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

Domestic Homicide Review Overview Report

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1. INTRODUCTION

1.1 This domestic homicide review relates to the death of a female adult (A) who was killed on 21st July 2012 and her son B, age sixteen, who was arrested and charged with her murder. B was convicted of murder on 10th December 2012 and was sentenced to Detention at her Majesty's Pleasure with a minimum tariff of fifteen years. Details of the age and ethnicity of the victim have been omitted in order to preserve the privacy of remaining family members.

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

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

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

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

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

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

1.4 Since the perpetrator in this review was under eighteen and the son of the victim, it was agreed with Dorset Safeguarding Children Board that the Domestic Homicide Review would consider the involvement of agencies with the perpetrator in addition to those involved with the victim. The review recommendations relevant to Children's Services would be received and acted upon by Dorset Safeguarding Children Board.

1.5 Individual management reviews were requested and received from:

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

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

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

1.8 In addition, the overview author has had sight of the pre-sentence report and Youth Offender Assessment Profile (Asset) assessment completed by the Youth Offending Team (YOT) after the arrest and conviction of B. The panel recognises that there had been limited time to undertake a full assessment and that the information was primarily based on

self-report by B.

1.9 Records revealed that A and B had spent time in a different local authority area and that B had two older brothers who remained living there with their father. The records in Dorset also contained allegations of domestic violence perpetrated by B's father on A. In order to ascertain whether there was any relevant information regarding the time that A and B spent in this area, Children's Services were contacted and an 'external organisation request information form' completed, listing the names and dates of birth for A, B, his father and two brothers. No reference to B was found on their system but there was one brief record for his brother, who had moved in with A for a short time when she split from B's father. The brother's behaviour was challenging and he moved back with his father.

1.10 B spoke to the overview author about the primary school he attended in the previous area and a children's centre he went to for help with anger problems when he was about seven years of age. Every effort was made by Dorset Children's Services to trace any relevant information and contact was made with primary schools and a children's centre in the area where he had lived. No records have been found and it is possible that school records were destroyed in a flood.

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

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

Family Involvement

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

1.13 A's father had the opportunity to discuss the findings of the review with the overview report

author and the panel chair. He expressed serious concerns about the possibility of the executive summary being published as, in his view, the case is very identifiable and he was concerned about the detrimental effect of further press interest on the emotional wellbeing of his family.

2. THE FACTS

2.1 In November 2006 B (age 11) and his mother (A) moved to Dorset and B was enrolled at a local primary school. There are limited records regarding A's history prior to this time but information from family members, and her own self-report to professionals during her time in Dorset, indicates that she moved to the previous area as a result of a relationship with B's father. The couple met in Dorset where A was living after serving a short prison sentence. A had three boys, B being the youngest. The older boys remained with their father after A's move south. It has been suggested that A is likely to have experienced domestic violence from B's father whilst living in the previous area, and it is probable that this was witnessed by all three boys.

2.2 Following the move to Dorset, A registered with the local GP's surgery and her first appointment at this practice was in March 2007, relating to muscle pain in her neck. She was subsequently seen again in March and May in relation to migraines, from which she appeared to have suffered for a number of years. There was no information in the health records received from the previous area which raised any significant concerns about the family circumstances. The only information that might relate to problems for A is a record that she saw a counsellor in 2005 but did not engage, repeatedly failing to attend appointments.

2.3 By July 2007, A was finding it hard to control B's behaviour and following advice from Sure Start, she made a self-referral to the Youth Inclusion and Support Panel (YISP). The referral noted that B (still age 11) was damaging property at home and was angry and abusive towards her, although he was not violent.

2.4 In September 2007 B began to attend a Secondary School 1 (now part of a Community Academy). Following some 'behaviour difficulties' he was offered additional support in the

classroom, breakfast and lunchtime activities and additional support with reading. Further behaviour problems included lighting a fire in the school toilets with another pupil. A referral was made by the school to the YISP (who were already involved following A's self-referral). A Common Assessment Framework was completed and on 15th November an Integrated Support Plan was agreed by the YISP. This noted that A 'finds it difficult to set boundaries for B at home' and B 'is often abusive to mum and has damaged property when angry'. Recommended YISP activities in the plan included:

- Living with Parents Day (which brings the parent and child together to share exercises that explore the role of the parent and young person, why parental boundaries are required and how relationships can be improved).
- After school activities for B
- Anger management sessions with school nurse or YISP.

2.5 A informed the YISP worker that she had moved to Dorset to be closer to her parents and sister. However, she said that they were 'funny with her', possibly because she looked like her brother who had died.

2.6 Records indicate some improvement in B's behaviour although this was not consistent as on the 21st November 2007, six days after the the YISP Panel meeting, he was excluded from Secondary School 1 following an assault on another pupil. He is noted to have dragged a girl across the floor and kicked her in the stomach.

2.7 By 10th December B was described as calmer in lessons and A reported to the YISP worker that she felt more confident as a parent.

2.8 Between December 2007 and February 2008 YISP offered practical help, including transport to after school activities, supporting A in dealing with rent arrears (from her previous area), the provision of access to a washing machine, providing football boots and trainers for B and funding for a trip to the area where he previously lived. In addition YISP also arranged for:

- A and B to attend the One2One Club together which explored parent/child relationships. At this point A reported being firmer with B and that he was responding to this.

- STEPS training for A (an intensive course over a few days designed to develop confidence and positive thinking). A was reported to have enjoyed the course and was happier and more confident.
- Counselling for A as she had said she had not grieved for her dead brother, but had bereavement counselling in the area she had previously lived and had found this helpful. A did not, however, feel the need to take up the counselling offered.

2.9 During February, school reports indicate that B's behaviour had improved although, in a one to one with a YOT worker who had been engaged to look at ways he could manage his anger, B said that he hated being in school.

2.10 In April 2008 the case was closed by the YISP and notes from the YISP sent to Children's Social Care. Recorded outcomes achieved included:
Be healthy outcome – football boots provided for B for him to play football for the school
Stay safe outcome – work undertaken with B to manage his anger
Enjoy and Achieve outcome – attended After School Club
Make a positive contribution outcome – staying out of trouble
Achieve economic well-being outcome – supported A to access advice.

2.11 In April 2008 A attended the GP with migraine-related issues, and in November 2008 she registered at Surgery 2, where she was seen in December 2008 for a migraine which was treated with medication.

2.12 On 4th January 2009 B (aged 13) was arrested for criminal damage to a window following a fight at school on 11th December 2008. During the fight B was separated from another pupil by a school dinner lady and the matter reported to a teacher. The following day B was seen by the daughter of the dinner lady to approach their home address and throw a brick through a conservatory window. He then said to the daughter, 'I did this to get back at your mother for reporting me'. He was excluded from school on 15th December. B in interview with the police denied causing the damage and was not charged with any offence. A safeguarding referral form was completed by Dorset Police, but not copied to Children's Social Care.

