



Domestic Homicide Review

West Cumbria Community Safety Partnership

**Chair: Lesley Storey
July 2015**

PREFACE

This Domestic Homicide Review (DHR) was carried out following the death of Susan and Amy. This was the second statutory homicide review carried out in Cumbria. It was carried out in accordance with Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

We would like to express our profound sympathy to the family and friends of Susan and Amy. Their kindness, warmth and generosity have humbled the panel. The information they provided to the review has enabled an insight into the lives of Susan and Amy which was invaluable.

We would like to thank those involved for their time and valuable input throughout this review process.

We would also like to thank staff within all agencies that have contributed to this review.

OVERVIEW REPORT

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Domestic Homicide Review Overview Report –Cumbria

April 2015

Introduction

This Domestic Homicide was carried out following the deaths of two women in Cumbria. For the purposes of this review in order to protect the identity of those involved the subjects will be known by the names outlined in the table below.

These names were approved by the family.

Subjects of the Review

Susan	Deceased	Mother of Amy and Simon	Died aged 58
Amy	Deceased	Sister	Died aged 20
Simon	Perpetrator	Son and brother	Detained aged 23
Andrew	Deceased	Father	Died aged 49

1. Background

- 1.1 In Cumbria Police received a 999 call from a member of the public stating a row was occurring at an address in Cumbria and a dog was dead in the garden. Officers attending the address found the bodies of two adult females, Susan and her daughter Amy. Simon, a resident of the house and the son of Susan was located on a beach some miles from the address. He confessed to the killings and officers arrested him.
- 1.2 In 2014 Simon was found guilty at Preston Crown Court of two counts of manslaughter on the grounds of diminished responsibility. He was sentenced to life imprisonment with a minimum of 12 years.
- 1.3 Some two weeks later, The Judge, on reflection, reviewed the sentence and reduced this tariff to a six year hospital order. The Crown Prosecution Service then referred the sentence to the Attorney General on the grounds of undue leniency.
- 1.4 Later in 2014 the court of appeal found there was no evidence to support the defence that Simon was psychotic at the time he committed the killings. Lawyers representing the Attorney General in presenting the case argued that the aggravating factors in this case were “Simon’s lack of remorse” and “His self-induced psychosis, brought on by his use of drugs and alcohol”.
- 1.5 The Judge in summing up the case stated “*Simon had significant residual culpability and “the plain intention to kill both women was a significant factor”.*

- 1.6 The final conclusion was the sentence should be increased to 13 years and 4 months.
- 1.7 These events led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the Community Safety Partnership (CSP). The initial meeting of the panel was held on 4th September 2013 and there have been 4 subsequent meetings of the DHR panel to consider the circumstances of these deaths. These meetings were held on 14th January 2014, 21st May 2014, 15th September, 7th November 2014 and 20th February 2015.
- 1.8 In addition to the panel meetings one workshop for Individual Management Report Writers (IMRs) and panel members was held on 21st May 2014 following the meeting.
- 1.9 The DHR was established under Section 9(3), Domestic Violence Crime and Victims Act 2004.
- 1.10 The key purpose of undertaking a DHR is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
- 1.11 This review process does not take the place of the criminal or coroner's courts proceedings nor does it take the form of any disciplinary process.

2. Terms of Reference

- 2.1 The full Terms of Reference (TOR) for this review are included in Appendix 1. The conduct of the DHR must follow statutory guidance that was published by the Home Office in April 2011. This guidance was subsequently amended in July 2013 and came into effect in August 2013.
- 2.2 Cumbria has undertaken one previous DHR since the statutory guidance was implemented. Lessons learnt from this DHR have been considered in order to avoid duplication.

3. Time Period Covered in this Review

- 3.1. The review panel agreed the time period covered by the review would be from January 2012 to the day of the deaths. Individual Management Reviews (IMRs) and background reports were commissioned in line with this timeframe. All agencies were also asked to undertake a full review of all records relating to the subjects of the review dating back to the 1990s in order to provide a context for the subsequent events that took place.

4. Methodology and Sources of Information

- 4.1. The following methodology was used to ensure a thorough investigation into all the facts relating to this case.
- 4.2. Chronologies from all agencies identified as having contact with Simon, Susan and Amy and also the deceased father Andrew were produced. These were amalgamated into a full multi- agency contact chronology.
- 4.3. Details of those agencies that then provided full IMRs are outlined in the TOR. Background reports were also commissioned from a number of agencies who had had significant historical contact with the family. Although this contact was outside the timescales identified as relevant to the incident it was felt they provided a context which enabled the panel to view the family holistically. Again, those agencies providing background reports are identified within the TOR.
- 4.4. All reports and IMRs were shared with panel members and the opportunity to scrutinise and challenge the documents was provided on two occasions. This iterative process allowed a deep level of discussion and analysis to take place in a multi-agency context. This report is the product of that process.
- 4.5. Documents and research used to inform the review are set out in Appendix 3.
- 4.6. This report has been produced with full cognisance by the panel and author of the tendency towards hindsight bias. Whilst due care has been observed and every effort has been made to avoid this bias this did at times prove challenging. It became clear very early on in panel discussions that two children and an adult victim of domestic abuse had historically not received standards of care, empathy and critically safeguarding that they needed to protect them.
- 4.7. Improvements made by agencies in approximately the last 10 years in responding to victims of domestic and sexual violence are significant. Cumbria has a solid partnership approach to tackling domestic and sexual violence and has implemented a number of approaches that can be seen as good practice, one example being the active Champions Network. Cumbria Constabulary has recently been subject to audit by HMIC they were found to have a robust and proactive response regarding domestic violence.
- 4.8. The further back in time travelled, the more problematic it becomes to examine policies, procedures and practice against contemporary standards. The Panel were cautious in analysing practice that was historical. Nevertheless, the Panel were unanimous in their view that Susan, Amy and Simon were all let down by the agencies that had contact with them in the period from 1990 to 2006 by the standards that would have been expected at this time. This will be examined in some detail in the section on historical information.

5. Consent and Obtaining Confidential Information

- 5.1 The Panel Chair wrote to the perpetrator, via his solicitor, requesting permission for disclosure of confidential records. No response was received within the period of time set for a reply, which was 28 days. Therefore the agencies were asked to consider whether the public interest in maintaining the duty of confidentiality owed to the individuals was outweighed by the public interest in the use and disclosure of confidential information, records and health records for the purpose of this review. All Panel members concluded that there was an overriding public interest in favour of the provision of relevant information, records and health records in order to complete Individual Management Reviews. There was no confidential material that was relevant to the review that was withheld for legal reasons.
- 5.2. The G.P practice sought advice from their defence solicitor and would not participate in the review backed by their defence without explicit permission from Simon.
- 5.3. This impasse was finally overcome by the chair going back to Simon via his solicitor and after some delay he agreed to allow access to his records.
- 5.4. The sharing of confidential records pertaining to the perpetrator caused a significant delay in this review. Timescales set by Home Office Guidance were not adhered to. Although this was eventually overcome by Simon agreeing his records could be released the partnership should be aware that he could have refused. It is strongly recommended that the Safer Cumbria Partnership engages with GPs through the CCGs locally and raise awareness of the statutory nature of DHRs and the importance of ensuring lessons are learnt as early as possible.

6. Panel Membership

University Hospitals of Morecambe Bay
Cumbria County Council, Children's Services
Cumbria County Council, Adult Social Care
Impact Housing – Let Go Domestic Abuse Service Provider
Cumbria Constabulary
West Cumbria Community Safety Partnership
NHS England
National Society for the Prevention Cruelty to Children
Cumbria Partnership Foundation Trust
Cumbria Partnership NHS
Cumbria Clinical Commissioning Group
Probation Trust
Crown Prosecution Service
Greater Manchester West Mental Health NHS Foundation Trust (Unity Alcohol and Drug Recovery Service)

- 6.1. The independent chair and overview report writer of the DHR is Lesley Storey, a Domestic Violence Coordinator for Newcastle City Council. She has no connection with Cumbria County Council or any of the agencies involved in this case. Lesley has completed the Home Office Accredited Training for DHR Chairs and Overview Report Writers.

7. Timescales

- 7.1. It should be noted that this DHR was not completed within the recommended time scales set by Home Office. There was a delay from the onset with Community Safety Partnership commissioning a Chair and overview report writer. At the first meeting the Panel were advised to stand down the review until the criminal justice process was completed. Agencies developed chronologies but did not share any information due to disclosure concerns.

- 7.2. The DHR became further delayed due to the perpetrator's GP practice seeking advice from their defence union. They were supported in their view that they should not share confidential information regarding the perpetrator without his consent. The chair had written to ask Simon to permit access in line with good practice guidance, he did not respond to this. The Panel's view was firmly it is in the public interest to override confidentiality but this view was not shared by the practice and the position became entrenched.

8. Engagement with Family and Close Friend

- 8.1. This review has benefitted hugely from the engagement of the wider extended family on the maternal side of the family and a close friend of Amy's. All homicides are painful and cause untold grief. The circumstances of this homicide are horrific. Somehow in the depths of their pain the family managed to meet with the chair or have telephone interviews and shared significant information regarding the family dynamics. Their insightful views as to what could and should have happened differently to prevent future homicide has informed this review and the lens in which the overview report was written has at all times attempted to consider the family. What questions did they want to ask? What answers do they need to know? Reflection on the views of family has been of significant influence throughout the process. Our heartfelt condolences go out to them.

- 8.2. The information and views of the family are set out at section Two.

9. Engagement with the Perpetrator Simon

- 9.1. The panel has sought to engage Simon with this DHR. Letters were sent to him via his solicitor informing him of the process at the start of the review. Simon agreed to his medical record being shared. He was subsequently

contacted through his Integrated Offender Manager and again through his solicitor. He has not responded to the Panel's requests to interview him.

10. Parallel Reviews/Process

10.1. A Serious Untoward Incident (SUI) Report was carried out by The Cumbria Partnership Foundation Trust (CPFT) on 24th February 2014. The DHR panel has had sight of the report and action plan developed by the trust. Details from the SUI were used to inform the agency IMR. The TOR of the SIU is set out at Appendix 2.

10.2. On 7th May 2014 Cumbria Partnership Foundation Trust met to consider this case in relation to meeting the criteria to undertake an independent mental health investigation. The Northern Regional Mental Health group agreed not to commission independent investigation as the perpetrator Simon was not subject to formal Care Programme Approach (CPA) in the previous 6 months prior to the incident. The case therefore did not meet the criteria for an independent investigation.

11. The Facts

11.1 The victims, Amy, and her mother, Susan, were killed by axe wounds in the family home. The police log details police being called to an address in Cumbria by the neighbour who reported a major argument taking place between the mother and son. The initial call also details that the family dog had been killed by Simon. Officers arrived at the house and discovered the bodies of Amy and Susan inside the house. The injuries sustained were extensive and incompatible with life. Simon was arrested a short time later located on a beach some miles from the address. During the course of the official interview Simon made full admission to killing Amy and Susan. Simon stated that he had attempted to have intercourse with his sister Amy's body following her killing. Whilst this cannot be evidenced forensically scene examination corroborates Simon's disclosure.

11.1.1 Susan and Simon lived in Cumbria in a privately rented house. The property was rented when the mother and son returned to live in the area. Prior to this the whole family, mother, son and daughter resided in Wales where they moved in 2009 to be near to extended family. Amy remained in Wales living with her aunt then later her boyfriend.

11.1.2 Neither victim had reported any concerns or incidents relating to current domestic abuse to any agencies leading up to the homicides.

11.2 Section One

11.2.1 Family Background

11.2.2 There is a significant and substantial history of domestic and sexual abuse in this case. The known perpetrator of the domestic abuse was Andrew, husband of Susan and father to both children.

11.2.3 Susan and Andrew married in 1989. The first known record of abuse dates back to the first year of the marriage in 1990, with GP records showing Susan was seriously assaulted by Andrew on 28th May 1990. No referral was made into Children's Social Care and we also know no referral was made into a domestic violence service for Susan.

11.2.4 Susan and Andrew separated in 1996 but the domestic abuse perpetrated against Susan, was both witnessed and directly experienced by her children, continued up until Andrew died suddenly and unexpectedly in 2006 aged 49 years.

11.3 **Historical Involvement with Services**

11.3.1 It is clear from background reports and chronology submitted by Children's Social Care (CSC) that both children inhabited the child protection arena for a significant number of years. Records of referral into CSC date back to 29th January 1993, at this time Amy was aged 1 and Simon was aged 3.

11.3.2 The first note on record is unclear but relates to a referral made by Susan regarding concerns that the children's father sexually abused a relative when she was a child. From the limited information provided to the panel it appears that this intelligence had some factual basis. However, although a section 37 was recommended no file notes could be located that confirmed any action had been taken regarding this.

11.3.3 Examination of records from both Cumbria Constabulary (CC) and CSC from 1994 onwards highlights the significant number of Child at Risk notifications that were submitted regarding the children.

11.3.4 On 11th November 1994 the police were called to the family home in Cumbria following an argument, the explanation given to officers by Andrew was he had come to the house to find the children alone and Susan out. Susan had returned drunk and an argument began. The police record shows the children were found to be asleep in bed by officers and a family friend was there with Susan. The police left the family friend caring for the children and Andrew was asked to leave. A Child at Risk notification was submitted.

11.3.5 File records from CSC show this referral was recorded on 28th November 1994. A home visit was undertaken by Children's Services. Susan was interviewed and she explained that the couple were separating and Andrew was sleeping elsewhere. On the night the police were called both parties had been out drinking separately and when they returned an argument began. The case was closed by CSC as Andrew was reported to be "moving out of the family home". This appears to have been accepted and no further checks on the children's safety were made.

11.3.6 On 6th September 1995 the police were again called when Andrew was returning the children from a contact visit. The maternal aunt threatened Andrew with a bread knife following what was termed "a long standing family

dispute” .The maternal aunt was arrested and again a Child at Risk notification was submitted.

