Domestic Homicide Review
Overview Report
DHR 02

Report into the death of a man

in August 2015

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Independent Chair and Author

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CONTENTS

List of Abbreviations

AAFDA	Advocacy After Fatal Domestic Abuse
BAWSO	Black Association of Women Step Out
CAMHS	Child and Adolescent Mental Health Services
C&VUHB	Cardiff and Vale University Health Board
CCC	Cardiff Council
CPB	Cardiff Partnership Board
CPS	Crown Prosecutions Service
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
EDT	Emergency Duty Team (Social Services)
GP	General Practitioner
IMR	Individual Management Report
LSCB	Local Safeguarding Children Board
MDT	Multi-Disciplinary Team
SAO	School Attendance Officer
SARC	Sexual Assault Referral Centre
SpR	Specialist Registrar Community Paediatrician
WAST	Welsh Ambulance Services NHS Trust
YMLW	Youth Mentoring Lead Worker

Introduction and Background

The Domestic Homicide Review Panel express their deepest condolences

to the family members that have suffered due to this tragic incident

1.1 Introduction

1.1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 67 year old White British man, (the Victim) in August 2015 at hospital. His 16 year old White British grandson (the Perpetrator) was arrested and initially charged with wounding his grandfather with intent. Following his death the Perpetrator was further charged with his murder. The Perpetrator appeared before the Crown, and was convicted of manslaughter on the grounds of diminished responsibility. He was sentenced to 3 years imprisonment. He was subsequently released on licence.

1.1.2 Throughout this report the deceased will be referred to as the Victim and the individual responsible for the death as the Perpetrator, in accordance with Home Office DHR training. All members of the family are white British citizens.

1.2 Purpose of a Domestic Homicide Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011 and reviewed in December 2016[2]. Under this section, 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 house hold as himself, held with a view to identifying the lessons to be learnt from the death"

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[3], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

"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

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2011 Home Office revised again by 2016 guidance

partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

  - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

  - Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

  - Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

- Contribute to a better understanding of the nature of domestic violence and abuse; and

- Highlight good practice

1.3 Process of the Review

1.3.1 South Wales Police notified Cardiff Partnership Board (CPB) of the homicide on 24th September 2015, CPB reviewed the circumstances of this case against the criteria set out in Government Guidance and decided that a Domestic Homicide Review should be undertaken.

1.3.2 The Home Office was notified of the intention to conduct a DHR in October 2015. An independent company, Winston Ltd was commissioned and appointed a chair for the DHR Panel and an author for the Overview Report. At the first Review Panel terms of reference were drafted. On 26th April 2017, the CPB approved the final version of the Overview Report and its recommendations.

1.4 Timescales

1.4.1 Home Office Guidance[4] recommends that DHRs should be completed within 6 months of the date of the decision to proceed with the Review. However there have been a number of contributing factors that has meant this deadline has not been met in this case. Contributing factors include the necessity to:

[4] Home Office Guidance 2016 pages 16 and 35

- Establish a new multi-agency process for conducting Domestic Homicide Reviews, that is distinct from Serious Case Reviews and which required approval from Cardiff's Public Services Board member organisations.
- Develop a commissioning framework to recruit Independent Chairs/Authors to facilitate Domestic Homicide Reviews

1.4.2 In addition there has also been a delay between the completion of the Overview Report, Action Plans, and submission to the Home Office Quality Assurance Panel. This has been hampered by periods of long-term sickness of key members of staff contributing to the Action Plans and the Local Authority Officer who co-ordinated the Domestic Homicide Review on behalf of Cardiff Council. However, Cardiff Council have provided regular updates on progress to the Home Office.

1.5 Time Period

1.5.1 The DHR focussed on events from January 2010 to the date of the death of the Victim in August 2015 unless it became apparent to the independent chair that the timescale in relation to some aspect of the Review should be extended.

1.5.2 The Review should also consider relevant information relating to agency contact with the Victim and Perpetrator outside that timeframe if it impacts on the assessments in relation to this case.

1.6 Confidentiality

1.6.1 It was agreed by the Review Panel that all information obtained during the course of this review remains confidential.