2.13 YOT records note that in May 2009 B was arrested for burglary. There is no record of the arrest in the police chronology although this does record an arrest for burglary on 13th June 2009. According to police records B, together with another youth, entered a disused public house where they set off fire extinguishers and wrote graffiti on the walls. B's DNA was found in the scene, he admitted the offence and a 'restorative justice' meeting with the victim was held, which resulted in an agreement that B would make good the damage. This information was not shared by Dorset Police with Children's Social Care.

2.14 In June 2009 B was seen by an Out of Hours (OOH) GP at a local hospital. Following examination he was admitted to hospital with a possible torsion (twisting) of testis. Reports do not state whether A was present at this appointment.

2.15 On 10th July 2009 the GP practice received an Emergency Department (ED) summary letter from Dorset County Hospital Foundation Trust (DCHFT) informing them that B (age 13 years 9 months) had been brought in by the police suffering from alcohol intoxication. He had been found by the police on the local beach where he had been drinking vodka and beer with some older boys. This incident is not referred to in the police individual management review as B's details were not recorded in the searchable fields of the incident log system and there is no record of a child safeguarding report being completed. It is unclear why this did not happen.

2.16 His mother is recorded as being present during his attendance at hospital and is noted to have been concerned about B's general behaviour. Following a paediatric assessment B was discharged home with his mother, and the NHS Bournemouth , Poole and Dorset individual management review states that a referral was made at that time to the School Nursing Service for follow up and further assessment. However, according to school nursing records, the paperwork completed was a notification rather than a referral and no request was made for specific intervention.

2.17 On 27th July 2009 B was arrested for assault. The victim and B had previously been friends until they were both apprehended for a burglary and blamed each other. As a consequence B assaulted the victim, kicking and punching him. B admitted the offence and was given a final warning. This information was not shared by Dorset Police with Children's Social Care,

but the final warning process resulted in a notification to the youth offending team who completed a final warning Young Offender's Assessment Profile (ASSET). This is a less detailed assessment than the Court Order Asset tool and according to guidance [2] was used to:

- assess the re-offending risk factors.
- determine the nature and content of the intervention programme that would be appropriate to deal with the risk factors.
- explore the young person's attitude to intervention and assess and encourage the likelihood of him or her engaging with an intervention programme.
- explore with the young person the possibility of their participating in a restorative conference for the delivery of the warning.

The final warning profile completed by YOT noted that B was a 'low risk of serious harm to others'.

2.18 In August 2009 B (aged 13 years 10 months) self-presented at a local walk-in treatment centre requesting condoms. The notes make reference to the fact that this was the second time that week that B had made the same request, and that he said he had given them away to his friends. The nurse practitioner advised B not to give them away, and that his friends should obtain them for themselves. A sexual infection advice leaflet was offered to him. Unfortunately it has not been possible to obtain any further information from Urgent Care Services regarding this contact, including the exploration of any safeguarding concerns, as the staff member involved has left the post. However, GP records note that the practice was informed of the visits and that B was advised that it was illegal for him to have sexual intercourse because he was underage.

2.19 On 27th August 2009 there was community intelligence that youths were drinking and causing problems in the locality. They were using a shed in the area and B was known often to sleep in the shed overnight. It was noted by Dorset Police that B's mother was not reporting him missing. Information obtained after the murder of A, as part of the reports presented to court, indicated that B was possibly living in the shed for four or five months,

[2] Home Office (2002) *Final Warning Scheme: Guidance for Police and Youth Offending Teams.* Home Office/Youth Justice Board.

having left home after an argument with his mother.

2.20 A safeguarding referral was made to Children's Social Care and an initial assessment was instigated by the local assessment team. This assessment referred to the recent school incident and included information from YOT that B was becoming more compliant and was 'sorting himself out'. A felt that YOT involvement had been positive as 'things were much better'. The initial assessment concluded that support was required to prevent further escalation of B's behaviour but that since YOT were involved there was no need for input from Children's Social Care. The YOT were noted to have agreed with this approach and were to work with A on developing stronger boundaries and with B on improving his behaviour.

2.21 The Children's Social Care individual management review notes that between 7th and 16th September 2009 (whilst the Social Care initial assessment was being completed) B was reported by Secondary School 1 to have had eleven 'misdemeanours' for impertinence, disruptive behaviour, missing detention and defiance. He was excluded for two days for smoking, and the police had to be called when he was on the premises whilst excluded and was allegedly behaving in a threatening manner. This incident is not in the police individual management review. A meeting to discuss his behaviour was held attended by representatives from YOT, Secondary School 1 and the Education Centre. A 'Pastoral Support Plan' was developed which included support in lessons and anger management sessions. He was placed on the Special Educational Needs Code of Practice (School Action Plus) and was given advice from a 'smoke stop' counsellor.

2.22 On 22nd September 2009 an assessment by a health worker in YOT recorded that A thought that anger was B's 'main problem at the moment' and six days later the ASSET assessment author identified emotional and mental health as the main cause for concern, noting that B had a lack of understanding for others, impulsivity, erratic temper and no apparent remorse. The YOT psychologist concluded that B had 'an apparent peak on the unregulated emotions' raising questions 'about his ability to regulate his arousal system'. The Children's Social Care individual management review notes that:

Whilst this information informed work undertaken by YOT there is no evidence that this

information was known or utilised by agencies outside the YOT environment. The YOT were keen to emphasise that this information would have been available to other agencies on request. (Para 5.25)

2.23 During September the school nurse, following the notification from ED the previous July, attempted to visit the home but was unable to reach A via telephone to make an appointment. B was seen in school on 1st October; he admitted drinking too much and was advised regarding reducing his alcohol intake. He declined a referral to a local young people's drug and alcohol service, and the school nurse recorded that they would 'await contact from parent'. The school nurse did not consult the school health record which would have included information on the involvement with YISP, and there is also no evidence that the school nurse was contacted during the initial assessment, either by Children's Social Care or by any other professional working with B. The contact between the school nurse and B therefore took place in isolation from other professional contact with B and A at that time.

2.24 On 16th October 2009 the YOT parenting worker referred B to an advice and information centre run locally by the Children's Society. The referral stated 'B's relationship with mother not good. Anger/alcohol/smoking issues with B. Uses volatile language.'

2.25 On 23rd October 2009 there was community intelligence that B (who attended Secondary School 1) was selling cannabis to pupils on school property.

2.26 On 31st October 2009 B (on his 14th birthday) again self-presented (with a 16 year old male friend) at a local walk-in treatment centre requesting condoms. B explained that he was having sexual intercourse with a regular partner. The practitioner has informed this review that Fraser Guidelines were applied; the criteria had been met and in line with usual practice, three condoms would have been offered. An automatic fax was generated to the GP later on that evening.

2.27 On 3rd November 2009 B was arrested for shoplifting two CDs from ASDA. He was charged with the offence and sentenced to a four month referral order by the local Youth Court. This is a mandatory order for a first time offence before the court. A safeguarding

referral form was completed and copied to Children's Social Care.