- 11.3.7 Following this notification the file records show that on 2nd October 1995 CSC made some inquiries with other agencies including CC. On finding out the Aunt did not reside at the same address as the children, the case was closed.
- 11.3.8 On 31st August 1996 Susan rang the police stating Andrew was refusing to return the children from a contact visit. It is clear from the record that at this point Susan requested help from CSC and told officers she was seeking an injunction with an arrest clause to keep Andrew from attacking her. A letter was sent by CC to CSC advising them of this incident. There was no information available to the Panel confirming Susan had injunctive relief.
- 11.3.9 On 4th September 1996 CSC undertook a check on the child protection register and spoke to professionals, though it is not clear which agencies were contacted. No further action was taken.
- 11.3.10 On 29th December 1996 CC attended the family home following an incident described as an altercation between Andrew and Susan the previous night, when Susan went out so Andrew took the children to his girlfriend’s house. An argument broke out that night, and again the next morning .The children were recorded to be safe and well. The police gave advice about contacting a solicitor regarding child custody issues and on 2nd January 1997 they faxed a Child at Risk notification into CSC. No further action is recorded as the action on CSC records.
- 11.3.11 On 24th January 1997 CC were called to the family home by the children’s baby sitter. Andrew had attended the home drunk and had punched the front window in. He then gained entry to the house via the front door. The babysitter fled the house to go next door to call the police .The police attending found Andrew to be drunk and aggressive; he was arrested on suspicion of causing Criminal Damage and Breach of the Peace. The police did go to see the children, both of whom they found sleeping undisturbed. Susan was not present and again a child at risk letter was sent to CSC.
- 11.3.12 On 11th June 1997 Andrew threatened to keep the children following a day out with him. He came to Susan’s house to tell her this and she contacted the police for help. The children were returned a short time later. Again, a Child at Risk notice was submitted but there is no indication from file records that this was acted upon.
- 11.3.13 On 8th January 1998 Susan was arrested following an incident where she poured paint stripper on Andrews’s car and was found to be in possession of a Stanley knife. Andrew requested no further action was taken against her as she was a good mother. The records also show that Susan made allegations of abuse by Andrew, but this was viewed as malicious by the police. CC sent a Child at Risk letter received on 16th January 1998 but no action from CSC is recorded.

- 11.3.14 On 10th February 1999 the family's health visitor referred Amy to Children Adolescence Mental Health Service (CAMHS). Susan described Amy as "depressed and she seemed to cry a lot". An appointment was offered but not taken up by the family. A follow up letter was sent but no response was received.
- 11.3.15 On 13th April 1999 CC were called when Andrew, who had been staying at Susan's house, woke up at 11pm and became abusive. This carried on for some hours until the early hours of the morning when he became violent. He dragged Susan around the house by her hair and stood on her stomach and her throat. Amy was woken by the noise and screamed. Andrew left at this point and threatened Susan that he would tell the police she was drunk and had fallen down the stairs if she rang them.
- 11.3.16 Susan was taken to hospital with a suspected broken bone in her neck and Andrew was arrested and charged with GBH. A Child at Risk notification was submitted.
- 11.3.17 File records from CSC show the notification was received and states that on 15th April 1999 a home visit may have been undertaken by CSC, but there is no record of any action taken to safeguard the children.
- 11.3.18 Children's Social Care were contacted directly by Andrew on 18th November 1999, he informed them that he intended to leave England to live in Australia. He expressed concerned about the "amount of sexual activity his daughter is witnessing between his ex-wife and different men .He reports "Susan is taking all sorts of men home and Amy has frequently seen her Mother having sex." He also makes allegations that Susan was drinking and taking drugs and had been date raped. CSC is recorded as writing to Andrew to inform him these matters have been discussed with Susan and the children are well. Andrew was informed that any further incidents of domestic violence would result in a child protection conference being convened.
- 11.3.19 Days later the police were called again on 23rd November 1999 when Andrew tried to break into Susan's home and an argument took place. Andrew had fled the scene by the time police arrived. Simon who was aged ten at this point had witnessed this and was outside the house with his father. A Child at Risk notification was submitted.
- 11.3.20 Records show that CSC made a home visit to Susan on 23rd November 1999 in direct response to the allegations made by Andrew .The issues he raised were explored and Susan stated he was a violent man, he was jealous and obsessed that she has a succession of men. She told the CSC visiting officer that Andrew had told the children she would bring men home who would burn them with a cigarette; he has threatened to have the children taken from her. Amy was spoken to and she said her father leaves her alone to go to the pub and tells lies and is nasty. Susan also told the social worker she feels the police do not take action against Andrew and he has broken his injunction.

- 11.3.21 CSC responded to this visit by sending another letter to Andrew stating once again that if any other incidents took place the case would be escalated. No further Action was recorded on 3rd December 1999.
- 11.3.22 Another incident of domestic abuse took place on 26th November 1999 when the police were called following a verbal argument which the police intelligence record as “No more than verbal disputes, Susan alleges that Andrew had sexually assaulted his son when he was a baby by inappropriate touching. Andrew states that Susan is a heavy drinker”. A Child at Risk Notification is submitted.
- 11.3.23 During December 1999 Amy was seen by her GP as she had a “red perineum”, she refused to be examined and was upset. There is no record of a referral into CSC or of any other action taken.
- 11.3.24 Police records from 1st December 1999 show that the allegation of child sexual abuse was recorded and Susan was talked to regarding this. Susan stated that Simon had been in the bed with her and Andrew and he had said “*Don’t ever touch me there again Daddy*”, he refused to cuddle Andrew. She also said Andrew had masturbated over the bed when Simon was a baby. She is recorded as telling officers she did not want to make a formal complaint as Andrew had moved to Australia. A Child at Risk Notification is submitted.
- 11.3.25 Records from 3rd December 1999 highlight CSC are aware of this notification and a home visit was to take place on 6th or 7th December. There was no record of outcome available other than a supervision note that indicates an allegation of abuse against Simon was made and it was investigated at the time. There was no other information available to the Panel regarding the investigation of the allegations of sexual abuse.
- 11.3.26 From this record until the 28th August 2000 there is no contact with the family from either CC or CSC possibly due to Andrew being out of the country, as we know from GP records that he visited Thailand during this time.
- 11.3.27 On 28th August 2000 Susan rang CC for assistance when Andrew became abusive when he returned Amy from a contact visit with him. Susan alleged Andrew had spat at her in the hallway. She was reported as having no visible injuries and was advised to contact a solicitor. The records also show Susan was asked to contact the police in future if she was harassed again and a note on file stated “She has not helped the police in the past”. A Child at Risk notification was submitted.
- 11.3.28 CC did speak to Andrew regarding this incident and issued what was described as a warning regarding harassment.
- 11.3.29 CSC records on 4th September 2000 show the Child at Risk notification was received but No Further Action is stated as the outcome.

- 11.3.30 On 3rd February 2000 Susan contacted the police stating she did not want Andrew to take Amy swimming because she was concerned about his child care, on this occasion no Child at Risk was submitted to CSC.
- 11.3.31 On 28th August 2001 records from CSC show that a referral was made into the service by an employee of Children Services who had received information that Andrew was a paedophile and that he is in dispute with his ex-wife over contact with his children. A file entry reads:
- “Principal Social Work recording states that records do not confirm allegation re: father being a paedophile. Contact dispute maybe on-going and Susan has been written to requesting that she contacts Children Services and she has not replied therefore, No Further Action”.*
- 11.3.32 On 19th November 2001 Susan is recorded as contacting CSC herself directly regarding concerns for her children. She expressed concern that her children were being emotionally, physically and sexually abused by Andrew. Susan stated that she has previously had a visit by a Social Worker and a Police Officer and was told that they would need evidence to proceed.
- 11.3.33 Susan reported that Amy was crying following contact with her father. Amy had told Susan she was sick of her father cuddling up to her in bed and saying “you’re my girlfriend”. Susan believes Amy is being abused – she is always dirty after contact – and her vaginal area is sore. Susan is quoted as saying “this may be due to a lack of cleanliness but she has been scared to look for fear of what she may find”. It is also clear that Susan described domestic abuse and actual physical abuse against her children from Andrew. In response to this referral Susan was advised to stop contact with Andrew and to seek legal advice. A strategy meeting was recommended.
- 11.3.34 Records from both CC and CSC dated 23rd November 2001 highlight that a strategy meeting did take place and a recorded outcome from this was that Amy was to be interviewed on video by CC and CSC. There is however no evidence of this ever having taken place on either agency’s record.
- 11.3.35 On 19th December 2001 Amy is seen by the GP as she has a urine infection. There is no record of any discussion or advice other than providing treatment for the infection.
- 11.3.36 On 14th January 2002 Susan sought assistance from her GP as Amy (aged 9) had another urine infection. At this consultation Susan raised concerns that both Amy and Simon were being sexually abused by Andrew. She gave two examples of the sexual abuse of Simon which were that Andrew had masturbated over Simon when he was a baby, and that she had found the baby’s blanket covered in semen. She also stated when he was aged three Simon had said to his father “Don’t ever touch me there again”.
- 11.3.37 CSC responded to the request from the GP for services for the family by convening another strategy meeting and the outcome from this was Amy was to be medically examined by a designated Doctor for child protection.

- 11.3.38 Records show Amy was medically examined on 15th January 2002 and the examination showed signs of vaginal and possibly anal abuse. Following the medical examination Amy was also interviewed by CC and CSC. During the interview she did not disclose abuse but did say she shared a bed with her father and he called her his girlfriend.
- 11.3.39 Despite concerns being raised about Simon being sexually abused by his Father he was neither talked to nor examined. There was no available information to the Panel outlining the thought processes or responses of CSC regarding Simon as a potential victim of sexual abuse. Opportunities to explore this with Simon were missed.
- 11.3.40 On 22nd January 2002 a further strategy meeting was held as Susan had reported further concerns regarding Andrew sexually abusing Amy. The outcome of this was that Amy was to be interviewed again. No minutes were found of this strategy meeting.
- 11.3.41 Amy was video interviewed the following day on 23rd January 2002; CSC records from this interview are as follows:
- “Amy stated that Susan had said that the Doctor had found finger prints inside her and she believed that Andrew abused her but she couldn’t remember anything about it. Amy was happy for Andrew to go to jail as she believed Andrew raped her auntie”.*
- 11.3.42 On 5th February 2002 during a home visit in which both children were seen and spoken to it is clear that Simon was very upset. He told the social worker that he got a bad head at his father’s and when prompted by Susan about his father rubbing himself in front of him Simon said “ He only did that once “.
- 11.3.43 Despite clear forensic evidence CC were not able to prosecute any individual regarding the abuse that Amy had suffered. No direct disclosure was ever made by Amy regarding who had sexually abused her. The medical evidence however was clear, Amy had been sexually abused. When questioned by CSC Andrew denied he had abused Amy. Child Protection investigations were undertaken and both Amy and Simon became subject to Child Protection plans under the category of Sexual Abuse 12th February 2002. It was also recorded that the category they were registered under was emotional abuse and this discrepancy was not cleared during the review.
- 11.3.44 Following the Child Protection Conference a social worker visited the children and the file note from this visit is as follows:
- 11.3.45 SW informed Amy that her hymen had been rubbed away and that she did not think that Andrew was responsible and the injury could have been caused some years ago. Susan stated that it may have been a babysitter. Amy states that she tries to remember every night who abused her.
- 11.3.46 From the file record it is also evident that Susan was angry with the response from CSC. “She appeared to be sure that Andrew was the perpetrator of the abuse towards Amy, she did concede that she had also used

babysitters/boyfriends that could have carried out such an act but her overwhelming belief was that Andrew had abused Amy". Susan informed CSC that she would be moving away from Cumbria to Colne, Lancashire.

- 11.3.47 The family did move to Colne the following week on 17th February 2002 and there is evidence on file of the case being transferred to Lancashire CSC with information being shared with Lancashire Police also, advising them that two children who are on a child protection register because of sexual abuse concerns are living in their area.
- 11.3.48 On 20th March 2002 a Transfer Child Protection Conference was held in Colne and the children were registered under the category of Neglect. No information was made available to the panel as to the rationale behind the change in category from sexual or emotional abuse to neglect.
- 11.3.49 The file records from this time are very unclear but it seems likely that following the move Andrew then approached a solicitor regarding contact with Amy (aged 10) and Simon (aged 14).
- 11.3.50 As the children were living in Lancashire the court case regarding child contact was held in Blackburn. The Judge at Blackburn County Court on the 28th February 2003 ruled that given that "Amy had been clearly sexually abused and is still in the care of one parent where the other denies the abuse and there are no findings, the court requested the completion of a Section 37 report and Interim Care Orders were granted". Amy and Simon were to remain living with their mother.
- 11.3.51 A review of Child Protection Plan took place in Colne on 14th June 2002 and the case was de-escalated from Child Protection Plan to a Child in Need. A family support package was put in place and both children were referred into a service to undertake safety work. It is not known if this work took place as Lancashire CSC closed the case only a month later on 17th July 2002.
- 11.3.52 On 13th November 2002 CSC records show Andrew contacted them to advise them that Susan and the children had returned back to Millom. The family were not contacted by CSC and the records are unclear as to why Andrew contacted them and what his expectations were. The records read as follows "Lancashire Children's Services had prepared a Section 37 report which stated they did not intend to issue legal proceedings regarding the children nor make a referral into Cumbria Children's Services as the case was closed".
- 11.3.53 Despite all previous concerns regarding the children CSC did not take this opportunity to make contact with the family and check on children's safety.
- 11.3.54 On 09th November 2002 Andrew was stopped and questioned by Police officers whilst driving; he claimed to be a police officer from Leeds.
- 11.3.55 On 24th December 2003 a Health Visitor contacts CSC to advise them the family are back in Cumbria.