1.7 Terms of Reference for the Review

1.7.1 The Terms of Reference for this DHR relate to the period from January 2010 to August 2015.

1.7.2 The scope of the Review relates to the victim, a 67 year old man, his grandson aged 16 years, the Perpetrator, and the female sibling of the Perpetrator, aged 18 years.

1.7.3 The Terms of Reference for this DHR are divided into two categories i.e.

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

1.7.4 The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?

4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?

5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

7. What were the key points or opportunities for assessment and decision making in this case?

8. Do assessments and decisions appear to have been reached in an informed and professional way?

9. Did actions or risk management plans fit with the assessment and the decisions made?

10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

11. When, and in what way, were the victim's wishes and feelings ascertained and considered?

12. Is it reasonable to assume that the wishes of the victim should have been known?

13. Was the victim informed of options/choices to make informed decisions?

14. Were they signposted to other agencies?

15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?

16. Had the victim disclosed to anyone and if so, was the response appropriate?

17. Was this information recorded and shared, where appropriate?

18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?

19. Was consideration for vulnerability and disability necessary?

20. Were Senior Managers or agencies and professionals involved at the appropriate points?

21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

22. Are there ways of working effectively that could be passed on to other organisations or individuals?

23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

24. How accessible were the services for the victim and the perpetrator?

25. To what degree could the homicide have been accurately predicted and prevented?

1.7.5 In addition to the above, some agencies will asked to respond specifically to individual questions once they are identified following the submission of IMR's.

1.8 Equality and Diversity

1.8.1 Home Office Guidance[5] requires consideration of individual needs and specifically:

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?"

1.8.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this Review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.8.3 The Review gave due consideration to all of the Protected Characteristics under the Act.

1.8.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

1.8.5 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act. However accessing services was sometimes difficult due to the travelling arrangements needed to keep the children's appointments and also the expense involved with bus fares. This sometimes proved to be a barrier for the mother to keep the children's appointment with health agencies in particular.

1.9 Family Involvement

1.9.1 Home Office Guidance[6] requires that:

> "Consideration should also be given at an early stage to working with Family Liaison Officers and Senior Investigating Officers involved in any related Police

[5] Home Office Guidance 2016 page 36
[6] Home Office Guidance 2016 page 18

investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

1.9.2 The 2016 Guidance[7] illustrates the benefits of involving family members, friends and other support networks as:

a) assisting the victim's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;

b) giving family members the opportunity to meet the Review Panel if they wish and be given the opportunity to influence the scope, content and impact of the Review. Their contributions, whenever given in the Review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on the victims and perpetrator's perspectives rather than just agency views.

c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.

d) enabling families to inform the Review constructively, by allowing the Review Panel to get a more complete view of the lives of the victim and/or perpetrator in order to see the homicide through the eyes of the victim and/or perpetrator. This approach can help the Panel understand the decisions and choices the victim and/or perpetrator made.

e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the Review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The Review Panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the Review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

1.9.3 In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from South Wales Police at an early stage. Contact with the family was initially made by a letter, sent via the Police Family Liaison Officer to the Mother, explaining the Review process and inviting her and her family to contribute to the Review should they wish to do so. The Mother, Aunt and S2 were seen at their family home in January 2016. The Perpetrator was seen on 6th April 2016 and on 16th

[7] Home Office Guidance 2016 pages 17 - 18

December 2016 at the secure unit where he was then residing. The family have been supported by a representative from the support charity AAFDA.[8]

1.10 Methodology

1.10.1 The process for this review began with an initial scoping exercise prior to the first Panel meeting. The scoping exercise was completed by the CPB to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies were requested to inform the Review by a report. In the course of obtaining information from agencies IMR authors interviewed a number of practitioners and managers of their agencies.

1.10.2 The panel met on the following dates: 8th January 2016, 23rd February 2016, 15th March 2016, 23rd September 2016 and 4th November 2016.

1.11 Individual Management Reports

1.11.1 An Individual Management Report (IMR) and comprehensive chronology was received from each of the following organisations:

Children's Services
Housing
Education
Health
Child and Adolescent Mental Health Services (CAMHS)

1.11.2 As agreed reports for information were received from:

South Wales Police
Welsh Ambulance Service Trust
Barnardo's

1.11.3 Guidance[9] was provided to IMR Authors through local and statutory guidance and through an author's briefing. All IMR authors confirmed their independence as none had direct contact with the family prior to the review being commissioned. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

1.11.4 Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the Reports. The recommendations are supported by the Overview Author and the Panel.