2.28 Records indicate that B and A were first seen by the parenting support worker from the Children's Society project on 13th November 2009. During this session A commented that she and B had a very good relationship but that he was in with the wrong crowd. She said that B was 'crying out for help' and nobody had done anything about it. She said that his biggest problem was his anger. The Children's Society project records show that the plan was for B to be referred to a specific Children's Society project and to a worker for anger management. The first session took place on 26th November and noted that an initial assessment was undertaken and that it was a 'good introductory session'. There are brief notes but no record within the Children's Society project file of any assessment of the causes of B's anger, or subsequent progress made regarding anger management.

2.29 There are records indicting several more contacts with A by the Children's Society project parenting support worker via telephone and text, but A declined further help saying that by early January things were 'brilliant' following a move to a new flat. B had been seeing a worker for anger management work and this was going well. YOT records note that B had stated that he found these sessions helpful because the worker 'starts at his level'. In fact the Children's Society project records indicate little progress, with sessions finishing in January 2010 due to no further contact from B.

2.30 On the 2nd December 2009 a meeting held at college to review the Pastoral Support Plan highlighted that B continued to show disruptive and abusive behaviour. A indicated at this meeting that she had been offered a house exchange in another area of her town; the meeting concluded that the best way forward was to seek a fresh start, and proposed a managed move to Secondary School 2 in January. Prior to the move on the 11th December 2009 B was given a five day exclusion for verbal abuse/threatening behaviour towards an adult.

2.31 On the 3rd December 2009 a report written by YOT described B as 'inclined to act impulsively and has a great need for excitement'. He 'would give into pressure from others' and 'his temper can be erratic'. He 'has a lack of understanding of the effect of his behaviour on others' and 'there appears to be no remorse' and 'a lack of understanding for

his mother'. The Children's Social Care individual management review notes there was no evidence to suggest that B was assessed as to whether he was on the autistic spectrum. However, when this was explored with the YOT worker in interview they commented that the information was considered to be 'unremarkable' in the context of what they perceived to be a relatively minor index offence and similar to that of many young people known to YOT at that time.

2.32 On 14th December 2009 A and B moved from their privately rented accommodation to accommodation managed by the local Housing Association. The purpose of the move was to secure more affordable, secure accommodation on the social rented sector.

2.33 During December 2009 A attended the GP practice with a cough and shortness of breath and it was recorded that the environmental health department had found eggs and larvae in the carpets that could have affected her lungs.

2.34 On the 5th January 2010 a YOT initial panel meeting proposed community reparation for the shoplifting, and that work with B would explore the effects of peer pressure, thinking about his behaviour and developing his victim awareness. The Children's Society project anger management sessions would continue and B agreed to improve his behaviour at his new school. However, the Children's Society project records show that B's case was closed following a last contact on 27th January as he chose to end work with the project.

2.35 Two days after starting at Secondary School 2 B was caught smoking and was verbally abusive and threatening to teachers, left the site and subsequently refused to attend. The head teacher was not willing for the planned move to continue.

2.36 On the 2nd February 2010 B was considered to be at the point of permanent exclusion due to disruptive and abusive behaviour in school. Dual registration with Secondary School 1 and the Education Centre, and a Children Out of School Service referral were proposed, and three days later B was inducted at the Education Centre. Tests concluded that he had low reading skills, low verbal reasoning and a low spelling age and was behind his chronological age in reading and comprehension. The records note that this would make access to secondary education a struggle, raising his stress levels which would create

blocks to learning. Subsequent psychological testing after the murder of A has revealed that B has an IQ of 69-79; i.e. borderline learning disability.

2.37 B rejected the reduced Year 9 timetable proposed for him at the Education Centre and, in February and March 2010, only attended on three occasions. A was contacted by the Education Centre staff but this led to no improvement in attendance and on 16th March 2009 he was referred to the Education Social Work and Attendance Service (ESWAS).

2.38 During this period, the anti-social behaviour officer at the local Housing Association was contacted by a neighbour of A reporting a 'terrible disturbance' over the weekend at A's flat (3rd February 2011). The neighbour had sent a text to A asking if she was alright and A had replied that her son was having problems with his computer. Five days later the same neighbour advised the Housing Association that she had heard further noise but was not sure what flat it was coming from, and on 24th February the neighbour reported that the noise was very bad and A's son and a friend had deliberately made excessive noise in the communal hallway. There is no recorded action in respect of this, although lack of action may have been influenced by the fact that the neighbour who had made the complaint had previously complained about noise coming from another flat which, on investigation, had been found to be an unfair complaint.

2.39 Meanwhile there are recorded problems with A's health. She was seen in February 2010 with an ongoing cough and shortness of breath and she subsequently had an x-ray that proved normal. Blood tests were conducted and she attended on a further nine occasions during 2010 and early 2011 with coughs, asthma and migraine. There was one failed appointment.

2.40 The involvement of YOT continued and the YOT final panel on 29th April 2010 recorded that B had achieved all aspects of his Referral Order Contract. At this point A and B were noted to be positive about B's progress and reported less frequent episodes of temper loss and that, because of the progress made, the appointments at the Children's Society project had finished. This is contrary to the Children's Society project records completed by the Children's Society project worker in January which had noted 'I am not sure where we are going at present so have asked [B] to decide on what if any help he needs'. In a summary

of case recording, the YOT case manager noted that engaging with B was more difficult when his mother was present and that the significant ongoing issue at this time was B's reluctance to engage in education.

2.41 On 5th May 2010 the education social worker (ESW) had meetings to encourage B to attend the Education Centre, which resulted in him attending four times. The records of the ESWAS note that A was 'timid' and did not 'do anything spontaneously' and appeared 'worried by the threat of an Educational Supervision Order'. No formal action was instigated as it was felt by the service that the imposition of an Educational Supervision Order was punitive and unlikely to result in increased attendance, and that a fine would place A in increased debt.

2.42 On 9th June B was seen by the local Minor Injuries Unit with an injury to his right foot/ankle. No other details about this incident are recorded within the GP record.

2.43 On the 18th June 2010 A visited the Education Centre and whilst there telephoned Children's Social Care. The records note that she 'believes her son B is taking drugs and using alcohol' … 'She is 'no longer able to control his behaviour, she is nervous and scared of him'. An initial assessment was instigated and a secondary referral made to the Specialist Prevention Service (Adolescent Support) by the social worker. This is a service which works to prevent children from requiring social care accommodation or supports children in social care accommodation to return home. The referral stated that 'concerns that B will become physically violent towards mum are very real at the moment'. Between June and October Specialist Prevention undertook ten visits to the family to develop positive parenting strategies, encourage clear boundary setting, work with B on anger management and work on communication.