- 11.3.56 On 3rd January 2003 Susan contacted CC as Andrew had called to her house with Christmas presents when he should not be having contact with his children. He had been verbally abusive to her. It is clear from police intelligence relating to this incident that Simon had been distressed by this incident. The police issued a warning against Andrew under Harassment Act and made a Child at Risk referral to CSC.
- 11.3.57 Following this incident on 5th March 2003 a SW undertook a home visit. Susan was reported to be defensive; the children did not want to talk to a SW. A core assessment was strongly recommended.
- 11.3.58 On 8th March 2003 the NSPCC Wedgewood Centre, a centre that offered therapeutic services to children who have been sexually abused was consulted by CSC. The case for the family was opened and views from the NSPCC were sought as how best to proceed. CSC was advised of the need to have Simon medically examined. No family members including the children were seen by NSPCC at this point. The consultation was specifically to assist CSC on the management of the case.
- 11.3.59 On 9th March 2003 another home visit is undertaken by a SW. Susan is recorded as being "Hostile throughout the home visit", and this appears to be in relation to a remark made in court that Susan had "failed to protect her children" and that "she was not very cooperative in allowing her children to speak to a SW".
- 11.3.60 It was also noted that the children appeared to have a lot of information regarding the court case and during the visit Susan had a conversation with both children about "how protective she was of them". An outcome recorded from this visit was that a Child Protection Conference would be convened.
- 11.3.61 On 14th March 2003 a multi-Agency meeting is recorded as having taken place, no records of this were available. A file note from 26th March 2003 does show that a SW would be undertaking work with Amy on sexual boundaries and also records "Amy does not want to see her Father as he used to hit them". This work was to take place in the family home at Amy's request.
- 11.3.62 A Child Protection Conference was held on 29th April 2003 and both children were registered under the category of Sexual Abuse. At this point neither child was recorded as having made any complaints against their father regarding inappropriate sexual behaviour, but both were recorded as having witnessed domestic violence, having made allegations of physical abuse against their father and of not wanting to have contact with him.
- 11.3.63 On 2nd July 2003 a second consultation was sought from the NSPCC by CSC, again no family members were seen and it was noted "Little headway was being made by the social worker with her assessment due to the level of cooperation from the children's mother".
- 11.3.64 The NSPCC recording from this second consultation is extensively covered in their agency IMR. Issues that are covered included concern that Simon is

refusing to speak to a SW and that Amy had only been seen on one occasion. Susan is described by CSC as resistant and hostile.

- 11.3.65 There is also concern that Simon was reported by the school as not achieving as well as he had been, he was living in a dream world and not making friends.
- 11.3.66 It is unclear from the recording of CSC and NSPCC as to how this information was used within assessments for the children and there was no consideration within NSPCC records of whether further action was required by them as an agency.
- 11.3.67 Case notes from CSC on 8th May 2003 highlight discussion between the appointed Guardian for the children and the SW in which it is felt Susan has “Coached the children”; in particular concern is noted regarding “discrepancies when she has been talking about Simon”. A psychological assessment of both Susan and Andrew is recommended.
- 11.3.68 CSC then held a review of Child Protection Conference/Looked after Review and decided to keep both children on the register and retain the category of Sexual Abuse. There were no minutes available from this conference but a report contains the record that the view of professionals is that it is “difficult to know which parent is telling the truth”.
- 11.3.69 On 11th September 2003 Amy tells a SW her father “used to batter them and leave them on their own”.
- 11.3.70 On 20th November 2003 the record from a home visit highlights Andrew is in Prison at this point for a driving offence. The SW discussed Criminal Injuries Compensation with the family and advised them that only Amy is eligible to apply. Amy and Susan are reported to be concerned that Simon will feel his allegations have not been taken seriously.
- 11.3.71 The issue of CIC came up many times in this case; it appears to have become well known within the family that this was an issue that deeply affected Simon. The family identified this immediately as an issue that would cause distress to Simon and it would appear their instincts were correct. The issue of CIC was divisive and a cause of deep seated resentment by Simon.
- 11.3.72 Following this visit the SW had a conversation with the children’s Guardian, which was recorded as “Noted that the children are becoming increasingly angry” and feels “Susan is drawing the children into the animosity she feels about Andrew”.
- 11.3.73 CSC file records from 8th December 2003 provide insight into the children’s feelings towards their father at this time. A psychologist’s report which had been commissioned for court proceedings for both children is cited as “recommended that neither child wished to have any contact with their father, nor both appear to be very upset by any prospect of contact even if accidental”.

- 11.3.74 The report commented that Amy's failure to recall who had sexually abused her could be due to the abuse occurring too long ago for her to remember, or that she was too emotionally distressed and had blocked the memory. The report highlighted a very close bond between the children noting they were "strongly attached to each other and take strength from mutual support. It also commented that they needed their mother. The report was very positive regarding Susan and reinforced that the children's relationship with her was "Strong and positive and they do not feel overly or inappropriately influenced by her".
- 11.3.75 The report was clear that it would be detrimental for either child to see their father. Some therapeutic work was recommended for Amy, but the focus of this should be to assist her to come to terms with what had happened and should avoid questioning her as this was causing her "considerable distress"
- 11.3.76 On 19th December 2003 Andrew was released from Prison with a home detention curfew, which expired on 15th March 2004.
- 11.3.77 Despite there being a clear recommendation that Andrew should not have contact with his children this did not happen. We know that Susan called the police on 15th January 2004 regarding concerns that the children were being sedated when they were with their father over Christmas. Simon told his mother that his father had given him drops that would make him sleep and he would wake up with a headache. A referral was made into CSC who established the drops given were harmless and No Further Action was taken by the CC or CSC. This represents a significant lost opportunity to safeguard Simon and Amy.
- 11.3.78 On 2nd February 2004 a supervision order is recorded on CSC files has being granted and Andrew is to have no contact with the children. Andrew did not attend court nor did he instruct counsel to agree or contest the application. There is no further information on record regarding this matter.
- 11.3.79 On 16th February 2004 both children's names were removed from the Child Protection Register as they are now on a supervision order and "having no contact with their father".
- 11.3.80 On 17th February 2004 a home visit is conducted by SW and a Family Support Worker who had been allocated to the case following completion of the court case and the children being de-registered. The record from this visit shows Susan as being "Hostile that the children were not being listened too and that the SW had stopped the police investigation".
- 11.3.81 The Family Support worker visited the home again on 6th April 2004 and Susan asked for help and counselling for Amy as she was telling lies, drinking alcohol and staying out at friends. What is not clear from the records is why therapeutic work as recommended in the psychologist's report had not begun. A referral to The Wedgwood Centre is recorded as having been made.

- 11.3.82 On 4th May 2004 Amy began her therapeutic work with NSPCC .She was seen on a one to one basis and had 13 sessions. During this time the therapeutic practitioner met with Susan on limited occasions and Simon was in the family home on one occasion when Amy had her one to one. The counsellor had full access to CSC files and was fully informed regarding the background issues of the case.
- 11.3.83 There is a lack of clarity, noted by the NSPCC in their report, regarding the purpose of the therapeutic work with Amy. Amy herself initially believed she had been referred for counselling following a self-harm attempt.
- 11.3.84 It is clear from the IMR that the counsellor was sensitive to the needs of Amy and identified “The importance of Amy being in control of the session, particularly bearing in mind the pressures around the sessions, in particular her Mother’s controlling influence”. Amy took part in planning her sessions and identified issues she wanted to talk about, these included:
- Discussing words/technical terms used by people in relation to her sexual abuse that she did not understand
 - Feelings connected to learning she had been sexually abused
 - Feelings about her mother
 - Feelings about Social Workers
 - Discussing self-harm
- 11.3.85 During this period, sometime between 4th May 2004 and 14th January 2005 we also know from NSPCC records that Amy disclosed that her mother had hit her and she had hit her Mother back and smashed some furniture and a chess set. It is not clear from the records of any agency that this information was shared with CSC.
- 11.3.86 In another session Amy spoke of fighting with Simon, kicking and hitting each other and they also hit their mother. This was discussed by the practitioner in supervision and consideration was given as to whether Simon or her Mother could be abusing Amy and whether she was safe. It was decided there was nothing to suggest Amy was “unsafe” and it would appear no referral was made into CSC.
- 11.3.87 At no point during the therapeutic intervention did Amy ever disclose who had sexually abused her; indeed she stated she was not sure she wanted to remember.
- 11.3.88 On 5th May 2004 The Family Support worker visit record highlights that Amy was upset that her CIC application has been refused due to a lack of evidence Amy is reported as being concerned people will think she is lying. Amy is also recorded as being bullied at school and had attempted suicide; she had some lacerations on her wrist and had seen her GP. Susan also reported Andrew had been attempting to contact the children via a third party, his niece, and Susan said she was going to apply for an injunction to prevent this. Actions recorded from this visit are to appeal against CIC claim, make a

referral for Amy to The Wedgewood Centre for therapy and discussed with Andrew his attempts to contact the children, which he denies.

- 11.3.89 On 14th May 2004 Susan made a telephone call to the police stating she felt her children were in danger. She was described as crying and confused. She told the police her ex-husband had had sex with a 14 year old girl. The police advised they could only take action if a formal complaint was made by her. She was advised to seek legal advice.
- 11.3.90 Susan again rang the police on 25th May 2004 reporting Andrew had been abusive towards her; no further information regarding this call is recorded.
- 11.3.91 On 21st July 2004 a SW and family support worker visited the home. The notes from this visit are summarized as follows:

Amy states that "Susan interrogates her about her father and on at least four occasions Susan has stated to Amy that Andrew is the perpetrator of her abuse". Susan initially denied this and then stated that "Andrew was the perpetrator and that Amy was too frightened to say anything". Susan was challenged about this and it was stated to her that Amy has made no disclosure.

Susan was shouting calling Andrew a paedophile Amy was angry saying that she does not know who the perpetrator of her abuse was and she is tired of Susan telling everyone. Amy states that "she tries to remember every night". Amy stated that "she understood that her mother was angry with her father and she has witnessed him being abusive and threatening to kill Susan". Amy stated that "she had seen her father and he had shouted at her and she was frightened".

- 11.3.92 The record also shows that Susan was offered some counselling but she refused this, she was also informed her behaviour was damaging to both her children and she was not meeting their needs.
- 11.3.93 This visit was discussed with the Team Manager and the outcome of this visit was that no further direct work was to happen with Susan.
- 11.3.94 On 18th August 2004 Susan again rang CC to complain her ex-husband had driven past Simon causing him distress and that she is applying for a non-molestation order against him.
- 11.3.95 Three further visits are recorded by CSC as being made to see the family between 25th August 2004 and 17th November 2004, the scant notes from these visits indicate Susan expressed concern regarding ongoing problems with her ex-husband and on one occasion concern that Simon does not respect her and blames her ex-husband.

- 11.3.96 On 24th November 2004 a file record shows a telephone conversation regarding Amy's CIC claim, this had now been awarded and valued at £6,000. The notes on file are recorded as follows:
- "Call to Susan she is unhappy with the compensation provided to Amy £6,000, is that this is what Amy's virginity is worth? Amy has been crying and she has been hurt by this. Susan was requesting to know how the claim has been graded". The action recorded from this phone call was to consult with legal services.
- 11.3.97 On 13th December 2004 NSPCC closed Amy's case and there is no further record of contact with the family from this point.
- 11.3.98 It is clear that during this time Andrew continued to harass Susan and on 6th January 2005 she contacted CSC to inform them Andrew had breached the injunction and it does not have powers of arrest, he had been loitering in the street.
- 11.3.99 On 27th January 2005 a file note from CSC records Amy is discharged from Wedgwood centre as work with her has been completed. Also recorded is that Simon was offered counselling by Child and Family Worker but he refused. The IMR from CSC noted "Throughout this time the case files focused on Amy, with little evidence of interaction with Simon. CSC closed the case regarding Amy and Simon on 7th February 2005.
- 11.3.100 On 20th April 2005 Susan contacted CC and reported historical assaults on Simon by his father. She stated Simon "*had been troubled by previous memories and beatings he received from his Father*". An officer spoke to Susan and established "there had been issues in the past which had been dealt with, counselling was suggested".
- 11.3.101 On 27th July 2005 Simon was seen by the CAMHS team in the presence of his mother. We know from the notes taken from this assessment that Simon described himself in terms of being the exact opposite to Amy. He also talked about being beaten by his father and that this still makes him angry, however he identified he had friends he could talk to and his mother, so he did not want counselling at this time.
- 11.3.102 Simon was observed in the assessment session as being assertive, asking his Mother to be quiet, and stating he "often gets annoyed when people thought his Mother put words into his mouth"
- 11.3.103 Notes recorded in the file by CSC highlight that Simon was viewed as a "very damaged child" and that CSC had considered care proceedings but Simon and Amy had "colluded" with their Mother.
- 11.3.104 A CAMHS practitioner reviewed the CSC file 8th August 2005, as there was a significant discrepancy between the views of the psychology service and that of CSC There was no record available to the panel regarding the outcome of the discussion that took place regarding this matter.

11.3.105 On 6th December 2005 Susan contacted the police to advise them Andrew had sent a card to the children and she was concerned as to what his intentions were. A notification was sent to CSC. No record of outcome or action was available.