1.11.5 The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

[8] AAFDA – Advocacy After Fatal Domestic Abuse – a National Charity supporting relatives of domestic homicides.
[9] Home Office Guidance 2016 Page 20

1.12 DHR Panel

1.12.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the Review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. The Panel met on 9 occasions. Other members of the Panel and their professional responsibilities were:

Natalie Southgate	Policy and Development Manager, Cardiff Council
Chris Fox	Social Inclusion Manager (Housing), Cardiff Council
Nicola Jones	Domestic Abuse Coordinator, Cardiff Council (Independent)
Natasha James	Interim Operations Manager, Children's Safeguarding Services Cardiff Council
Neil Hardee	Head of Performance, Resources & Services, Education and Lifelong Learning, Cardiff Council
Sue Hurley	Independent Protecting Vulnerable Persons Manager, South Wales Police
Nikki Harvey	Head of Safeguarding, Welsh Ambulance Services NHS Trust
Judy Brown	Safeguarding Nurse Advisor – Safeguarding Children Team, Cardiff and Vale University Health Board
Karen Maxwell	Service Standards Manager, Safer Wales (Independent)
Angelina Rodrigues	Deputy Chief Executive, BAWSO (Independent)
Helen Weston	Minute Taker, South Wales Police
Martyn Jones	Independent Report Author
Malcolm Ross	Independent Report Author

The Panel members confirm they had no direct involvement in the case, nor had line management responsibility for any of those involved.

1.12.2 The Panel was supported by an Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this Review having been undertaken.

1.13 Independent Chair and Author

1.13.1 Home Office Guidance[10] requires that;
"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

1.13.2 CPB decided that in this case to appoint an independent chair and an independent author as commissioned by Winston Ltd.

1.13.3 The Independent Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has over 30 years' experience in writing over 80 Serious Case Reviews, over 50 DHRs and chairing those processes before and since retiring from the police. After retiring from the Police service 21 years ago, he has been performing both functions

[10] Home Office Guidance 2016 page 12

in relation to Domestic Homicide Reviews. Prior to this Review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the Panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.14 Parallel Proceedings

1.14.1 The Panel were aware that the following parallel proceedings were being undertaken:

- Advised HM Coroner on 11th January 2016, that a DHR was being undertaken.
- Criminal proceedings had been commenced and this Review was aware of any issues of disclosure that may arise.