2.44 On 23rd June 2010, B was arrested for criminal damage. The police were called to the family home, where A reported that B was drunk and had pulled a photograph from the wall and thrown it, breaking the glass. In interview B explained that he had drunk six litres of cider during the evening and on returning home he had had an argument with his mother and had broken the frame. B admitted he had an alcohol, and an anger, problem. He was interviewed by police (YOT provided an Appropriate Adult) and charged with the offence. A

safeguarding referral form was completed by Dorset Police, but not forwarded to Children's Social Care. B was sentenced to a 12 month conditional discharge by the local Youth Court on 21st July. The Court's decision was made without a YOT report. The initial assessment report completed by Children's Social Care noted that the police constable dealing with the charge for criminal damage suggested that B 'presented as not understanding the severity of the charge and appeared to be 'cocky with no empathy for others''.

2.45 The social worker discussed the initial assessment with the ESWAS worker who recorded B's difficulties including, possible attachment disorder, abuse towards mother and problems with anger. A final copy of the initial assessment was not received by the ESWAS.

2.46 On the 24th June 2010 B stated to the social worker, 'I lose my temper with my mother when she shouts and whines but I would never hurt her'. The final assessment report notes A's and B's complex history including:

- A being a victim of domestic violence from B's father.
- A's belief that drugs and alcohol led to her brother's death.

2.47 There is evidence in the GP records that the social worker contacted the GP by telephone, requesting information regarding any health issues relating to B or his mother. The GP record states that the information shared was based on what was held within the GP record.

2.48 The Children's Social Care initial assessment concludes, 'there is significant evidence of B being the perpetrator of domestic abuse towards his mother, which appears to make it difficult for her to fulfil her parenting role. B's hostility towards her appears to be evoking memories and feelings from her past relationship with his father'. The social worker identified that the situation required an immediate response to prevent family breakdown.

2.49 On the evening of 8th July 2010 B was drunk and a taxi had refused to take him home. A member of the public called the police, but they did not have anyone to send so she called the ambulance service. The crew arrived and found B conscious and breathing, sitting in the taxi office. Although he had been drinking alcohol he was able to give his name, age

and address and who he lived with. They were part way through their assessment of him when he suddenly became verbally abusive and refused to have any further assessment. The police were called, and they took B to his home address. The attending officers' record on the control room log and the safeguarding referral form show that in their opinion his mother was not concerned for his welfare or about the fact that emergency services had had to bring him home. A safeguarding referral form was completed. However, the form does not record whether it was forwarded to Children's Social Care.

2.50 On 9th July 2010 B (age 14 years 8 months) was seen by police officers with four other youths, all under 18 years, drinking cider. The alcohol was confiscated and poured away. Advice was given by the officers. A safeguarding referral form was completed but the individual management review does not note whether it was forwarded to Children's Social Care.

2.51 Records show that the worker from Specialist Prevention Adolescent Support Service explored past history with both A and B that confirmed A's previous imprisonment for petty offences, experiences of domestic violence between A and B's father, witnessed by B, and B's limited contact with his father and siblings. A was noted to have previously attended parenting classes which helped her to be less aggressive in her parenting style. A strength based assessment was completed by the Adolescent Support Service which noted that:

- 'B gets frustrated with [A's] parenting and communication style; he asserts that she nags him and keeps on about things. This results in them arguing and B lashing out. When B becomes angry he becomes aggressive and will smash items in the house, shouting and swearing at A'.
- A's past 'does impact on her ability to develop effective parenting strategies' and she 'is not able to acknowledge B's feelings and tends to compare his life to her own childhood'.
- A 'does not have a good understanding of adolescent needs and behaviour because of her own life experiences. She has a tendency to compare her history to B's life'.
- A 'is not direct and assertive in the way she parents B and at times can be passive-aggressive in her parenting style'. 'B gets frustrated with A's parenting and communicating style, he asserts that she nags him and keeps on about things. This results in them arguing and B lashing out. When B becomes angry he becomes

aggressive and will smash items in the house, shouting and swearing at A. A is not able to address this'.

2.52 B's grandfather recalls a social worker during this period suggesting to B that he should get a punch bag and take his anger out on that. After A's death a punch bag was found in the flat, still in its box and unused.

2.53 Whilst working with the Adolescent Support Service, A was offered the opportunity to attend the Freedom Programme but declined. This programme is a twelve week course for women who have been abused that explores abusive behaviour, the characteristics of a perpetrator, the cycle of behaviour and the effect of domestic violence on children. The worker suggested the course as they felt that A was responding to B as a perpetrator. A was noted to have 'strongly declined' the offer, becoming 'borderline aggressive in her mannerisms' and to have said that she was not going for counselling again as it had been unhelpful before.

2.54 Educational attendance continued to be a problem and in September 2010 responsibility for this aspect of work with the family moved to the Early Intervention Service who took over the functions of the ESWAS. Records at the Education Centre show that B attended once during the week of 18th October and by 25th November 2010 (age 15) he had a 14% attendance record, prompting the Early Intervention Education Social Worker to write to A informing her that an Education Supervision Order 'might be the best way forward'. However following further consideration, it was felt by the Early Intervention Service that mother was helpless to control B that he was responsible for his actions regarding education and that prosecution was not the most appropriate course of action.

2.55 On the 26th November 2010 the work undertaken by Adolescent Support concluded. Records note that there had been no altercations within the family home and that B and A were not prepared to do further work and did not need support. The closing summary notes that the situation was deemed to be 'calmer' with a 'considerable reduction in conflict'.

2.56 On the 26th December 2010 Children's Social Care closed the case as A was deemed to be able to meet B's needs, and did not want to engage with services. Reasons stated were

similar to those cited by the Adolescent Support Service. Information from B obtained following the murder of A now indicates that he spent most of his time watching horror DVDs in the flat from the end of 2010 onwards until he was arrested. He told his grandfather in March 2012 that he did not leave the flat, as when he went out he got into trouble.

2.57 On 7th February 2011 Dorset Police recorded concerns that a sex offender might be having contact with B. The circumstances were that during a 'home visit' to a sex offender by Dorset Police, A was present. It was established A was friends with the sex offender. There was also intelligence that A was visiting the sex offender to purchase an eighth of cannabis every Tuesday and concern that the sex offender might have access to B through his mother. A disclosure was made to A regarding the previous convictions of the sex offender and A agreed that whilst she intended to continue to see the sex offender she would protect B. This incident prompted a referral to Children's Social Care by the Police Offender Management Unit. A letter was sent by Children's Social Care to A advising there was to be no contact between her son and the sex offender. The referral was closed as a contact.

2.58 On 6th April 2011 the family moved GPs to a new local surgery. It is not clear what precipitated this change in GP practices at this point, as the family do not appear to have changed their home address. There were a number of visits by A to the practice during April and May with migraines and numbness in her face, some nausea and tremor. Smoking cessation and asthma management were discussed. She also attended with pains in her joints and blood tests were conducted and were found to be normal, reflecting a virus rather than arthritis.

2.59 On 26th May 2011 B was offered a course at a local college; however, this was not taken up and there was some confusion as to whether A and B were leaving the area as A had indicated that they intended to move away from Dorset. There were two visits to the home by the worker from the Early Intervention Service in June and September 2011. In June the possibility of virtual learning was discussed and in September he told the Early Intervention Worker that he was moving.