12 **Analysis of Childhood period a history of Domestic Abuse**

- 12.1 It is evident that both children were exposed to and directly experienced domestic abuse throughout their childhoods. The abuse began when they were both very small children, in infancy and potentially pre-birth.
- 12.1.1 Susan sought support from her GP as early on as one year into her marriage to Andrew, at this time Simon was aged 8 months old. We know the GP documented the actual physical injuries but made no referral regarding Child Protection concerns, and does not seem to have given advice to Susan regarding domestic abuse services.
- 12.1.2 There is now a well-established evidence base that confirms the risks to small babies exposed to domestic abuse, it is known that those aged less than 12 months are very vulnerable, and agencies' policies and procedures would now be expected to reflect this. Simon was at risk of significant harm and the GP missed an opportunity to make the appropriate Child Protection referral, however this was by no means unusual in the early 90s.
- 12.1.3 Cumbria Constabulary attended the family home on 8 occasions from November 1994 to November 1999. The children were seen and recorded as asleep on many of these occasions. It would appear CSC felt this warranted no further action on their behalf to protect Amy and Simon. Additionally, no consideration was given to Susan's needs. There is some evidence to suggest Cumbria Constabulary advised her to get legal support but no information that suggested there were services Susan could seek support from in her own right. Certainly in this time frame Cumbria had a Women's Refuge who could have provided support.
- 12.1.4 CSC response during this period was minimal and limited to "superficial checks" with other agencies or on at least one occasion a letter to both Susan and Andrew to "enforce the effects of domestic abuse on children".
- 12.1.5 A clear assessment and analysis of what was happening within the home, who the primary victim was, what the risks were and what plan needed to be put in place in order to protect both the victim and children was not considered. It is likely that writing to Susan and Andrew together was not helpful and may in part explain why the relationship with Susan was strained from the onset of CSC engagement with her.
- 12.1.6 Susan was written to on one occasion when she was not present during an incident. Her home had been broken into by her ex-husband, and he was subsequently arrested, and yet Susan was somehow viewed as in some way responsible for this attack.
- 12.1.7 There was no evidence or information presented to the panel to demonstrate that at any time Susan's risks or needs in relation to being a victim of domestic abuse were ever considered. The abuse that Susan experienced was both physical and emotional; harassment and stalking behaviour were persistent for years post separation. On one occasion Susan had a bone

broken in her neck and this did not result in CSC visiting the family to safeguard and support. She was on one occasion asked if she wanted counselling, however this was within the context of being advised she was not meeting her children's needs.

- 12.1.8 Susan must at times have felt overwhelmed and isolated struggling to bring up two children on her own, with constant harassment from her ex-husband. When CSC did intervene Susan was clearly viewed as uncooperative and as an inadequate mother who had "failed to protect" her children from both domestic abuse and sexual abuse. There is a view expressed by both CC and CSC in records that Susan's claims that her ex-husband is both physically abusive and sexually abusive to her and her children are either vindictive or malicious.
- 12.1.9 The impact of experiencing abuse within their home over the entire duration of their childhoods cannot be underestimated. Living in a home where domestic abuse is taking place is an ongoing threat to physical safety and wellbeing and can undermine social and emotional functioning. (Lannert 2014)
- 12.1.10 Furthermore, the impact of the ongoing abuse Susan experienced would have had a potentially traumatic impact on her. Maternal trauma can in turn impact on care giving and can affect relationships between mother and child.
- 12.1.11 Scheeringa and Zeanah's 2001 study takes this further and demonstrates a mother showing signs of trauma can exacerbate trauma in her children. The IMR author for the GPs practice recognised this from her examination of the records and wrote "Susan's emotionally labile state could be understood to be post-traumatic stress disorder or continuing violence and fear". Susan contacted her GP on many occasions and was referred many times to gynaecology, endoscopy and Ear Nose and Throat often with functional symptoms. The GP IMR author writes:
- "In my opinion this is a somatization of distress. This presentation is common in people who experience domestic abuse. The referral letters to or back from medical specialities do not on the whole detail the social history. Multiple opportunities were therefore missed for referral into appropriate agencies. There was a lack of opportunity for her to make sense of herself and her life"*
- 12.1.12 It should also be noted that Susan's consultation rates dropped markedly when her ex-husband died which supports the view that ongoing domestic abuse was the root cause of Susan's health needs.
- 12.1.13 This may in part explain Susan's behaviour witnessed and described by professionals as inappropriate in relation to her children. Susan's capacity to parent may have been compromised by trauma.
- 12.1.14 It also seems likely Susan's engagement with CSC could have compounded this trauma. Susan was viewed with deep suspicion by CSC, she would have

been aware of this, her children would also have been aware of this and this was evident in records. A lack of trust ran throughout her relationship and contact with Social Workers and this impeded the support that was offered to her children. Susan was viewed as a barrier and difficult to work with and as a result CSC disengaged from her.

- 12.1.15 An ongoing feature in this case was the statutory services response of treating each incident reported to them in isolation, this was present in both CC and CSC. A holistic understanding of the chronic long term systematic abuse experienced within the home by Susan and her children was not compiled. The understanding of the family's history should be the fundamental basis for any assessment for deciding the initial response to decisions about thresholds and interventions. In this case the risks to mother and children were assessed as significantly lower than they actually were as previous information, fully and readily available to practitioners, was ignored.
- 12.1.16 This importance of the use of family history is well evidenced, specifically from Serious Case Reviews and the Panel could not understand why CSC response was not informed by information easily accessible within their own agency records.
- 12.1.17 On several occasions the chronology evidenced CSC response as being that of "If another incident occurs action will be taken". On the 8th reported incident of domestic abuse it was noted "the matter would be escalated if another referral was received however we know this did not occur" cited from CSC Background Report.
- 12.1.18 This lack of understanding of the importance of holistic assessment resulted in what Brandon et al 2010 describe as "Start again syndrome". Each incident was seen in isolation and the ongoing nature of the abuse and therefore risks to the children were missed. It should be made explicitly clear that CSC have fully accepted within their agency background report that "the social work practice was poor and the children were not effectively safeguarded".
- 12.1.19 Themes identified by CSC as evidence of poor practice during this period would be summarized as:
- Poor record keeping categorised as hand written notes that were difficult to follow or in some cases paperwork was absent.
 - Views of the children were not heard hence we have very little idea of what life was like for Simon and Amy.
 - Lack of pro-active response.
- 12.1.20 The CSC IMR states "That since the Munroe Review of Child Protection Services in 2011, the significance of hearing the voice of the child within Child Protection System has been highlighted. There are now various quality assurances measures in place within Children Services to ensure this would not occur now within current practice".

- 12.1.21 Service improvements made in the last ten years also include the introduction of Triage and multi – agency safeguarding hub (MASH) within Triage .The agencies represented within the MASH include Health, Police, Children Services and Education. This was presented as a more robust multi-agency risk assessment that leads to a more proactive response.
- 12.1.22 Cumbria County Council commissioned Strengthening Practice Training in 2012 aimed at promoting a critical approach to assessments; this was made available to all Children’s Services staff. An audit framework is also in place where in cases are Quality Assured by Senior Managers. This was described as providing clear evidence assessments have improved.
- 12.1.23 Record keeping has been subject to significant changes since this case was open and from 2005 a computerised system was established, this holds all relevant case information and enables access readily to previous involvement with a family. Clearer policies and procedures are stated as being in place, located on the LSCB website and this supports practitioners in assessing risk and how to use the CAADA –DASH.
- 12.1.24 Clearly changes have been made; the CSC report clearly stated the importance of listening to the voice of the child is now central within child protection in Cumbria.
- 12.1.25 The report also identified some areas of improvement in relation to supporting adult victims of domestic abuse, for example access to a Domestic Abuse Co-ordinator. It remains the contention of panel however that more could be done to ensure adult victims of domestic abuse are safeguarded and supported in Cumbria by Children Services.
- 12.1.26 Humphreys and Stanley, 2006, demonstrate that there is a major structural problem that lies at the heart of child protection. This is namely that there is both a child victim and an adult victim. Inadequate responses at a strategic level to this issue consistently create problems for front line workers. It is for this reason they suggest two workers are allocated, one for the child and another to focus on issues for the adult victim.
- 12.1.27 It has long been recognised that the support to the non–abusive parent is one of the most effective ways to safeguard children in a context of domestic abuse and this approach could be achieved by locating a specialist support worker possibly an IDVA within the MASH .This would ensure the adult victim was given support in their own right and freeing up Social Workers to concentrate on the needs of the child.
- 12.1.28 An IDVA would undertake CAADA – DASH risk assessments and this could then be considered alongside and in complement to the risks to the child. Co-location in this way has also been found to have increased the awareness of other professionals in relation to domestic abuse, what services are available, increased experience in risk assessment and a general awareness raising and an increase in “institutional advocacy”.

13 Sexual Abuse

- 13.1 It was evident from the records available to the panel that Susan struggled to get services to take her concerns regarding sexual abuse seriously. She raised this issue on a number of occasions with CC, CSC and her GP. It is of concern that Susan's fears were not taken seriously and that she became viewed with suspicion when she refused to let this matter be dropped. Susan was questioned about why she hadn't brought up the matter of sexual abuse earlier and her reasoning was she was afraid of Andrew.
- 13.1.1 Susan had experienced domestic abuse for many years; her fear levels would have been very high; this was intentional on Andrew's behalf. Evidence firmly establishes a link of the co-existence between domestic abuse and the sexual abuse of children. A terrorized Mother is less able to protect her children or speak out about her fears.
- 13.1.2 Susan was relentless in her pursuit of safety for her children; she refused to let the issue be dropped. In response to this she became viewed as being difficult to work with.
- 13.1.3 Susan eventually managed to get her fears recognised with support from her GP regarding Amy. Her concerns regarding Simon were not taken seriously and were never substantiated.
- 13.1.4 The Panel had insufficient material available to them to understand why Simon was not considered to be a victim of sexual abuse. It had been clearly recorded within CSC files that Susan thought Simon had been abused; he was, on two distinct and separate occasions, recorded as being on a Child Protection Plan under the category of sexual abuse yet he was never spoken to as a child about this.
- 13.1.5 It is concerning that the NSPCC had advised CSC of the need to have Simon medically examined and this advice was not followed. There is therefore no forensic evidence that confirms Simon was sexually abused.
- 13.1.6 Despite no criminal conviction taking place we know Amy was sexually abused. It is therefore possible and indeed probable that Simon was both exposed to the sexual abuse of his sister in some way or was indeed directly abused himself. Certainly Simon was fully aware his sister had been sexually abused and was present on many occasions when this was discussed in some detail.
- 13.1.7 It is also possible that Simon sexually abused Amy and this may have continued beyond the period in which CSC and the NSPCC were in contact with the family. We know Amy informed her boyfriend that *"sometimes in the back of my mind I try to remember then I don't want to as I think it may have been Simon who abused me"*.
- 13.1.8 Evidence informs us that children and young people are more likely to be sexually abused by another child than an adult, and the risks associated with sexually harmful behaviour from children would have been known to the

NSPCC at the time. Indeed the NSPCC report states “*The NSPCC had guidelines at that time in relation to sexually harmful behaviour , and it would have been expected for a service specialising in the sexual abuse of children to have considered this as a possibility and to have offered some guidance to the social worker*”.

13.1.9 The NSPCC did not make safeguarding referrals into CSC regarding the concerning information Amy disclosed during her counselling sessions. NSPCC have stated as a Children’s Charity this was unacceptable and even though this occurred a number of years ago it fell outside their practice standards at the time.

13.1.10 The NSPCC did not make safeguarding referrals into CSC regarding the concerning information Amy disclosed during her counselling sessions. In their own words the NSPCC have stated as a Children’s Charity this was unacceptable and fell outside their standards.

14 **Section Two**

14.1 **Interim Period**

14.1.1 From 2005 onwards up until two days before the homicides there was very little information available to the panel regarding the lives of Amy, Simon or Susan. This interim period in the narrative is restricted to only a few key events. There were some seemingly unrelated GP appointments; however these were fewer than had been usual for the family pattern. It was noted within the GP’s IMR that consultation rates for Amy, Susan and Simon dropped considerably from 2006 onwards. The family did not come to the attention of any service or agency.

14.1.2 This period in the chronology is associated with the sudden death of Andrew in 2006.

14.1.3 Amy aged 16 was referred into CAMHS service by her GP for “Low self-esteem and problems with her body image”. Four attempts were made to contact Amy from June till October 2009 then the file was closed. There is no record from the GP records that any questions were asked of Amy regarding her home life or indeed any exploration of her previous history and how this could be impacting on her current feelings.

14.1.4 The family had then moved to South Wales in 2009 to be nearer Susan’s sister. Again there was scant information from services in South Wales available to the panel. We know on 1st October 2010 Amy again consulted her new GP in Wales regarding body image problems and was recorded as being a little overweight so referred into an exercise programme.

14.1.5 There is one recorded incident from South Wales Police Constabulary regarding Simon.

14.1.6 On 15th October 2010 Simon was involved in a “street fracas”. Attending officers found he was slightly intoxicated and had minor lacerations to his

head. He was unwilling to make a formal complaint, refused medical care and was taken home and left in the care of his parent.

15 **Simon and Susan Move back to Cumbria**

- 15.1 Simon and his mother returned back to live in Cumbria. Amy had built a new life for herself and decided to remain in south Wales. She lived with her maternal Aunt to whom she was very close and later with her boyfriend in her own tenancy. Amy was enrolled in a social care course in University and was happy. She had learnt to drive and was independent but very committed to her family and rang her mother on a daily basis. Her aunt described her as “Like a daughter to me” and the bond between the two was very strong.
- 15.1.1 Susan had not been able to settle in south Wales, she had not found work and at times the Aunt described the family were short on money and she would often take them food or lend money.
- 15.1.2 Susan gained employment in Cumbria and worked in a prison for a very short period of time on a fixed term contract. Simon was unemployed and not in education although his extended family have commented that he was “bright”.
- 15.1.3 Simon attended the GP practice in Cumbria to register and a general medical questionnaire was undertaken. He registered promptly as he wished to find out about abnormal liver function tests he had undertaken in South Wales. The tests came back as “normal”. The GP also used the session to take routine information regarding his consumption of drugs and alcohol. Simon denied this was an issue for him, although in view of his recent concern regarding his liver function this could have been explored in further detail by the GP. He did disclose in a further on consultation that he used “legal highs”.
- 15.1.4 The GP dealt with two major clinical issues, genetic testing for myotonic dystrophy and Simon also asked about the possibly he may have ADHD. Simon had filled in an online questionnaire regarding ADHD and wanted further testing. He told the GP that he “has done online test for adult ADHD and came back strongly positive. Has very wide field of interests but finds it difficult to focus on one thing for any length of time, affects his ability to function”. There is a note regarding waiting for psychology to get back to us but no further information was made available to the panel. The genetic testing did happen and the results came back that Simon was normal after the killings.
- 15.1.5 In April Susan consulted with her GP and was diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and she required a further x ray. It seems Susan’s lungs were deteriorating and in the months leading up to her murder she was treated for her medical condition. There is no record of the GP asking Susan how she was coping at home or what her family life was like.

