list of child mental health codes to all GP practices and highlight the issues regarding GP record coding from this case. This should be done via an alert and through SAT.

3. GP practices to broaden the scope of existing safeguarding ('Supporting families') meetings to discuss cases that involve children who are known to be violent and/or aggressive.

To be shared at GP Network and incorporated into all SAT as a case scenario. GP practices may consider inviting health professionals such as mental health workers to attend 'Supporting Families' meetings where appropriate. Raise awareness of 'Supporting Families' meetings with other agencies in order for them to link in to the 'Think Family' approach.

4. All children with serious mental health issues should be visible within the GP practice and their thoughts and wishes (as well as those of their families) documented. This good practice should be visible in the child and family GP records.

GP Practices to audit the contact they have with children that are known to them with serious mental health diagnoses including those with violent and aggressive behaviour. These children should have appropriate and regular primary care 'face to face' contact. These mental health reviews should incorporate their physical, mental, social and safeguarding circumstances. This information should be clearly documented in the GP records.

5. Where a patient discloses fear of or actual violence perpetrated by someone known to them, this should be documented with a clear plan of action.

This should be included in SAT, briefings and via an alert.

6. GP's should take appropriate action when it is known a child or adult is accessing illegal, harmful, abusive or particularly violent web sites on the internet including those involving radicalisation. GPs may need to discuss their concerns with other agencies or even make referrals into Safeguarding if it is agreed that there is concern about the welfare of the child, their family, or the public.

Health WRAP training for all GPs and practice nurses to raise awareness of the Government 'Prevent' programme. In order to support GP practices with their role and responsibility with regards to preventing children from online exploitation, information about the Child Exploitation and Online Protection Centre (CEOP) 'thinkuknow' programme should be circulated to all GP practices, with specific reference to the available online training 'Keeping Children Safe Online (KCSO)'.

7. GP's should not make assumptions regarding the care of any of their patients without establishing the facts. This could involve speaking directly to the patient, their family and lead professional involved. This must include regular updates.

This will be covered using case examples during SAT and GP network meetings as a theme.

Northumbria Healthcare NHS Foundation Trust (NHCFT)

- Changes made to training and guidance to ensure practitioners have a greater understanding of Domestic abuse in its wider context and be able to support those identified at potential risk of harm.
- Health psychology has access to all information pertaining to their clients which may be held in main hospital records or on alert systems.
- Health psychology to ensure cases involving concerns with children are discussed with peers and advice sought from Safeguarding Children team.
- Health psychology can evidence cases discussed during supervision and actions agreed. Peer supervision session for Paediatricians to include discussion about long standing chronic cases.

Northumbria Police

- To raise awareness of and ensure adherence to the Policies & Procedures in relation to Child Concern Notifications, Domestic Abuse & Hate incidents.
- Implement case audit process with regards to Hate Incidents & Hate Crime, Domestic Abuse incidents and Child & Adult Concern Notification submissions.
- Ensure Resolution Without Deployment model has a Policy & Procedure in place which includes when and in what circumstances (RWD) is appropriate.
- Review intelligence management to ensure that when a particular department receives information/intelligence, which concerns matters outside of their remit, that a system exists in order to pass this to the relevant department for actioning.

Housing Services, Northumberland County Council

- Learning from this case will be disseminated to the Homefinder Registration and Assessment team through a learning event in their next team meeting (which took place on 09/05/16). This will discuss the opportunities for improved investigation and questioning of information provided on applications and increased information sharing to help in the assessment of risk and need.
- A review of the Northumberland Homefinder application form will be completed to determine if it is possible to help support applicants to self-assess their circumstances and determine if they are victims of Domestic

Abuse where they may not view themselves as such.

- Outcomes from this training will be monitored through regular case reviews on a 1 to 1 basis with team members, with any common themes and good practice shared across the team.

Executive Summary