2.60 The Education Centre was unclear as to whether B had left the local area until informed by Early Intervention on 12th November 2011 this was not the case. B did not attend the Education Centre throughout the academic year 2011 – 2012 and during this period, on 30th November 2011, the dual registration with the Education Centre and Secondary School 1 was ended by the Secondary School 1. Sole registration for education provision was therefore with the Education Centre and he remained on their roll until 29th June 2012, when he was removed due to his age.

2.61 In July 2011 A attended the GP practice, reporting daily headaches and 'getting upset a lot', although there was no cause for this recorded. At a second appointment that month A's GP concluded that her ongoing headaches may well have been analgesia induced. The practice received a letter from A's mother at the end of July 2011, raising concerns relating to lumps on A's head and neck that she had spoken to her mother about over the phone. At a subsequent appointment A was 'not impressed' that her mother had written. During September 2011, A was treated by the GP practice for head and neck pain. She was next seen in March 2012 and the GP recorded that A's depression (which had been treated since February 2011) had settled, she was engaging with smoking cessation services and had some pain in right knee and shoulder. She was seen again in the same month reporting that her shoulder had dislocated, but that she had repositioned it herself. A steroid injection for joint pain was given by the practice. A was last seen at the GP practice in May 2012 wanting an inhaler. She reported that she had some dizziness and was told to book an appointment with the nurse for a blood pressure check. At this point she had reported to the GP that she had started a computer course, her pain was much improved and she was no longer depressed.

2.62 On 21st July 2012 A was killed and B was arrested and charged with the murder. He was subsequently convicted on 10th December 2012 and given a mandatory life sentence.

3. EVALUATION OF THE QUALITY OF SERVICES PROVIDED TO A

Services to A

3.1 The services delivered to A in Dorset were primarily in relation her role as the mother of B. There is little known about the help she may have received whilst living in a reportedly

abusive relationship with the father of B in the previous local authority area. A reported attending bereavement counselling and this is confirmed within the GP records. However, these records provide no indication of potential domestic violence. It is therefore likely that in common with many victims of domestic violence A did not bring any injuries she may have suffered to the attention of others.[3] There is nothing in the records to indicate that agencies in Dorset contacted agencies in the previous area to gain any further understanding of the family history beyond that reported to them by A. It is significant that when B was asked for this review whether he recalls telling anyone on Dorset about his childhood he replied that 'people aren't interested in your childhood'.

3.2 The health care provided to A mainly focused on joint pain, migraine and depression which the GP believed to be associated with the pain she was experiencing. Her treatment was carried out in isolation from the knowledge available within the professional network as a whole regarding the behaviour of B and her expressed fear of him.

3.3 A was described as one of the GP's most frequent attendees; treatment of the presenting problems was appropriate and A did not volunteer any information about the problems she was experiencing with B. This is congruent with her father's description of her as someone who was independent and did not easily ask for help. However, her symptoms may have been seen in context if a link had been made between A's and B's records. The information that would have been on the B's GP records regarding alcohol intoxication, underage sexual activity, and a referral to the School Nursing Service as well as his involvement with Children's Social Care may have alerted the GP to possible stressors within the family and provided an opportunity to explore whether A's symptoms were exacerbated by her home environment. The current GP safeguarding children and young people self-assessment tool issued by NHS Dorset does advise GP Practices to ensure that they 'link family members in medical records especially if they have different surnames so they can be flagged'. This case confirms the importance of this approach.

3.4 A was provided with information on the Dorset Women's Outreach Project, (DWOP) a specialist domestic violence support organisation in 2007 and in 2010 a referral was made

[3] See for example Abrahams, H (2007) *Supporting Woman After Domestic Violence: Loss, Trauma and Recovery.* London: JKP

to the project by Children's Social Care. A worker from DWOP made contact with A but she declined the offer of support.

3.5 No risk assessments were contemplated in relation to A as a potential victim of domestic violence (e.g. CAADA DASH) [4] which if completed today may have prompted consideration of referral to MARAC.[5] At the time of A's death local process was that when a parent was being abused by a child there would have been no referral to MARAC even if the threshold for referral had been met, since the national definition of domestic violence did not include violence by children against parents. This has now changed.

Services to A in her role as mother of B

3.6 Three periods of specialist provision in relation to A in her parenting role are identified within the chronology :

1. July 2007 – April 2008. Intervention by the Youth Inclusion and Support Panel (YISP) soon after A and B arrived in Dorset.
2. July 2009 – April 2010. Intervention by the YOT as a result of a final warning following an assault. This included help offered by the Children's Society project to both A as a parent and B in managing his anger.
3. June 2010 – December 2010. Intervention by the Adolescent Support Service following a self-referral to Children's Social Care by A, concerned that she could no longer control B.

3.7 This work with A as a parent was characterised by short periods of involvement by specialist services and closure of the case following some apparent improvements.

Involvement with YISP

3.8 This period involved intervention by the Youth Inclusion and Support Panel (YISP) soon after the A and B arrived in Dorset. B was 11 years old at this point, there were emerging

[4] Domestic Abuse Stalking and Honour Based Violence risk assessment tool.
[5] MARAC is a Multi-Agency Risk Assessment Conference. This is where local agencies meet to discuss the highest risk victims of Domestic Abuse in their area. Information about the risks faced by those victims, the actions needed to ensure safety, and the resources available locally is shared and used to create a risk management plan involving all agencies. The aim of the MARAC is to increase the safety, health and wellbeing of the victim – adults and any children. (source Dorset Police website)

problems with his behaviour and A was asking for help. It is important to note that at this early stage she was asking for support, since later it appears that she became defined as a mother who did not wish to engage with services.

3.9 YISP worked with the family for nine months, with evidence of improvement in B's behaviour, and it seems that the service was successful in working alongside A and B, providing a range of interventions. There were fifty five contacts with the family in total, indicating a high degree of engagement. The outcomes stated at the point of closure, however, were not necessarily indicative of long term change. For example, the outcome in relation to 'enjoy and achieve' was that B had attended the after school club. Attending in itself was positive, but simply attending might not achieve the underlying change required. Similarly, the stated outcome that work was undertaken with B to manage his anger does not explore how successful this work was. It is noted that he had stayed out of trouble but, in the light of his past behaviour and family circumstances, there should have been more consideration given to sustainability at this point.

Work with the youth offending team

3.10 This period involved intervention by the youth offending team as a result of a final warning following an assault. This happened after a period where B's behaviour had been deteriorating outside school, including an arrest for criminal damage (not charged), a restorative justice meeting being held following a burglary, and being found to be intoxicated on the beach. The final warning profile completed in August 2009 noted low risk of serious harm to others, however, there is no indication that this was revised when the assessment undertaken by YOT contained information that A thought anger was B's main problem, that he was impulsive, had an inability to regulate his arousal system, lacked remorse and that emotional and mental health were the main causes for concern. These issues warranted further exploration; mother's concern about B's anger should have been shared with others involved with B and consideration given to further mental health assessments. However, the context for the YOT decision-making was a view that the assessment was 'unremarkable' and that B did not stand out from many of the young people they were working with.