- 15.1.6 The GP practice would have known Simon was being tested for a genetic condition and he had concerns himself and also that he was also using so called legal highs. The GP practice would also have had full background information on the significant domestic and sexual abuse that both Susan and Simon had experienced.

16 Events leading up to the Killings

- 16.1 This period in the narrative describes the crucial two days, from Simon's self-harm attempt to the killing of his family.
- 16.1.1 Police were called by a member of the public following concerns about an adult male. The man was described as having blond hair, 5'8 to 5'9, wearing combats, black jumper, green man bag and his lip pierced. This man was in a road in Cumbria, and came up to the informant and said 'I've got nothing up my sleeves, I won't get it out, I won't pass you it, I won't kill my mother, I'm going somewhere quiet'. The informant told police that he thought the incident was very weird and that the man was not with it and possibly on drugs. The informant stated that he was concerned for the man's mental health.
- 16.1.2 This incident was passed to PC 1 and PC 2, who were then assigned a police vehicle. These officers made their way to an area in Cumbria, conducted an area search for a person fitting the description but did not locate him. From the description given by the caller it is highly likely that the subject of this call to police was Simon.
- 16.1.3 At 9.48am PC 1 informed the police control room that there was no trace of anyone matching the description. At 9.49am a police despatcher added a summary to this log 'summary- concern for male walking round street patrols attended and checked area no one seen matching description no further sightings'.
- 16.1.4 A further log 84 is recorded at the exact same time of 9.49am which details reports of a strange man who had blood on his hands said to be in the nature reserve in Cumbria .The same officers PC 1 and PC 2 were dispatched to attend to this incident and they duly located the man who was Simon. He presented with cuts to his lower arm which appeared to be self-inflicted and caused by a seashell. Simon was very reluctant to talk to the officers and he seemed to be intoxicated. He denied this initially but later told ambulance staff he had taken a cocktail of codeine, cannabis and LSD.
- 16.1.5 An ambulance was called by the attending officers and arrived at 10.00 am.
- 16.1.6 The police then went to Simon's home to talk to his mother. Susan told officers nothing out of the ordinary had happened and she had left home before Simon had got up that morning. She stated that she had tried to call him as he had been due to attend a job course in Barrow that day but he had not answered his phone.

- 16.1.7 Susan is recorded as saying she was aware Simon had self-harmed in the past but she had not recognised this at the time and he had recently undergone tests for a hereditary condition and the results were unknown. She told officers she would attend the hospital.
- 16.1.8 PC1 then returned to the station and completed a Vulnerable Adults form in respect of Simon; this was faxed as per the protocol at 2.17pm the same day.
- 16.1.9 Simon was taken to FGH Emergency Department by ambulance. The ambulance service handed over contact information which included a medical history and clinical observations.
- 16.1.10 The Ambulance Service had recorded the incident as self-harm to right wrist and a suspected overdose. It was noted Simon had drunk whiskey and taken 2 LSD the previous night. He had also used marijuana. He had then woken up at 6am and taken 15 co-codamol tablets. He had then vomited. Following this he cut his wrist. He was now saying he did not wish to die. The following details were also provided:
- Details of history of the ambulance call
 - Patient was reluctant to speak
 - Patient reported being depressed
 - Physiological observations
- 16.1.11 The self-harm was assessed and treated and Simon was also tested for Paracetamol and salicylate levels none detected, further treatment was not required.
- 16.1.12 Simon's psychological state was assessed in accordance with a Modified SAD Persons Scale as published in the Oxford Handbook of Emergency Medicine, which is policy for the Emergency Department. The assessment includes a numerical score for gender, age, depression, suicide attempt, alcohol or drug use, rationality, marital status, organisation, social support and stated future suicide attempts. The total score is then translated into bandings with recommended actions. Simon was classified as medium risk (score of 3 to 5) which results in the following recommendations:
- Should have specialist mental health assessment but possibly no further action required if patient doesn't wish to engage
 - Advised to seek further help if necessary e.g. from GP
 - Liaison Team and GP to be informed as well as mental health services if already known
 - Non urgent referral to Liaison Psychiatry Team so person can be seen within 2 hours of arrival
 - Out of hours should either be seen by duty psychiatrist (Crisis Resolution and Home Treatment team or referred to Liaison team for next day follow up)
- 16.1.13 As Simon was identified to be at medium risk he was referred to the liaison psychiatric team for specialist advice.

- 16.1.14 Simon was assessed by a Mental Health Liaison Practitioner whose role is to provide urgent mental health assessments within acute settings. The assessment focuses on whether a person can be supported at home or needs to be admitted to hospital.
- 16.1.15 The assessment by MHLP lasted approximately 70 minutes and included:
- A review of CPFT records to enable an understanding of previous involvement with services
 - An interview to gain understanding of the carer's perspective, in this case the mother
 - Completion of a Mental Health and Social Needs Assessment: This provides a structured holistic assessment of an individual's mental health and social needs. This includes information on mental health history, employment, education, medical history and substance misuse history. This assessment also includes social support networks, cultural identity and finance. Focus on presentation including appearance and behaviour, mood, speech, thoughts perception, cognitive state and insight.
 - Completion of a GRIST risk assessment: This will be covered in more detail
 - Completion of a HoNos assessment: This assessment provides an indication of the care pathway most appropriate to meet the individual's needs.
 - Formulation of an initial care plan: a plan of the proposed interventions agreed with the service user.
- 16.1.16 The assessment found Simon was not previously known to services and had no history of mental illness either reported on the system or self-reported. He admitted having a history of self-harm and drug use, both in the past and current. He was found to have a history of domestic and child sexual abuse in which he was the victim, the perpetrator being his father who was deceased. He was described as engaging in the process; in an appropriate manner. No evidence was found of delusion.
- 16.1.17 Other factors he reported in respect of his low mood were housing issues he felt he should not be reliant on his mother and employment issues. He described his use of self-harm and substances as coping mechanisms in response to stress.
- 16.1.18 Simon's risk level to both to himself and others were assessed by use of structured clinical judgement supported by a using a web based tool GRIST which stands for Galatean Risk Assessment Screening Tool.
- 16.1.19 The GRIST system was implemented in Cumbria in 2012 .The tool is not widely used within NHS settings with only two other sites Hull and Birmingham Children's Hospital utilising the tool. The tool is described as a web-based decision support system that can be used by clinicians to help them assess the problems and associated risks more clearly.

- 16.1.20 The tool is recognised by the Department of Health, however they note “There is no evidence to support its reliability or validity” p35
- 16.1.21 GRIST covers various areas of risk; this includes suicide, self-harm, harm to others, or damage to property, self –neglect, risk to dependents. The risk formulation covers a review of precipitating factors, predisposing factors, perpetuating factors and protective factors.
- 16.1.22 In relation to risk of harm to self or to others the assessment recorded “Risk judged to be no risk, no past or current episodes of harm or damage, no intention of harm or damage, no ideation about violence and no prospective harm or damage in the current context”. Simon’s risk of suicide was recorded as medium to low and his overall assessment of risk rated no risk.
- 16.1.23 A number of protective factors were described within the assessment. He had accepted a referral into a mental health service, First Steps for Cognitive Behavioural Therapy. He was remorseful about self-harming and had no further intention of self-harming. He identified he had friends and family he could talk to if he felt low again.
- 16.1.24 Susan was also interviewed by the same Liaison Mental Health Practitioner (LMHP). This was appropriate in order to gain a carer perspective on the situation and significantly the risks posed by Simon both to himself and others. She was seen alone and with the permission of Simon as part of the assessment undertaken. This interview is described as being brief and part of normal practice to involve carers in any action/safety planning.
- 16.1.25 During the interview Susan was directly asked about the risk of domestic violence Simon posed and she is quoted as stating “He does not have a violent bone in his body”. This is the sole record of any discussion having taken place explicitly with Susan about the risks of violence or abuse from Simon. The MHP accepted this statement as factual and this will be explored further in the analysis section of the report.
- 16.1.26 Relationships with his family more generally were also discussed with Simon and formed part of the assessment, Simon stated he had problems with his relationships with his sister and mother. He explained his poor relationship with his sister was as a result of an incident when he was eleven and was found in bed with her, in what he described as a role playing sexual experience. He reported this was stopped and he had had no sexual feeling for his sister since.
- 16.1.27 This disclosure regarding a past sexual experience with his sister was not further explored and Simon’s explanation was accepted at face value as the truth. Risks of sexual offending against his sister or other young women or children do not seem to have been considered at this point despite the unusual disclosure of information at a first meeting in this crisis setting.
- 16.1.28 Simon had recently attempted suicide and had a history of being subject to sexual abuse. His admission could have been probed. The panels view was

that if the MHLP had demonstrated professional curiosity risks regarding sexual offending could have been explored further. It may not have been appropriate for the MHLP to press Simon for more information but a referral for a more complete risk assessment could have been considered. This issue will also be explored further within the analysis section.

- 16.1.29 The agreed care plan derived from this assessment was Simon was to attend First Steps for Cognitive Behavioural Therapy and a letter was sent to his GP informing them of this.
- 16.1.30 Simon declined referral to the Crisis Team and he declined referral to services for his drug and alcohol. He also expressed he did not wish to be referred to the Community Mental Health Team.
- 16.1.31 Simon left the hospital with his mother; they were described as “*together and smiling*”.
- 16.1.32 On return from the hospital Susan rang Amy and told her Simon had tried to kill himself. Amy immediately set off back to Cumbria to offer support to her Mother and Brother and she arrived that evening.
- 16.1.33 On the following day, Adult Social Care (ASC) received the Vulnerable Adults (VA) referral from the police. As stated by the police and as per protocol at the time, this referral was faxed. It was then placed into a work pending in tray by a Locality Support Worker (LSW) whose role is to log onto the Integrated Adult System and pass the information to the Community Mental Health Team. This did not happen as the fax from the police became attached (by a paper clip) to another referral and was missed on that day. The report was therefore not logged onto the system and no practitioner had sight of the VA form that day with the exception of the LSW whose sole function is admin.
- 16.1.34 The information contained on the VA did not indicate that action was required by ASC and stated that Simon had been taken by ambulance to hospital. There had been no previous contact by ASC with any member of the family.
- 16.1.35 Simon kills Amy and Susan.

17 **Analysis Contact with:**

17.1 **Adult Social Care**

- 17.1.1 ASC had one sole contact with this case. That was the referral made by CC. Due to an administration human error this referral did not get logged onto the relevant systems CareFirst and Integrated Adult System (IAS). This was 2 days after Simon had committed the killings of his mother and sister. A multi-agency safeguarding meeting was not held and no action was taken by ACS in relation to providing services for Simon or his family.
- 17.1.2 Faxing critical information in respect of vulnerable adults is a system that lacks rigour. As is highlighted by this case the information simply became lost

and without a backup transfer of information Simon's referral became subsumed within the other 5 police referrals that were made on the same day.

- 17.1.3 The information received should have been logged on to the system and passed onto the Community Mental Health Team for action. It has not been made clear to the panel what action could or should have resulted had the referral been logged correctly.
- 17.1.4 The view expressed by ASC during panel meetings was that Simon would not have met the threshold for services from the CMHT based on the information provided from CC, i.e. that Simon had self-harmed and had been taken to hospital.
- 17.1.5 The process of managing police referrals into ASC requires improvement and agency recommendations and activity already undertaken as a result of early lessons learnt were addressed within the agency IMR.

17.2 **Analysis of Contact with GP**

17.2.1 **Practice Profile**

- 17.2.2 The GP Practice in Cumbria has been described by the IMR author as being under a considerable amount of pressure during the timescales in which this review focused.
- 17.2.3 The practice has about 8,700 patients and is the only practice in this part of Cumbria. It has three doctors and one salaried GP. Over the last few years they have relied on locum doctors to fill in due to problems in staff recruitment. There had been a period of severe understaffing when 2 GPs retired at the same time and a new salaried partner has only just been recruited. A GP with necessary drug and alcohol skills died a few years ago and his skills have not been replaced in the practice. As a result of these difficulties in recruitment, an action group has been formed to support endeavours to employ more doctors. Public Health figures show a fourfold increase of acute hospital admissions. There is also an increase of alcohol related admissions.
- 17.2.4 Mental Health services for adults used to be provided within the surgery but are now based at the Network Centre with the Drug and Alcohol services. First Steps (Primary Care Mental Health Service) are also based there now. The practice perceives there is a high DNA rate for First Steps.
- 17.2.5 Whilst there were clearly capacity issues for the practice there are other concerns regarding the culture of the practice that may have impacted on a lack of professional curiosity regarding the home situation of Simon and Susan.
- 17.2.6 Within the IMR the author reports "GP 1 and the Nurse Practitioner describe a geographically isolated community where violence is seen as normal and a way of sorting out disputes." It is clear that the practice views themselves as

disconnected from the outside world and this may have impacted on effective multi-agency working. The practice for example did not have contemporary literature regarding help for victims of domestic abuse and when asked during interview seemed to have little awareness of the types of support that could be offered to victims.