1.15 Dissemination

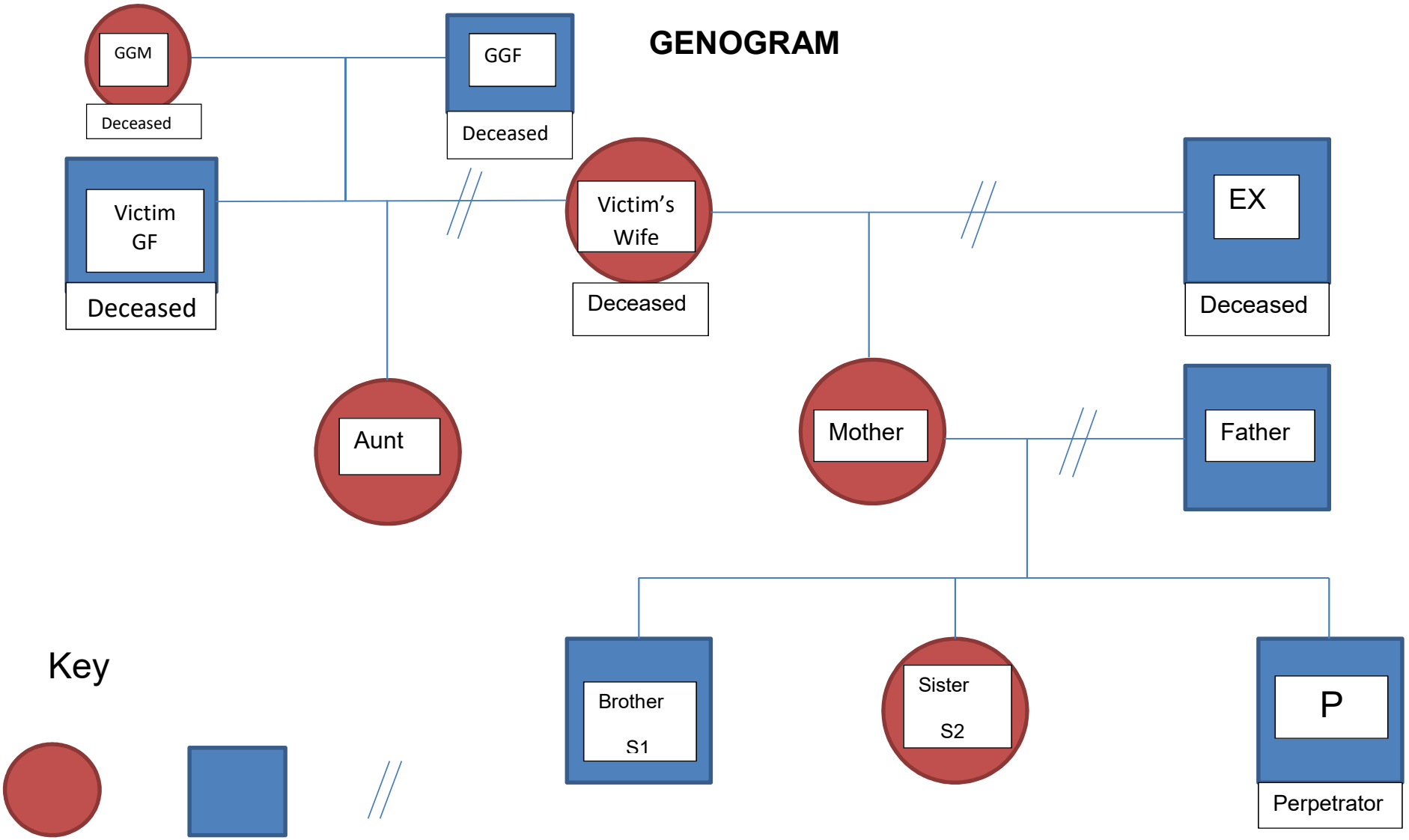
1.15.1 This report will be shared with partners of the Cardiff Public Services Board, the South Wales Police and Crime Commissioner, the Regional Safeguarding Board, Welsh Government, the family and AAFDA.

1.16 Family members concerned in this Review

1.16.1 The following genogram identifies the family members in this case, as represented by the following key:

	Relationship
Victim	67 year old deceased victim
Mother	Mother of Perpetrator –daughter of Victim
Aunt	Sister of Mother and daughter of Victim
Perpetrator	Grandson of Victim
Sister S2	Sister of Perpetrator
Brother S1	Brother of Perpetrator

GENOGRAM


GGM
Deceased
GGF
Deceased
Victim
GF
Deceased
Victim's
Wife
Deceased
EX
Deceased
Aunt
Mother
Father
Brother
S1
Sister
S2
P
Perpetrator
Key
Female
Male
Dissolved relationship
GGM – Great Grandmother
GGF - Great Grandfather

2. Summary

2.1 The Victim in this DHR is the 67 year old grandfather of the male perpetrator aged 16 years. The Perpetrator is the youngest of three siblings, a sister (S2) 2 years older and a brother (S1) 6 years older. The Perpetrator's mother is the daughter of the Victim. The Victim died on 8th August 2015 as a result of injuries sustained on 3rd August 2015. Very little is known about the Victim. He lived alone for many years after his wife died. All family members are white British citizens.

2.2 In 2010, the Perpetrator's sister, then aged 13 years, made allegations that the Victim had sexually abused her. Social Services were involved and dealt with the alleged allegation as a single agency enquiry. An agreement was made that the Victim would not have contact with the grandchildren. At this point the Perpetrator did not know of the alleged allegation of abuse but he found out by accident during a conversation his mother was having with his sister. From the time of the disclosure of alleged abuse by the Victim, the family disassociated themselves from the Victim's life.