3.11 Children's Social Care were briefly involved in August and completed an initial assessment

following a safeguarding referral from the police which noted B had been sleeping rough, abusing alcohol and involved in crime. However, the case was closed as YOT were working with the family. This was a reasonable decision at the time but Children's Social Care were therefore unaware of the additional issues that had emerged as a result of the YOT assessment regarding his emotional and mental health. Although the YOT worker informed this review that the information would have been available to any other professional, a more proactive approach by YOT should have been taken and consideration given to whether the information needed to be shared and with whom.

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

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

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

3.14 There is evidence of a reasonably thorough initial assessment being undertaken by Children's Social Care which gathered information from the Police and GP. This meant that although Dorset Police had not forwarded the safeguarding referral following B's arrest for criminal damage and there was no contact between Children's Social Care and YOT, the social worker was aware of the episode of criminal damage within the home and that B had been described by the police as 'cocky with no empathy for others'.

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

situation was calmer and case closure, due partly to the reluctance of both A and B to engage in further work.

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

3.17 It seems that two key issues hampered an understanding of the significance of the family situation and the implementation of more constructive approach to the work with the family:

1. an understanding of the research relating to children's violence towards parents and established frameworks for response, including services for A;
2. a lack of a holistic approach to intervention with B that included a gathering together of all known information, particularly taking account of the impact of poor attendance at school and work alongside schools and the Education Social Work and Welfare Service to address this.

3.18 Intervention might also have been strengthened if the Youth Court had requested a report from YOT prior to giving a Conditional Discharge. Such a report would have enabled the court to understand the behaviour within the overall context of B's history and may have resulted in a more structured approach to the prevention of re offending. However, it is common practice for no reports to be requested by the Court when the offence is of a minor nature. Information from the Courts Service to the review confirmed that little information is retained on the Court file and that due to the lapse of time no more specific information is available, including whether any oral information was given to the Court by the youth

offending team.

3.19 Following case closure by Children's Social Care there was no further involvement until February 2011, when they received the notification from Dorset Police that A was spending time with a known sex offender. Given the previous history, simply sending a letter advising A that there should be no contact was insufficient. Consideration of previous records would have revealed that this was a mother who was fearful of violence from her son, had difficulty in setting boundaries and was therefore unlikely to be able to implement the request to keep B away from the address. An assessment should have been completed in order to understand the current situation and had this been done at that point, it would have revealed continuing problems with educational attendance; a situation which increased risks in respect of B.

The role of Education

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

3.21 Psychological testing after his arrest revealed that B has an IQ of 69-79, placing him within the category of borderline learning disability. The lack of referral for psychological testing at school meant that there was insufficient attention paid to meeting his specific learning needs. The focus appears to have been mainly on his behavioural problems rather than exploring ways in which he could be appropriately supported to achieve at school. The result appears to be increasing frustration on the part of B, who ultimately opted out of education.

3.22 An additional concern in relation to B’s education is apparent confusion over who had overall responsibility for his education once he was in alternative provision, and on the role of the Education Centre. The joint responsibility between the Centre and the secondary school appears to have led to no-one assuming overall responsibility for ensuring that the curriculum met his needs, or working together with the Education Welfare Service when he did not attend. This dual responsibility appears to have led to a failure to recognise that he had not attended any education provision at all for at least one whole academic year. This was a crucial period as we are now aware that much of it was spent in the flat watching horror DVDs. It is unacceptable that his lack of school attendance was not picked up and addressed by any individual or organisation.

Dorset Police’s involvement with the family

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

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

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

3.25 An issue which needs further exploration is the extent to which police officers (and other professionals) become de-sensitised to the significance of adolescent behaviour. Since so called ‘normal’ adolescent behaviour is likely to put young people at some degree of risk, distinguishing those for whom this risk is heightened due to their family circumstances

becomes an important task. In this case information indicates that B's behaviour was placing both himself and others at risk and this was combined with family circumstances which indicated neglect; for example, A being unconcerned about his whereabouts and failing to report him missing. There was good practice on the part of Dorset Police in August 2009 in making a safeguarding referral to Children's Social Care but the inconsistencies in the responses to B's behaviour over time highlights the importance of the changes in procedures outlined in the paragraph above. Current safeguarding training programmes will also continue to be delivered to all front line staff and supervisors and will include early identification of risk and measures to mitigate and deal with risk in all domestic violence situations.

The role of Health Services

3.26 One significant issue linked to general responses to adolescents is the response when B presented at age 13 asking for condoms, and stating that he had a regular partner. The lack of evidence of any exploration of the circumstances surrounding this is worrying and, as highlighted by recent reviews into situations of sexual exploitation[6], professionals need to guard against the tendency to accept too readily the early onset of sexual activity.

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

The role of the Housing Association

3.28 Although there was little information that would have alerted housing providers to major issues within the family there was a lost opportunity to identify potential concerns in February 2011. However, the officer appears to have been deflected by the fact the person raising the concern previously made an unfair complaint.

[6] Torbay Safeguarding Children Board Forthcoming.

4. ANALYSIS – WHAT CAN WE LEARN FROM THIS CASE?

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

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

Recognition of risks associated with violence towards parents by their children

4.2 It is striking that throughout the records from 2007 onwards there are frequent references to B's anger, and particularly anger directed towards A, for example:

- 'Angry and abusive towards [A]' Age 11
- 'Often abusive to mum' Age 11
- 'Anger is his main problem at the moment' Age 13
- Mother reports 'his biggest problem is his anger' Age 14
- 'His temper can be erratic' Age 14
- Mother is 'nervous and scared of him' Age 14
- 'Concerns that B will become physically violent towards mum are very real' Age 14
- 'Anger problem' (self-reported by B) Age 14
- Angry and 'lashes out' (in the home) Age 14

4.3 The clearest articulation of the potential abuse of A was in the Children's Social Care assessment; however, without a clear framework for defining and responding to such circumstances, subsequent services to the family did not adequately address the issue.

4.4 Our current state of knowledge in relation to the abuse of parents is acknowledged to be in its infancy[7] with research showing that social workers may be unfamiliar with the term 'parent abuse' and their construction of the problem is likely to be hesitant and contradictory. Practitioners in the field of domestic violence are more ready to acknowledge parent abuse as a form of family violence but are also aware that due to the stigma associated with this form of family violence, it is particularly difficult to identify.[8] The emotional responses of parents to their abuse by their child may be complicated, including feeling that they will be judged as bad parents, fearing the consequences of their child becoming embroiled in the criminal justice system or guilt that they yearned for the child to leave home.[9]

4.5 Self-blame and shame on the part of the abused parent have been shown to be associated with a parental reluctance to seek help and be particularly likely when the abuse seems targeted only at them.[10] The fact that A did tell some professionals of her fear of B indicates that although some the emotional responses above may well have applied and reduced her help seeking behaviour, she also recognised that this was part of a more general problem for B. Her comment to the worker from the Children's Society project that he was 'crying out for help' and 'nobody had done anything about it' appears to indicate that although she might be reluctant to acknowledge his behaviour towards her, she viewed this as part of a bigger problem.