- 17.2.7 In relation to Simon a referral care pathway for ADHD does not seem to have been put in place. Simon described a number of fears and worries in the two consultations he had, issues that could have been identified for referral to services included ADHD, possible anxiety which manifested itself regarding his physical and emotional wellbeing, and use of legal highs. The GP made the referral for his concerns regarding the genetic disorder but appears to have paid less attention to the social and emotional issues Simon discussed.
- 17.2.8 The legal highs are viewed by the practice as “endemic in this area” but again were not picked up on as an issue of concern for Simon. They appear to consider this as something that happens here and that’s how it is, again linking back to cultural issues within the practice already stated.
- 17.2.9 The practice has undertaken work to ensure lessons from this case are learnt and has demonstrated a commitment to improving services for victims of domestic and sexual violence.
- 17.2.10 The IMR for the GP author notes
- “General Practice has historically not regarded identifying Domestic Violence as part of their remit. In the last couple of years with the advent of the appointment of Dr Gene Feder, Domestic Violence Champion for the RCGP (Royal College of General Practitioners), this attitude is changing. He has done pioneering research on the success of training GPs to ask questions about domestic abuse. This has resulted in a clear and concise guidance document from the RCGP. These guidelines should be used by all GPs practices across Cumbria”.*
- 17.2.11 Information from the GP practice in South Wales also indicates that an opportunity to provide support to Amy was not taken; her body image concerns were responded to solely as physical health concerns. She was therefore referred into an exercise programme rather than further inquiry being about her emotional wellbeing. Given Amy’s history the GP could have used this as an opportunity to ask her how she was more generally, did she require further support or counselling.
- 17.2.12 The panel found the general lack of professional curiosity by the GPs puzzling. GPs, due to their unique relationship with their service users are ideally placed to recognise and respond to victims of domestic and sexual abuse earlier than other agencies. It is imperative that the practice becomes well connected with the Multi-Agency Partnerships that address domestic abuse. The practice could become part of the Cumbria wide Domestic Violence Champions Network, a Champion could take responsibility in ensuring contemporary information for victims was available and more generally act as a point of contact to other agencies.

- 17.3 **Analysis of contact with Cumbria Partnership Foundation Trust (CPFT)**
- 17.3.1 Contact with the CPFT was subject to the scrutiny of both the internal IMR and the SUI. This section of the report seeks not to duplicate existing analysis but a number of issues have been identified that merit further exploration.
- 17.3.2 **Risk Assessment and Care Plan**
- 17.3.3 The MHLP had a number of options for Simon's future care that could have resulted from his assessment. Outcomes other than discharge that could have been an outcome from assessment included admission to hospital, either informally or with a Mental Health Assessment (MHA). Simon had expressed this was not something he wanted to happen and the MHLP did not assess this as necessary.
- 17.3.4 Simon could have been referred to the Community Mental Health Team (CMHT) or Crisis Resolution and Home Treatment (CRHT). The MHLP view was that Simon would have been discharged from these teams as *"He presented too well and there was no evidence of severe mental ill health"*
- 17.3.5 Whilst this was the stated view of the MHLP who assessed Simon, this assumption cannot be evidenced. Simon's mental health appears to have deteriorated sharply following discharge from hospital; this may or may not have been picked up by mental health professionals visiting him at home. This is an unknown; however there is a possibility that further contact with mental health services delivered within the home may have enabled Simon or Susan to share more information. Furthermore it would have been evident Simon was not following the agreed care plan and was continuing to drink and take drugs.
- 17.3.6 Simon did not or was not able to put into place any of the strategies that had been assessed as protective factors and the static factors, i.e. his housing, money concerns and his relationship with his family described as risks remained. What had also not changed was the fact Simon had experienced both sexual and physical abuse as a child and was using harmful coping strategies, namely self-harm and substance misuse.
- 17.3.7 It is paradoxical that Simon was assessed as "no to low risk" yet within thirty six hours of being discharged had killed two people and an animal in a brutal attack. The risk assessment process was carried out by an experienced practitioner, agency appropriate tools were used and guidelines were adhered to. The MHLP had demonstrated a clear awareness that tools alone cannot be used and that professional judgement should form part of the risk assessment process.
- 17.3.8 The internal SIU found that the *"the assessment by the MHLP was a comprehensive and robust Liaison Service assessment which followed appropriate Policy and Guidelines"*.

- 17.3.9 It is difficult to make sense of these findings in light of the events that unfolded some hours later and this has caused significant concern to the family. In order to make some sense of this paradox there are a number of issues to explore.
- 17.3.10 One factor worthy of consideration is questioning the assessment tool's validity and reliability or rather is the GRIST tool fit for purpose? The GRIST tool was utilised as per protocol by the MHLP and determined Simon was "at no to low risk of self-harm or suicide". This was questioned within the SUI and the investigation team felt this "*underrepresented the level of risk*".
- 17.3.11 The panel concur with this view and would question how a troubled young man who had already attempted self-harm and suicide could be at no further risk. Evidence informs us that past behaviour is a likely predictor of future behaviour and based on the information known Simon was at the very least capable of self-harm / suicide at the levels he demonstrated.
- 17.3.12 Risk factors in this case were apparent and identifiable and can be summarized as follows;
- A history of childhood domestic abuse
 - A history of childhood sexual abuse / complex psychosexual issues
 - Suicide /Self Harm
 - Complex Poly Substance Misuse
 - Low Mood/Mental Health Issues
 - Potential life changing medical condition myotonic dystrophy
 - Social Issues, unemployment, housing issues and social isolation, strained family relationships.
- 17.3.13 This was an extremely complex set of issues, many of which were chronic and long term in nature. Reliance on the GRIST tool to determine risk given Simon's profile proved to be inadequate and inaccurate.
- 17.3.14 The risk assessment process was also highly reliant on one individual, the MHLP who acted, in accordance with the Trusts policies and procedures, as a single point of contact and a gate-keeper to further mental health assessments. This is a significant responsibility for any one individual and the initial assessment conducted would have benefitted from discussion/collaboration with other professionals.
- 17.3.15 A telephone call to Simons GP would have enabled access to records containing information relevant regarding previous childhood abuse and the extent to which substance misuse was a concern. Support from a senior mental health professional could also have been sought.

- 17.3.16 In response to the challenge posed by the panel to CPFT regarding the GRIST suitability and effectiveness in identifying risk CPFT have advised the panel that a comprehensive review of GRIST risk assessment tool was undertaken in 2013 and this resulted in changes to both the tool and staff training.
- 17.3.17 The CPFT have also advised that the GRIST tool is one of the priority audits for 2015 to be undertaken by an internal group, The Mental Health Care Group.
- 17.3.18 The GRIST tool continues to be used in Cumbria and it is strongly recommended that CPFT consider an independent review that is outside the trust to review all risk assessment tools and the policies and procedures that support the use and delivery of such tools. This should include support to the frontline MHLP role within Accident and Emergency settings.
- 17.4 **Assessment of Mental Health Crisis within Accident and Emergency Settings**
- 17.4.1 Other factors for consideration are the actual environment in which the risk assessment was conducted. Simon was assessed in a busy Accident and Emergency Department then transferred to an observation ward. He was formally assessed by MHLP for a total of 70 minutes. In total Simon was either being assessed, treated or observed within the hospital environment for 5 hours and 33 minutes. At this time he was under the influence of the substances he had taken that morning, potentially withdrawing from some of the substances, possibly in some amount of pain and certainly in discomfort. On reflection, the environment and circumstances may not have supported the best possible risk assessment.
- 17.5 **Assessment of Patients who are under the influence of Alcohol or Psycho Tropic Drugs**
- 17.5.1 It is also possible Simon's alcohol and substance misuse influenced the assessment or masked other underlying mental health issues. The impact of so called legal highs is difficult to establish due to the highly variant nature of such substances and little is known about the effects on behaviour.
- 17.5.2 Simon admitted he had taken a cannabinoid "Black Spice". Evidence is emerging that suggests the psychoactive compounds in this type of legal high out last those of cannabis. The psychotropic properties of LSD can also be long lasting. The combined effects of the cocktail he had consumed may have lasted throughout the time he was assessed and beyond his discharge. We also know Simon continued to drink and take other substances following discharge from hospital and on the day he was arrested for the killing of his family he was under the influence of substances.
- 17.5.3 Simons thought and behaviour processes were likely to have been substantially affected from his ingestion of alcohol and drugs and the panel questioned was he fit for interview? On the balance of probabilities, given the

powerful substances Simon had taken it is the view of the Chair that Simon was not fit for interview.

- 17.5.4 Whilst it has been noted the MHLP was experienced in assessing those with the dual issues of drugs and alcohol and mental health it was not expressly stated within the IMR how this experience was used or to what extent Simon was intoxicated. Intoxication may significantly influence a person's mental health presentation and may imitate or mask symptoms of an underlying mental health issue. Furthermore the depressant effect on the central nervous system may increase the risk to self and others and increase the risk of suicide.
- 17.5.5 It may not be practicable or possible or even desirable to exert a blanket policy of refusal to assess an individual with mental health issues whilst under the influence of substances .Indeed almost half of all patients with a diagnosis of serious mental illness also have a co-morbid substance misuse problem (Phillips and Johnston, 2003). However staff needs to be clear when it is appropriate to proceed to an assessment and in what circumstances an assessment should be deferred.
- 17.5.6 CPFT have confirmed their policy regarding dual diagnosis has been reviewed recently and further training has been provided to staff regarding this matter.
- 17.5.7 **Access to Records**
- 17.5.8 Lastly and significantly the MHLP did not have relevant historical information. The MHLP was aware Simon had been involved with CAMHS service as a child but did not have access to these records. Those records held significant information regarding Simon's use of violence and abuse towards his family as a child. Had the MHLP been able to access this information he has stated he would not have accepted the information he was given by Simon and Susan regarding violence and would have challenged and questioned both of them further.
- 17.5.9 Although not stated within the agency IMR, access to these records would also have given him an insight into Simon's history of not attending referrals and not following up on support offered. This could have been factored into the support plan and a more realistic version could have been produced based on cognisance that Simon was potentially unlikely to attend the appointment with First Steps or indeed ask for help.
- 17.5.10 The MHLP was informed by Susan that Simon had been sexually abused as a child. Given the known impact of sexual abuse on mental health it is surprising that this was not an area explored in further depth; consideration could have been given to a referral into to a specialist service for sexual abuse. This may not have been taken up by Simon but could have provided some validation of his experience.

- 17.5.11 In conclusion the risk assessment process was weighted towards protective factors, the risks factors were not adequately considered largely due to the information available at the time to the MHLP.
- 17.5.12 It should also be recognised that Simon may have responded to the assessment questioning in a manner that would ensure he was able to get out of that environment as quickly as possible with the least amount of future scrutiny or control of his behaviour. His self-reporting of information regarding his future intent may not have been truthful. We know for example he claimed to have no sexual interest in his sister but the manner in which he treated her body after he killed her suggests he was not truthful about this. Therefore it is possible there were other issues he was not truthful about. Again, a further contact by mental health professionals within the home environment could have added depth to the initial assessment.
- 17.5.13 The MHLP did attempt to elicit Susan's views on Simon's risks levels and past use of abuse towards her. What he could not have known was Susan's history of accessing support, this was likely to have made her very reluctant to seek help and she was therefore very unlikely to say Simon was abusing her or she was afraid of him in any way. Mistrust of authority, as embodied by statutory services, is common in victims of abuse who may have experienced poor or unhelpful interventions in the past. Gaining a victim's trust is likely to take time and it is therefore much more usual for victims to respond to routine enquiry with "No I am not being abused" than a "Yes". Caution should therefore be demonstrated when weighting responses from family members /intimate partners about domestic abuse.
- 17.5.14 Interventions that she may have responded to include support for herself as a parent of a child who has been sexually abused or support as a carer for someone with alcohol /substance misuse or self-harm.
- 17.5.15 In conclusion the MHLP had incomplete information regarding the actual risk Simon presented to both himself and his family, and the quality of the clinical setting may have been an influence.

18 **Good Practice**

18.1 The practitioner did describe during interview for this process an awareness of domestic abuse issues and was a DA Champion; we know he took the opportunity to ask Susan directly if she was at risk from Simon. The MHLP described being fully aware and able to utilize the CAADA risk assessment checklist for domestic violence and the Trusts Domestic Violence Policy but had no need to do so, as no disclosure was made.

18.2 **Contact with Housing**

18.2.1 A full review has been undertaken by Cumbria's Impact Housing and there are no records held in relation to the parties subject to this report. It was difficult to get a full picture of the family's housing history; we know they moved many times both within Cumbria and to other parts of the UK presumably renting private tenancies rather than requesting social housing.

Housing providers often hold vital information relating to their tenants social histories however the panel were able to gain no insight or lessons learnt as no record of the family was held.

18.3 **Analysis of Contact with Cumbria Constabulary**

18.3.1 Officers from CC reacted swiftly in their locating of Simon and calling for medical assistance. Information regarding Simon's ingestion of substances was shared with ambulance staff. Support for Simon was also at the forefront of officers' minds and they acted appropriately in contacting Simon's mother and in making a safeguarding referral that day. Policies and protocols were followed.

18.3.2 Use of the Mental Health Act was explored within CC IMR and was recorded as follows:

"I have considered whether, under the circumstances, the two officers should have used powers under section 136 of the Mental Health Act. This act and section gives police the power to detain an individual (in a public place) who is mentally ill. The person would then be taken to a 'place of safety' to enable a mental health assessment to take place. This police power is used as a last resort as it can involve depriving someone of their liberty even though they have not committed any criminal offence. As Simon was compliant on police arrival and with the Paramedics and willingly accompanied them to Hospital where he was mentally assessed it would not have been an appropriate use of section 136 of the Mental Health Act to utilise the power of detention".