2.3 In August 2014, the sister made an attempt to take her own life. It appears that the Victim's mother, (who was also the great grandmother of the Perpetrator) died shortly before the incident on 3rd August 2015, and the Perpetrator visited the Victim at 7.00pm on 3rd August 2015, to tell his grandfather that he should not attend the funeral.

2.4 An altercation ensued and an ambulance was called to the Victim's address at 7.13pm. The Victim was found with serious stab wounds to the base of his skull and the base of his neck. His wounds later proved fatal. The Perpetrator was arrested and detained. He was initially charged with wounding with intent. Following the death of the Victim the Perpetrator was subsequently charged with his murder. At Cardiff Crown Court in November 2015, following a trial the Perpetrator was convicted of manslaughter. He was given a three year custodial sentence. He was released on licence in March 2017.

3 Overview

3.1 Although the scope of this Review is between 10th January 2010 to the date of the death of the Victim in August 2015, there is a built in proviso:

> 'unless it becomes apparent to the independent chair that the timescale in relation to some aspect of the review should be extended' and that the review should also consider relevant information relating agencies contact with the Victim and alleged Perpetrator outside that time frame as it impacts on the assessments in relation to this case.'

3.2 The Cardiff and Vale University Health Board IMR also indicates that even as young as 3 years 8 months old in January 2003, the Perpetrator displayed tantrums, had no sense of danger, was impulsive and demonstrated disruptive and aggressive behaviour towards his family and other people. It was noted that his older sister S2 displayed similar traits.

3.3 At this time the Perpetrator was under the care of a Community Paediatrician and a Clinical Psychologist.

3.4 However records show that due to the children missing their Psychologist's appointments their case was closed repeatedly in 2000, 2003 and 2004, in accordance with policies of that time. During that time it was deemed appropriate to close cases if there was a failure of patients to attend appointments, even in the case of child patients. Since then the Health Board have introduced a more robust approach to enquire why child patients have not been taken to appointments.

3.5 In October 2004, a referral was made by the Health Visitor to the Community Paediatrician seeking advice, on behalf of the Mother, regarding behavioural problems of the Perpetrator. As he was over 5 years of age he was out of the remit of the Health Visiting Service but the Mother sought help from the Health Visitor as she was a professional that the Mother knew and who understood the family.

3.6 In January 2005, the Mother sought assistance via the Health Visitor to arrange another appointment with the Consultant Paediatrician due to the children's ever increasing problematic behaviour. They attended with their Mother and it was noted that both children were openly defiant in the clinic and required a significant degree of encouragement from the Heath Visitor. This demonstrated that the Health Visitor had a good relationship with the Mother and went out of her way to arrange appointments for the children. However, on occasions the mother was unable to take her children to appointments as often the appointments involved long bus journeys across the city which the mother found difficult with children and also found such journeys very expensive.

3.7 It was suggested that both children be referred to CAMHS but the Cardiff and Vale University Health Board IMR indicates that both children had been subject to CAMHS services before with little sustained change, and the Mother had indicated on previous occasions that she had little faith in some of the CAMHS strategies. She had also demonstrated that she had had limited success in managing her children's behaviour. There was no mention of the older sibling S1 in this consideration.

3.8 On 18th January 2010, the Mother of S2 contacted Children's Social Services Emergency Duty Team disclosing an allegation of sexual abuse by the Grandfather, (the Victim then aged 61 years), on his granddaughter, who was at that time 13 years of age. A referral was made and sent to Children's Services Intake and Assessment Team for allocation.

3.9 The Children's Services Key Directions Management Document the same day raised the following points to be considered with the referral:

'a' The fact that reports had allegedly been made to ChildLine and NSPCC, but neither organisation had made a referral to Children's Services

'b' Why Mother took so long to report the incident

'c' To explore the details of the alleged incident with [S2]

'd' Has Mother stopped the children's contact with the grandfather?

'e' Does [S2] want to make a complaint to the Police?

3.10 The following day a Social Worker was to undertake an assessment and arrangements were made for a home visit on 20th January 2010. That visit however was cancelled by the Social Worker due to another case taking priority. There was no referral made to SARC (Sexual Assault Referral Centre).

3.11 On 22nd January 2010, a letter was sent to the Mother for another appointment for a home visit on 26th January 2010, 8 days after the initial report.