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

[7] Holt, A. (2013) *Adolescent-to-parent abuse.* Bristol: The Policy Press. Page 13.
[8] Nixon. J. (2012) 'Practitioners' constructions of parent abuse' *Social Policy and Society.* Vol 11 Issue 2, pp229-239.
[9] Holt, A. (2013) *Adolescent-to-parent abuse.* Bristol: The Policy Press. Page 51.
[10] Ibid Page 50.

4.7 Knowledge in relation to risk factors present for young people abusing parents points to the significance of having witnessed domestic violence themselves as a child. One study[11] notes that:

half of the families in which parent abuse occurred had a history of domestic violence. Young people who were violent to parents were nearly three times more likely to have witnessed partner violence (28%) than those who were not violent to parents (10%). Among young people violent to parents, those who had witnessed partner violence were more than twice as likely to be currently living with a lone mother. (Page 256)

4.8 In the case of B there is little indication that his early childhood experiences were explored in sufficient depth in order for his current behaviour to have been interpreted in the light of this understanding. Had this been done there may have been more of a focus on his mental health and the need to move beyond short term approaches towards sustained change over time.

Current knowledge regarding the risk of adolescent parricide

4.9 The literature in respect of parent abuse distinguishes between parent abuse and parricide (the killing of a parent by their child), describing parricide as an extremely rare phenomenon that is distinct from parent abuse in terms of its case characteristics.[12] The rarity of such events points to the fact that even if parent abuse had been more clearly recognised it may have been very unlikely that practitioners could have predicted that B would go on to kill his mother.

4.10 However, a review of the limited research into parricide highlights that this case does have a number of the factors known to be associated with a higher level of risk. Hyde's overview of research in this area identifies twelve characteristics of adolescents who kill family members, particularly fathers.[13]

1. *A pattern of family violence*

   There is evidence to suggest that B had lived in a family where there was a culture of aggression and violence.

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

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

[13] Heide (1995) *Why Kids Kill Parents: Child Abuse and Adolescent Homicide.* California: Sage. pp. 42-43

2. *Adolescents' attempts to get help failed*

   With hindsight B's behavioural problems could be seen as a cry for help. This was clearly the view of A who articulated this view to the worker from the Children's Society project.

3. *Failure of adolescents' attempts to escape the family situation*

   Although the research refers to adolescents trying to leave situations of continuing family violence (and this does not appear to be the case for B), he has spoken of his belief that his mother did not love him or care about him. His mother's failure to report him missing at age 13 when he was sleeping in the shed may well have confirmed his view.

4. *Isolated from others with few outlets than their peers*

   During the period leading up to the homicide there is evidence of increasing isolation exacerbated by the failure of the education system to identify that he was not attending school.

5. *Family situation became increasingly intolerable prior to the homicidal event.*

   There is no evidence that this was the case for B and he has spoken of fewer arguments immediately before the homicide.

6. *Adolescents felt increasingly helpless to deal with the home situation.*

   It appears that staying in, away from his peers, was B's attempt to deal with his situation and that he did not see any other strategies available to him.

7. *Criminally unsophisticated - little or no prior criminal history.*

   B was not seen as a heavily convicted young man.

8. *Easy availability of a gun.*

   This factor is less relevant in the UK. However, it is now known that B was interested in knives, had the wherewithal to make two homemade weapons and was able to buy a knife from the internet.

9. *Alcoholism or heavy drinking in homes.*

   There is no evidence that A misused alcohol although she was known to use cannabis. Alcohol misuse was, however, a feature of B's life.

10. *Offender in dissociative state during or after the homicide.*

    B has described having a temper and 'blackouts' during which he does not know what he is doing. Although there is no firm evidence that this was a feature of the attack on his mother, if a 'blackout' was a feature this would be consistent with

dissociation.

11. *Victim's death was perceived as a relief by the adolescent.*

    B has spoken of not missing his mother although he has said that at no time did he want her dead.

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

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

4.12 The review has raised questions as to how far A should have been seen as a victim of domestic violence from B and responded to accordingly.

4.13 Whether such processes were used depends upon whether or not the experience of A was seen as constituting domestic violence. The Police individual management review highlights the issue of how domestic violence is defined and how this definition affects responses; for example, the individual management review refers to the incident in June 2010 when B was arrested and charged with criminal damage within the home. Appropriate action was taken in respect of the criminal damage, and the offence would have been placed within the context of understanding parent-child disagreement as common within adolescence. This was not defined as a domestic violence incident since at the time the ACPO definition of domestic violence was an incident between adults aged eighteen and over.

4.14 However, from April 2013 this definition has been amended and now defines domestic violence as:

'any incident or pattern of incidents of controlling, coercive or threatening behaviour,

violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality'.

In addition, Dorset Police have confirmed that they will consider reports where under 16's are presenting a risk in relation to domestic violence. Risks will be identified on the appropriate form and dealt with by the Safeguarding Referral Unit officers in liaison with Children's Social Care.

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

4.16 The experience of A was more likely to be understood if the current situation with B was assessed in relation to her previous experiences. As identified above, there are many psychological and emotional barriers preventing parents from admitting that they are being abused by their children. In the case of A she described having previously been a victim of domestic violence; this may have also increased her tolerance to abuse within the home and increased the likelihood that she would not consistently bring this to the attention of others. The fact that she did from time to time speak of her fear of B should have been seen as an alert, and understood within this context.

4.17 The literature in relation to the legal framework in place to deal with such situations[14] argues that our existing frameworks do not:

Provide encouragement or compulsion for the release of resources to enable the complex intervention which is required to provide protection and support for the parent and rehabilitation for the child. (page 225)

It notes that the existing criminal law constructs the child as a criminal and the parent as

[14] Hunter, C., & Piper, C. (2012) 'Parent Abuse: Can Law be the Answer? *Social Policy and Society.* Vol 11. Issue 2 pp217-227.

responsible for the behaviour. The child care legislation, on the other hand, is based on the principle of protecting the child from harm and is not equipped to deal with situations where the child may be harming the parent. Protecting both parties and working the complexity of where appropriate promoting the on-going relationship between them is an issue that requires more research and debate at local and national levels.

4.18 In view of the limitations of the current legal framework, it is important for organisations to work together and consider how to most effectively develop clear pathways for response using domestic violence processes.

Responding to 'problematic' adolescent behaviour

4.19 The impact of beliefs and values regarding adolescent behaviour on professional responses has been highlighted by recent reviews into sexual exploitation[15] as well as research into adolescent neglect[16] and other reviews of practice.[17] Dealing with the presenting behaviour and regarding it as 'normal' for young people in this age group may become a feature of practice, particularly when professionals are dealing with large numbers of challenging or vulnerable young people on a day to day basis.