18.3.3 This view is supported by the fact that Simon was found not be mentally ill on assessment by professionals.

18.3.4 The family specifically raised their concerns during interview that Simon was reported to have said he *"wouldn't kill his mother"* and *"he had a weapon up his sleeve"*.

18.3.5 This information is not recorded as being shared during the handover of Simon into the care of the ambulance staff. Officers were directly questioned about this as part of this process. They could not recall sharing the possibility that the man the public were concerned about earlier that day may have been Simon. CC has acknowledged this information was relevant and early lessons learnt have resulted in systems being changed to ensure all relevant information regarding vulnerable adults is shared.

18.3.6 This identified weakness within multi-agency information should be considered by all agencies. Attention should be directed to improving information sharing at the interface of transferring service users between agencies. The information held by CC could have been explored further by mental health staff, and although the final outcome may not have been substantially influenced it is highly recommended all agencies examine agency protocol for the transfer of service users.

18.3.7 The initial response to the death of Amy and Susan fell outside CC timescales for responding to an emergency call. This has been recognised with the agency IMR. A 999 phone call was received by the Communications Centre at 8.39am. Police were despatched immediately with the first officers arriving at 9.04am. This was 25 minutes after the call was received. The IMR addresses this as follows:

“The current Cumbria Constabulary target is to arrive at the scene of 999 calls within 15 minutes for urban areas and within 20 minutes for rural areas. This target was not achieved on this occasion. There is no suggestion, at all, that either Susan or Amy would have survived had this police target been met as the injuries that they sustained were not compatible with life and they would have died of their injuries within a very short time”.

18.3.8 The panel were aware that the initial 999 call documented a neighbour stating screaming could be heard within the property and a dog was dead in the garden. Although there were no flags on the address relating to a history of domestic abuse or any other concern it was clear from the call an extremely serious incident was occurring. It is recommended the CC respond to all 999 calls within their set guidelines, again this would not have altered the outcome but could have significant impact on preventing future homicides.

18.3.9 Following the incident Cumbria Constabulary then took immediate steps to locate and arrest Simon, reducing the risk to the public and the risk Simon presented to himself.

19 **Views of the family and friend**

19.1 The extended family provided the panel with a huge amount of rich detail regarding their views on the family dynamic both historically and in the months before the homicides took place.

19.1.1 Amy and Simon’s childhood was difficult; their father was described as a bully. Many examples were given as to how this manifested itself, for example Amy was encouraged to spit on her mother and aunt by the father. This information provided a window through which to understand the issues described by CSC and NSPCC about the levels of aggression within the home when Andrew had moved out. It is not uncommon for mothers who have experienced control and abuse to struggle to exert appropriate discipline with their children.

19.1.2 As an adult Amy told her aunt she could not remember all that had happened and she wanted to forget.

19.1.3 The extended family were fully aware of the sexual abuse Amy had experienced and described Simon’s fury that he had not been awarded financial compensation for his abuse. This theme seems to have endured throughout adolescence and into adulthood with Simon feeling very let down and jealous of his sister.

- 19.1.4 Susan left her abusive husband however he continued to exert a controlling and abusive influence over her and the children. One family member described it as if they were still a couple. This insight into the family highlighted the ongoing abuse the children and Susan experienced, despite the relationship ending Andrew was ever present in their lives. Susan moved many times with her children to get away from the abuse, this will be revisited as an issue the panel struggled with as it was very difficult to get a picture of where the family lived.
- 19.1.5 The family view was very clear in that Simon was doted on by his mother who indulged him, allowing him to have his own way even if this caused her to go without. A theme presented frequently was food, Simon determined what the family ate and latterly before her death Susan appeared to be very gaunt, the family felt she was going without to provide for him or was very stressed due to looking after his needs.
- 19.1.6 Other examples were given that Simon would stay up all night playing his guitar or music. Susan was exhausted but felt either unable to challenge Simon or she was afraid of him. Both Amy and Susan seemed afraid of Simon to the family friend; deferring to him, letting him have his way and generally controlling the atmosphere in the home.
- 19.1.7 The family in Wales were also aware Simon was using alcohol and drugs. Amy rang her mother every day and even when she moved to Wales and was no longer around, had a picture of what was happening in the home. She tried to persuade her mother to get help, but Susan refused to do so.
- 19.1.8 The family friend lived with Simon and his mother for a short period of time and described that Simon would not speak to him. He also gave examples of Simon using excessive amounts of alcohol and beating up his friends and associates.
- 19.1.9 Following Simon's suicide attempt Amy headed immediately to Cumbria to support her mother and brother. She rang her Aunt and boyfriend when she arrived and expressed concern that both her mother and brother did not want to talk about this event and were saying that everything was now fine.
- 19.1.10 Amy rang her boyfriend from Cumbria and expressed concern that both Simon and Susan were behaving as if nothing had happened. Amy described during this phone call that she had said to Simon "please you can talk to me" and he had responded by saying "you know what it's about" and had then refused to talk to her. That was the last opportunity her boyfriend had to speak to her.
- 19.1.11 The family view of Susan was that of a woman devoted to her children, a full-time mother whose main purpose was to be a mother.
- 19.1.12 The family in Cumbria also tried to help and support following Simon's suicide attempt, they made offers to go and visit but were told no .The family worried that Simon might have been embarrassed and so listened to Susan's advice.

19.1.13 It is extremely sad that family relatives wanted to rally around to provide support and look after Simon and his mother. It seems likely Susan very much felt the need to withdraw back into the smaller unit of just her and Simon. Relatives commented many times that Susan doted on Simon and she perhaps wanted to protect him from exposure at this time. A small window of opportunity opened up for the extended family to see what was happening, and this was shut very firmly within hours of the crisis occurring. This also included shutting Amy out despite the fact that she had now arrived back into the family home.

20 **To What Extent was the Incident Preventable or Predictable**

20.1 The review panel, after thorough consideration, believes that under the circumstances it is very difficult to state whether agency intervention could have or would have prevented the killings of both Susan and Amy, given the information that has come to light through the review.

20.1.1 The evidence suggests that there was no **known** recent history of violence by the perpetrator against the victims.

20.1.2 However, there was evidence of Simon's abusive behaviour towards members of his family held within CAMHS records, NSPCC records and Children Social Care records. These records were historical and were not available to services assessing his risk levels in the critical two days prior to the homicides occurring.

20.1.3 A home visit either on the same day following discharge from hospital or the following day by a Community Mental Health Team may have presented an opportunity for further assessment and observation of either a continuation of using harmful coping strategies or deterioration in behaviour. A home visit may also have presented a further opportunity for Susan to discuss any concerns she had. This is by no means certain.

20.1.4 It is unlikely Susan would have disclosed immediately to any professional that Simon was being abusive to her, as her history of accessing support was not a positive one.

20.1.5 A picture did emerge from contact with the extended family and a close friend of Amy's that Simon was controlling and dominating. This information could not have been known to any of the agencies who had contact with the family in the two days leading up to the homicide.

20.1.6 Simon's abuse of alcohol and drugs including legal highs also emerged as significant issue in this case; again the family had a more comprehensive understanding than professionals. Simon appears to have been abusing substances for longer and at higher levels than he disclosed to his GP and the MHLP. This is not uncommon and self-reporting should be considered with some caution.

- 20.1.7 It is also far from clear to what extent Simon's mental health impacted or influenced his thought processes in the days leading up to the homicides. Indeed, it was far from clear to the panel throughout this process as to the condition of his mental health both pre and post incident.
- 20.1.8 There was not a consensus from psychiatric professionals as to the state of his mental health. Simon is currently detained within a psychiatric unit; however the view of the Judge, expressed during the final hearing was that Simon had significantly contributed to his psychotic episode by his voluntary use of substances.
- 20.1.9 Simon's ideation and fantasies of violence were expressed to the psychiatrist who assessed him post incident. He also reported "a poor relationship with his sister linked to a past possible sexual incident as a child" and feeling "suffocated by his mother". The statement regarding his Mother was not disclosed.
- 20.1.10 It is well known that there had been a murder within a six year period in the same street that this killing occurred. This had occurred in the same house Simon was living in. This would have been known to Simon and may have contributed to his thought processes leading up to him killing his sister and mother. In a drug induced psychotic state fantasies of violence may have been further fed by the environment. Again this is an unknown and certainly not an excuse.
- 20.1.11 Simon was almost certainly abused as a child; he received no support or even recognition that this had happened to him. He was also subject to physical and emotional abuse from infancy to adolescence. He struggled to cope and used harmful strategies, drugs, alcohol, legal highs and self-harm. Again this is not and cannot be an excuse for his behaviour. Simon was however failed as a child and ultimately his childhood experiences had an impact on his behaviour as an adult.

21 **Lessons Learnt and General Recommendations arising from the review**

As a result of the lessons learnt the following general recommendations have arisen from the review.

21.1 **Lesson Learnt**

The sharing of confidential records pertaining to the perpetrator caused a significant delay in this review. Timescales set by Home Office Guidance were not adhered to. Although this was eventually overcome by Simon agreeing his records could be released, the partnership should be aware that he could have refused.

21.1.1 **Recommendation 1**

Local

It is strongly recommended that the West Cumbria Community Safety Partnership engage with GPs through the CCGs locally and raise awareness of the statutory nature of DHRs and the importance of ensuring lessons are

learnt as early as possible. This could also increase rigour in multi-agency working.

21.1.2 **Recommendation 2**

National

This issue should also be raised at a national Level; this will be taken forward by NHS England.

21.2 **Lessons Learnt**

21.2.1 **Improving services for victims of domestic abuse**

This review highlighted historical weaknesses in responding empathically to adult victims of domestic abuse. Contemporary evidence informs us that this is an enduring feature in statutory services responses

21.2.2 **Recommendation 3**

Local

That CSC considers inclusion of or has clear links with specialist domestic violence workers into the Safeguarding Hub. This would enhance operational support and safeguarding to victims of domestic abuse and promote a culture of empathy and understanding.

21.3 **Lesson Learnt**

21.3.1 **Multi- Agency Working and Information Sharing**

Local

This case has highlighted the need to improve information sharing, specifically at points of handover from one service into another. CC and ASC have highlighted weaknesses in their systems and steps to address this are now in place

21.3.2 **Recommendation 4**

All agencies are requested to review policies and procedures in relation to referring or transferring cases.

21.4 **Lesson Learnt**

21.4.1 Responding to the challenges of treating individuals who are using legal highs and cocktails of other drugs is emerging as a national concern. This case highlighted that a perceived high number of people are using legal highs in Cumbria and services are not fully geared up to meet these challenges. Further consideration should be given to the effective management and assessment of individuals who are under the influence of substances and specifically Legal Highs in primary health and acute settings.

21.4.2 **Recommendation 5**

Information around “Legal Highs” and their effects to be more widely available within community organisations generally and in primary care and acute settings particularly.

Staff within primary care and acute settings to be upskilled around their knowledge of “Legal Highs” and their effects.

Psychosocial support for users of “Legal Highs” within specialist service substance misuse services to be more widely promoted within services most likely to come into contact with users (primary health and acute settings).

21.5 Lesson Learnt

21.5.1 Both victims and the perpetrator had some contact with their GPs in the timescales set out within the TOR. Consultations focused entirely on medical issues and opportunities to gain further insight into social/ emotional needs were not explored.

21.5.2 Recommendation 6

Local and National

Training should be provided that supports a culture of questioning and signposting to specialist services within GP practices in Cumbria

21.6 Lesson Learnt

The family and friends in this case had a substantial amount of information about the controlling behaviour and levels of substance misuse the perpetrator was using.

21.6.1 Recommendation 7

Local

Increase community awareness of domestic abuse and substance misuse so that family and friends can access support and signpost victims.

21.7 Lesson Learnt

Local

Risk assessment tools under represented the level of risk the perpetrator presented to his family and others

21.7.1 Recommendation 8

That CPFT commission an independent review as a matter of urgency and priority of all risk assessment tool, policies and procedures.

21.8 Lesson Learnt

Cumbria has an active Champions Network but this could be further invested in. Consideration should be given to nominating a Domestic Violence Champion in all GPs practices in Cumbria. The Champion could ensure all practices have relevant contemporary information and act as a conduit of good practice.

21.8.1 **Recommendation 9**

Champions Training to be provided for GPs

21.9 **Lesson Learnt**

Domestic and sexual violence cause significant harm to children, this case highlighted that the impact of abuse can endure for many years. There are potentially many other young people in Cumbria who need services to help them recover and the partnership is asked to consider the sufficiency of resources available to children and young people and the accessibility of these services.

21.9.1 **Recommendation 10**

Local

The partnership should audit available resources and ensure access to services is easily available across Cumbria

22 **Individual agency recommendations arising from IMRs**

Those agencies that undertook IMRs have identified individual agency Recommendations in order to both respond to specific issues identified within the IMR process and to generally improve practice in relation to domestic abuse.

22.1 **National Society for the Prevention of Cruelty to Children (NSPCC)**

The Director of Children's Services Development and Delivery confirms NSPCC Practice Standards with practitioners and managers in relation to the assessment and management of safeguarding risks. Safeguarding risk can be complex and multiple and as such must inform the assessment of risk not only at the onset of the work, but also throughout the intervention regardless of the focus of that intervention.

22.2 **Cumbria Constabulary**

Recommendation

Officers should record any comments, made by a vulnerable adult that could be considered threatening to any third party or significant in any other way. These comments should be included in the Vulnerable Adult (VA) report.

22.3 **Cumbria Partnership Foundation Trust (CPFT)**

There needs to be consideration given to the fact that the mental health practitioner was not able to access all the health records for Simon, had he been able to do so he would have had additional information to inform his assessment. CPFT are currently looking at transitional arrangements for patients as they move from one service to another. These transitional pathways will ensure that information is not lost as patients move through services.

CPFT have to identify how they can ensure that practitioners have access to all notes and a plan put in place to address this. CPFT is working towards an electronic patient record which will ensure that there is access to records for all practitioners.