3.12 On 26th January 2010, the Social Worker saw S2, at her home address with the Mother. The Mother stated that S2 was unsure if she wanted to make a formal complaint to the Police about the incident. S2 stated that this was the second time this had happened

with her grandfather, the first time being in a caravan in Aberystwyth but she was unsure when that had occurred.

3.13 As a consequence of S2 being unsure if she wished to make a formal complaint to the Police, the Social Worker arranged to contact her the following week. She told S2 that if she did not want to pursue a complaint through the Police, the case would be closed. However, information about the SARC was not provided to her. There appears to be no consideration of any safeguarding of other children that the Victim may have had access to at that time.

3.14 The Mother gave the Social Worker consent to make contact with other family members and a written agreement was put in place to the effect that any contact between the Victim and S2 would be fully supervised. The agreement was signed by the Mother, although there is nothing to indicate who was to supervise any contact that may take place.

3.15 The Mother stated that S2 had previously had a brain scan which had revealed abnormalities. S2 was said to be partially sighted and according to the Mother, she was possibly experiencing Asperger's Syndrome, although she had not been formally diagnosed.

3.16 On 3rd February 2010, the Social Worker contacted the Mother about reporting the matter to the Police but S2 was still undecided. The following day the Social Worker sent a letter to the Mother stating that she would make contact again about the possibility of reporting this to the Police during the following week.

3.17 Around this same time, the Mother discovered that the man who she considered to be her father, was not in fact her biological father. She found out that her biological father was a friend of the Victim. The Perpetrator wanted to find out who his Mother's real father was.

3.18 Children's Services case notes indicate that the Social Worker went off sick from work and a Service Manager wrote to the Mother asking her what decision S2 had arrived at. There is nothing to indicate a reply to that letter. This case was dealt with as a single agency response and a S.47 investigation was not initiated; there was no strategy discussion with any other agencies involved with the family. No further support was provided to S2 or the family.

3.19 On 6th September 2010, there is a school admission record for the Perpetrator at a Faith School in Cardiff. S2 was also a pupil at the same school.

3.20 The Perpetrator's school reports during 2011 showed a continuing trend of dysfunctional behaviour and significant disruption and aggressiveness towards the teachers. In June 2011, he told a Community Psychologist that:

> 'he likes being disruptive, cheeky and likes annoying people'.

3.21 He was referred to CAMHS again which was to be reviewed within 6 months.

3.22 It is reported that his Head of Year commented:

> '[the Perpetrator] is very popular in school and likes school but gets bored with lessons'.

3.23 On 29th June 2011, a SpR Community Paediatrician requested a referral to CAMHS regarding the Perpetrator's behaviour. However on 5th August 2011, a Primary Health Care Worker writing on behalf of a Consultant Child and Adolescent Psychiatrist stated

that the SpR Community Paediatrician's referral did not indicate a CAMHS psychiatric assessment was required.

3.24 On 8th May 2012, the Mother made a written application to Cardiff Council for a change of housing on the basis that living close to the Victim was causing stress within the family because of the alleged incident in 2010. A decision was made that she was not homeless. No referral was made by Housing. The Mother found her own accommodation elsewhere in the city.

3.25 Between May 2012 and October 2014, the Mother made several housing applications which indicated that the Perpetrator was living with her and the rest of the family. The basis for her applications to move to alternative housing was based on the historic alleged allegation that the Victim had abused S2 and he was no longer allowed to have contact with her. The Mother believed that living in the same area would cause stress and anxiety as well as pose a threat to her children. The Mother was admitted onto the housing list, but again no safeguarding considerations were made and no referral to Children's Social Care even though the details of the alleged sexual abuse had been explained by the Mother.

3.26 On 8th August 2012, the Mother telephoned the GP surgery concerned about S2's lack of energy. She was sleeping a great deal and appeared isolated and withdrawn.

3.27 S2 declined to attend the surgery and the Mother informed the GP over the phone about the alleged allegation of sexual abuse. S2 was offered support and routine clinical investigation for physical symptoms. There was no further relevant contact with the GP regarding this matter and the GP did not make any referral.