4.20 In this case it is notable that when B presented requesting condoms at the age of 13, his request was dealt with within Fraser guidelines[18]; but there was little consideration of the context which might be driving this behaviour, nor the potential risks to others involved. There was also a high tolerance of his alcohol misuse at a very young age by all concerned and little curiosity shown by the school nurse regarding B's social circumstances or reasons for his behaviour.

4.21 The Police individual management review notes that B's behaviour would not have been seen by police officers as outside the normal range of adolescent behaviour and the YOT

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

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

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

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

report is clear that he would not stood out within their service. In addition when he went before the youth court they did not feel that a social report was required prior to making a decision in his case. This review however has shown that B's behaviour was most likely indicative of underlying problems and the issue must therefore be how to assist professionals in distinguishing between this and adolescent behaviour that is within an expected range and that which is indicative of deeper underlying problems. Making this distinction will require very robust multi agency information sharing and assessment across schools, YOT, Children's Social Care and the Police, which was not always apparent in this case.

4.22 There are also clear indications that a fuller assessment of parenting capacity would have assisted decision making, particularly in relation to engagement with services and capacity to change. There were aspects of parenting behaviour that could be described as neglectful, the most apparent being when A failed to report B missing when he was found sleeping in a shed. This is particularly concerning as it now seems possible that he was, at age thirteen, sleeping there regularly and has told this review that he believes that his mother did not care about him. The response to this episode appears to have focused on B's problematic behaviour rather than naming the behaviour of his mother as neglectful and working with the case from a child protection perspective. This could have included further exploration with A about her feelings towards B and their relationship, and might have provided further opportunities for understanding the meaning of his behaviour. The picture presented to this review is of a mother who was struggling to cope, was feeling increasingly powerless and distanced herself from care of her son as a coping mechanism.

4.23 Such a professional response to potential neglect of adolescents is not uncommon and research into serious case reviews in respect of children has identified that young people may be labelled as 'hard to help' and professionals fail to explore the underlying *causes* of their behaviour.[19] It should, however, be acknowledged that in some instances defining adolescent neglect may be challenging and there are gaps in our knowledge base regarding whether there are causal links between neglectful parenting and young people's

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

behaviour[20]. Nevertheless, in this case there appears to have been a high tolerance of a parental behaviour which included not alerting police or social care to the fact that her thirteen year old was sleeping rough. The reasons for this may have been extremely complex, including relief on the part of A when B was out of the house, and helplessness at what to do next. It is notable, however, that B has said that he did not feel that his mother cared about him during the period when he was drinking heavily and that 'even if she had slapped him like she used to when he was younger at least he would have known she cared'[21].

4.24 Parent abuse has been found to be part of a broader pattern of violent behaviour, with one study identifying that in 63% of cases where a young person abused a parent they were also violent to others outside the family.[22] The tolerance of what was seen to be low level violence by B could have been understood as part of a pattern which included an increased risk of violence within the home.

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

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

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

[21] Information from YOT Asset Core Profile completed after trial.

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

she was known to be in contact with a known sex offender. Instead records suggest that the focus on management oversight was on closing cases.

The provision of alternative education following school exclusion

4.27 B was excluded from school on five occasions between 2007 and 2010; three were due to a physical assault on a pupil, one was drug and alcohol related and another due to persistent disruptive behaviour. Whilst there are clear lessons regarding the effectiveness of assessment planning within the school environment, one of the key questions raised by this review is how B managed to be absent from education for the best part of two years.

4.28 The problem stems from the point at which he transferred to the Education Centre and dual registration was agreed. At this point no one organisation saw themselves as responsible for his attendance and his lack of attendance was not monitored and addressed. In his report into The Edlington Case[23], Lord Carlile recommends that when a child is excluded, the excluding school should retain the responsibility for the education of the child and that there should be an underlying assumption that special provision should be provided on the same campus of the school itself. In this case if the school had retained responsibility for B it is less likely that he would have been at home for the extensive period prior to the homicide. The cultural shift in Dorset resulting in schools taking responsibility for attendance is noted by the panel, but more work should be done to ensure that lines of responsibility are absolutely clear so that young people do not fall between the net. This is a national as well as a local issue.

5. CONCLUSIONS

5.1 This is an extremely tragic case for all concerned and it is important that all possible steps are taken to learn lessons and improve practice in the future. The overarching conclusion must be that it would have been impossible to predict accurately that A was at risk of being

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

murdered by her son, and that practitioners generally acted in good faith within their current knowledge base and work environment. However, there were lost opportunities to act differently and lessons that can be learnt which should improve the response to similar situations in the future.

5.2 Had the following actions been undertaken, they would have provided specific opportunities to intervene differently:

1. The GP practice linking A's and B's records and assessing A's presentation with physical symptoms within her family context.
2. Referral to domestic violence services once A spoke of being scared of B and his anger towards her.
3. Recognition of the potential impact on B of early childhood experiences of domestic violence, and deeper consideration of the causes of his behaviour.
4. A more coordinated approach to assessment and intervention across YOT and Children's Social Care.
5. Recognition of adolescent neglect.
6. B being referred for psychological testing by the school in order to establish the precise degree of his learning difficulty.
7. Involvement of mental health services with B: i.e. referral by YOT, Children's Social Care or school.
8. The education system ensuring that one school had responsibility for monitoring B's attendance when he was referred to the special unit.

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

5.4 Would a better understanding of parent abuse and services for A as a victim have made a difference in this case or, was the act of violence so extreme and rare that nothing anyone

could have done would have prevented her death? The evidence from the case, combined with current knowledge suggests that, whilst more effective responses to A as a potential victim of violence from her son may have helped her to articulate what was happening and take steps to keep herself safe, this alone would not have been enough. In addition, work with B needed to move beyond a focus on anger management to a fundamental understanding of the causes of his behaviour and his likely mental health problems. Practitioners need skills in differentiating so called 'normal' adolescent behaviour from that which is indicative of deeper problems, and greater access to mental health services to assist them in their work. Fundamental to this approach must be an education system which always fully assesses young people's leaning needs, including where there may be a learning disability and crucially, takes full responsibility for identifying those young people who are not attending any education provision.

5.5 The review has identified that recognising and responding to situations where a parent may be being abused by a child is not easy. Our knowledge base in relation to this form of abuse is in its infancy and raises many complex issues which affect responses. Our child care system is understandably focused on the wellbeing of the child and naming what is happening may be hard for parents due to fear that they will themselves be blamed for poor parenting. This, combined with the complexities of identifying the factors that may be associated with parents at risk of severe harm including death, means that if organisations are to be able to respond effectively in situations such as this a fundamental review is needed of policy and practice at both a national and local level. This should include:

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

6. RECOMMENDATIONS

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

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

account of the needs of the parent and the child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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