Consideration needs to be given to developing policies that standardises the practice for practitioners when there is non-engagement following a referral into the service, this area of non-engagement and /or no access referenced in the CPFT Safeguarding policy.

The internal review (SUI) following the incident identified recommendations to improve practice and an action plan was formulated to address the issues raised. The actions resulting from this Domestic Homicide review will be linked with the internal action plan for CPFT.

22.4 **Adult Social Care**

The process of managing police referrals into ASC requires improvement. Specifically a more efficient and secure method of sending police referrals to ASC should be agreed and actioned.

The information on referrals needs to be specific about action required of ASC by the police.

Upon receipt all referrals should be logged and then passed on to a supervisor/manager for action to ensure a more robust management oversight CMHT should acknowledge referral in the first instance and where appropriate provide feedback on action.

An audit should take place on a quarterly basis to measure improved response.

22.5 **GP Practice**

Whilst not all actions are direct outcomes from this DHR the GP Practice used this process to reflect on general service improvements in relation to domestic abuse

1. Practices to adopt RCGP guidelines in response to domestic abuse to increase recognition and referral to Victim Support, Let Go, Marac.1 year. Named GP lead for each locality to work on knowledge of local resources. 6 months

2. Widespread adoption of CAADA risk assessment tool in Primary care 2015 - 2016
3. Inclusion of Domestic Violence competencies in GP appraisal for 2015-2016
4. Practice Managers to improve relationships with police to make practices safer places to work and safer places for patients to disclose domestic violence. 6 months
5. Increased written/email communication of DV incidents involving police to Primary Care 6 months
6. Increased written communication with Primary Care and SSD. 6 months
7. Practices to understand the referral pathways in health and voluntary sector for PTSD and other issues following historical sexual abuse. 2 years
8. Equity of service provision of Sexual health, women's centres, access to DVA help, community awareness raising training.
9. All practices to have DVA self-help literature in waiting rooms 6 months
10. Design of new patient medical form to reflect early identification of Adults at Risk. 6 months. Implementation 9 months
11. Referral of this case to Cumbria LSCB for consideration of Serious Case Review of management of abuse disclosures in early 2002. 2 months
12. Development of case based training materials to enable GPs and hospital doctors in particular Paediatricians and Gynaecologists to develop their skills in understanding and working with somatisation, in asking questions about domestic violence and Child Sexual Abuse and to know what referral pathways are available for the disclosure of underlying abuse. 3 months

Appendix 1

Domestic Homicide Review Terms of Reference for Susan and Amy

This Domestic Homicide Review is being completed to consider agency involvement with Susan and her daughter Amy following their homicide. The review will also consider agency involvement with the alleged perpetrator, Susan's son, Simon.

The Chair of the West Cumbria Community Safety Partnership was informed of events and confirmed to the Home Office that the criteria for a Domestic Violence Homicide Review had been met, and therefore a review would be established. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

The Review will work to the following Terms of Reference:

- 1) Domestic Homicide Reviews (DHR) places a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel until the panel agree what information is shared in the final report when published.
- 2) To explore the potential learning from these homicides and not to seek to apportion blame to individuals or agencies.
- 3) To review the involvement of each individual agency, statutory and non-statutory, with Susan, Amy and Simon between a relevant time period.
- 4) To summarise agency involvement prior to the killings
- 5) The contributing agencies to be as follows:
 - a) Cumbria Constabulary (IMR and chronology)
 - b) Cumbria CCG
 - c) Cumbria County Council – Children's Services
 - d) Cumbria County Council - Adult Social care
 - e) Cumbria NHS Partnership Trust (IMR and chronology)
 - f) Crown Prosecution Service
 - g) GP Services – Primary Care (IMR and chronology)
 - h) Impact Housing/Let Go
 - i) Copeland Borough Council
 - j) UHMBT (IMR and chronology)
 - k) UNITY (IMR and chronology)
6. for each contributing agency to provide a chronology of their involvement with Susan, Amy, Simon and Andrew; who is Susan's ex-husband and the father of Amy and Simon during the relevant time period.
7. For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

8. For each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with Susan, Amy and Simon critically analysing the service they provided in line with the specific terms of reference; identifying any commendations for practice or policy in relation to their agency.

Consider issues of activity in other areas and review impact in this specific case.

9. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following points:
 - Analyse the communication, procedures and discussions, which took place between agencies.
 - Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
 - Analyse the opportunity for agencies to identify and assess domestic abuse risk.
 - Analyse agency responses to any identification of domestic abuse issues.
 - Analyse organisations access to specialist domestic abuse agencies.
 - Analyse the training available to the agencies involved on domestic abuse issues.

And therefore:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
 - To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
 - To improve inter-agency working and better safeguard adults experiencing domestic abuse.
10. Agencies that have had no contact should attempt to develop an understanding of why this is the case, and how procedures could be changed within the partnership which could have brought Susan, Amy or Simon in contact with their agency.
 11. To sensitively involve the family of Susan and Amy in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process.
 12. To coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.
 13. To commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

14. To establish a clear action plan for individual agency implementation as a consequence of any recommendations.
15. To establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.
16. To provide an executive summary.
17. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the West Cumbria Community Safety Partnership.

Appendix 2 - Glossary of Terms

ADHD	Attention deficit hyperactivity disorder
Amy	Perpetrator's sister
Andrew	Perpetrator's father
ASC	Adult Social Care
CAADA DASH (Now known as Safe Lives 2015)	Coordinated Action Against Domestic Abuse Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Check List.
CAMHS	Children and Adolescent Mental Health Service
CC	Cumbria Constabulary
CIC	Criminal Injuries Compensation
CPA	Care Programme Approach
CSC	Children's Social Care
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPFT	Cumbria Partnership NHS Foundation Trust
CPS	Crown Prosecution Service
CRHT	Crisis Resolution and Home Treatment
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DNA	Do Not Attend
DV or DA	Domestic Violence/Domestic Abuse
FGH	Furness General Hospital
GBH	Grievous Bodily Harm
GP	General Practitioner
GRIST	Galatean Rist and Safety Tool (Clinical risk assessment)
HoNOS	Health of the Nation Outcome Scales
IAS	Integrated Adult System
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Report
HMIC	Her Majesty's Inspectorate of Constabularies
LSCB	Local Safeguarding Children's Board
LSD drug	Lysergic acid diethylamide
LSW	Local Support Worker
MASH	Multi-Agency Safeguarding Hub
MHA	Mental Health Assessment
MHLP	Mental Health Liaison Practitioner
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
PC	Police Constable
RCGP	Royal College of General Practitioners
Simon	Perpetrator
SUI	Serious Untoward Incident
Susan	Perpetrator's mother
SW	Social Worker
TOR	Terms of Reference
UHMBT	University Hospitals of Morecambe Bay Trust
Unity	Unity Greater Manchester West Mental Health Trust
VA	Vulnerable Adult

Appendix 3

Documents and research used

Brandon et al, Analysing child deaths and serious injury through abuse and neglect: what can we learn? *A biennial analysis of serious case reviews 2003-2005*

Hester, M. The Three Planet Model: Towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence. (*British Journal of Social Work*, 41; 2011)

Lannert, Brittany et al, Relationship Trauma in the context of intimate partner violence *Child Abuse or Neglect* 38 (2014)

Scheeringa H, S & Zeanah, C, H (2001) A relational perspective on PTSD in early childhood, *Journal of Traumatic Stress*, 14(4) 799-815

Stanley, N & Humphries C, (2006) Domestic Violence Children and Child Protection.

European Monitoring Centre for Drugs and Drugs Addiction: Synthetic cannabinoids and "Spice", 2011 www.emcdda.europa.eu/publications/drug-profiles/synthetic-cannabinoids [accessed 6th June 2014]

One new drug a week: Why Novel Psychoactive Substances and club drugs need a different response from UK treatment providers. Faculty of Addictions Psychiatry, Royal College of Psychiatrist, Faculty Report 2014

Best Practice in Managing Risk Principles for evidence and best practice in the assessment and management of risk to self and others in mental health. Department of Health. Document prepared for the National Mental Health Risk to National Health Risk Management Programme June 2007

Appendix 4

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.yu/homeoffice

Louise Kelly
Domestic & Sexual Violence Coordinator
Children's Services
Cumbria County Council

26 October 2015

Dear Ms Kelly

Thank you for submitting the Domestic Homicide Review report for Cumbria to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 23 September 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be an open and honest report with a good understanding of the dynamics of domestic abuse. The Panel particularly commended the author of the report for a sensitive and balanced narrative that demonstrated humanity and compassion.

There were some aspects of the report which the Panel felt may benefit from further consideration, or be revised, which you may wish to consider before you publish the final report:

- The Panel noted the scope of the review covers three different periods. The Panel felt further clarity around the reasons for the timeframes chosen would be helpful;
- Please anonymise. For example, the dates of the murders appear in the terms of reference;
- There is a contradiction in the report as to where the perpetrator was located. Paragraph 11.1 states he was "not far from the house". However, earlier in paragraph 1.1 it states that he was found "on a beach some miles from the address";
- The Panel noted paragraph 11.3.2 contains information about a child suspected of being sexually abused. The Panel sought reassurance that permission had been obtained to divulge this information as there is a risk the individual could be identified from her relationship to the family;

- Please provide further clarity to paragraph 11.3.4 as it is not clear why the children were left with a family friend when Susan had returned home;
- The action plan is missing outcomes and needs updating as target dates have all passed.

There were also a number of typing or other errors which you may wish to correct:

- Paragraph 16.1.27 – “fist” should read “first”;
- Paragraph 16.1.30 – should be two sentences;
- Paragraph 17.2.11 – “imagine” should be “image”;
- Paragraph 17.3.14 – “befitted” should be “benefitted”;
- Paragraph 17.5.5 – “differed” should be “deferred”;
- Paragraph 19.1.6 – punctuation errors;
- Paragraph 19.1.13 – please proof read as there may be words missing;
- Paragraph 20.1.5 – “whom” should be “who”;

Summary Report:

Paragraphs 4.3.2 to 4.3.4 – punctuation errors;

- Paragraphs 4.3.8 and 4.4.3 – typing errors.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR QA Panel

Domestic Homicide Review (DHR) into the deaths of Susan and Amy

Action Plan

The Panel is responsible for ensuring that all recommendations must be SMART (specific, measureable, achievable, realistic, time bound) and for the completion and implementation of the Action Plan.

The CSP will monitor the implementation and delivery of the Action Plan.

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
1. Statutory responsibilities around DHR's					
The Community Safety Partnership should engage with GP's to raise awareness of the statutory nature of DHR's and the lessons learnt from the process.	Produce and circulate a briefing for all GP surgeries across West Cumbria.	Venetia Young CCG Lead Adult Safeguarding	Produce the briefing Identify all surgeries and Practice Managers Send to Practice Managers requesting confirmation that it has been circulated.	December 2015	
2. Improving services for victims of domestic abuse					
That the Safeguarding Hub and Children's Services has clear links with and support from specialist domestic abuse services	Provide specific training for Children's Social Care frontline practitioners to include assessment of risk to children	Terri Irvine Cumbria Safeguarding Hub Lynn Berryman	Introduce an IDVA in to the MASH/HUB Develop course material Produce timetable of delivery	November 2015 and January 2016	Independent Domestic Abuse Advisor to be part of the Hub from Nov 2015 Training is

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
	where DV is a concern and working effectively to safeguard victims and their children.		Identify and invite attendees Provide training and evaluate.		programmed for January 2016. Delivery through the Local Safeguarding Children's Board.
3. Multi-agency working and information sharing					
All partner agencies are requested to review policies and procedures in relation to referring or transferring cases to improve information sharing at the point of handover from one service to another.	Identify policies and procedures relevant to referring or transferring cases. Write a policy and procedure if your agency does not currently have one.	All Partner Leads on DHR review to consider this action	Check for accuracy Update and publish Circulate to all frontline professionals to ensure they are aware and comply. Share a copy with the CSP Coordinator.	January 2016	
4. Training and Awareness raising					
Partner agencies should provide communities with information around "Legal Highs" and their effects more widely.	Front line staff to secure up to date information around 'Legal High's and share with clients, communities etc.	All Partner Leads on DHR review to consider this action	Identify materials and resources from health colleagues. Ensure front line staff has some knowledge about 'Legal High's and their	October/November 2015	Completed. Training being delivered to front line professionals

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
			effects.		
Staff within primary care and acute settings to be upskilled around their knowledge of “Legal Highs” and their effects	Front line staff to secure up to date information around ‘Legal High’s and share with clients, communities etc.	Venetia Young	Identify materials and resources from health colleagues. Ensure front line staff has some knowledge about ‘Legal High’s and their effects.	November 2015	
Specialist substance misuse services promote widely the use of Psychosocial support for users of “Legal Highs”	Front line staff to secure up to date information around ‘Legal High’s and share with clients, communities etc.	Cumbria Public Health Paul Musgrave	Identify materials and resources from health colleagues. Ensure front line staff has some knowledge about ‘Legal High’s and their effects.	November 2015	
Provide training to GP practices to support a culture of questioning and signposting to specialist services.	Produce a training plan to include dates, venues and objectives. Engage LSCB to develop and deliver	LSCB Training Pool	Level 3 advance domestic abuse and sexual assault training is being developed and will be available in the Autumn for front line professionals who engage directly with victims,	January 2016	

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
	training Deliver with multi-agency partners.		families and perpetrators		
Increase community awareness of domestic abuse and substance misuse ensuring family and friends can access support and signpost victims.	Run campaigns to raise awareness of services available. Utilise and raise the profile of the Champions Network	DV Op Grp Donna Lancaster	Produce information to provide advice, guidance and referral information. . New training and meetings have been developed and being rolled out across county	Jan 2016 March 2015 onwards	Champions training being delivered quarterly.