3.28 On 16th June 2014, S2 attended the GP's surgery with her Mother for bereavement counselling and other unrelated matters. She was signposted for a review and three weeks later she was referred to CAMHS by her GP with a provisional diagnosis of Post-Traumatic Stress Disorder after presenting with low mood, poor sleep and unspecified flashbacks.

3.29 On 23rd August 2014, S2 attended at Accident and Emergency Department at the local hospital following an overdose of mixed medication and 12 units of alcohol. She was with her boyfriend and she had disclosed to him the alleged sexual abuse by her grandfather to him.

3.30 S2 was not seen by CAMHS whilst in the Emergency Department but was seen at an existing appointment on 2nd September 2014. There is nothing to suggest that she was referred to the SARC or that a referral was made to Children's Social Services. She was 17 years of age at this time. Following her discharge the GP put in place a 'safety net' plan giving S2 access to the surgery in the period leading up her appointment with CAMHS on 20th September 2014. The GP did not make a referral to other agencies.

3.31 On 7th October 2014, CAMHS sent a referral regarding S2 to the Transition Service of Barnardo's. The CAMHS Psychologist had made arrangements for joint agency meetings with S2 and requested a Barnardo's worker to be present by way of introduction to S2 on at least one of those meetings.

3.32 The request was to provide S2 with support, confidence, education, training and employment, life skills and problem solving. S2 was described as displaying low moods, depression and possible post-traumatic stress reaction, possibly due to the alleged allegation of sexual abuse she had been subjected to by her grandfather when she was 13 years of age.

3.33 On 29th October 2014, the Barnardo's worker tried to confirm the details of the meeting but was told that the CAMHS psychologist was on sick leave and the meeting had to be cancelled. This happened on two more occasions into January 2015. S2 did not attend the following meeting and consequently S2 was not seen by Barnardo's at all.

3.34 As S2 approached her 18th birthday she and her mother were invited to a Multi-Disciplinary Team (MDT) meeting but they did not attend as the Mother had forgotten about it. The Mother did contact the Community Mental Health Team later and stated that S2 did not require any further support from Mental Health Services and consequently S2 was discharged to the care of her GP on 2nd March 2015. S2 was at this time an adult and her own views should have been canvassed rather than relying on her mother's views.

3.35 By April 2015 there had been no contact by CAMHS with S2 or her family and in August 2015 the case was closed due to non-engagement with S2.

3.36 Comments in the Education IMR concerning S2, indicate that there were issues with her behaviour in school years 7 and 8. In school years 9 and 10 comments are recorded as showing concerns about her attitude towards school work and towards the staff. There is no detailed information about how these issues were addressed and almost to the contrary view, the IMR analysis of the school's dealing with S2 quotes from school reports that S2 has grown into a mature young lady and has 'performed exceptionally well this year with outstanding achievements across many of her subjects'.

3.37 In relation to the Perpetrator, the school IMR indicates that during school years 7 and 8 there were concerns about his disruptive behaviour and failure to submit homework. This resulted in lunchtime detentions. In years 9, 10 and 11, school comments recorded indicate that the Perpetrator showed little effort towards school work and he had an attitude towards staff members. During November 2013, records indicate that the Perpetrator was off school all week and a home visit resulted in no answer at the family home. In January 2014, the Head of Year states that he contacted the Perpetrator's mother to discuss his non-attendance, but there is no record of that contact. During the remainder of that school year the Perpetrator was subject to sanctions that included individual behaviour plans, referrals to the deputy Head Teacher and contact made with his mother. The IMR states that:

> 'There is evidence to suggest that the school had a positive relationship with Mum and regular communication was maintained in an attempt to address these issues'.

3.38 Finally the IMR author comments:

> 'It is apparent that further enquiries into [the Perpetrator's] final year at school need to be made to explore further his non engagement and what was done to address this'.

3.39 The Perpetrator disengaged with school at the beginning of school year 11 and attempts to address this disengagement ceased on 25th November 2014. More information about the relationship between the school and the Perpetrator is contained in the section of this report 'The disputed meeting between the Perpetrator and Head of Year' (see 5.14).

3.40 Around July 2015, the mother of the Victim died aged 90. The Mother was close to her grandmother and wanted to go the funeral. The Victim also expressed a wish to go to

his own mother's funeral, albeit he had not spoken to her or had anything to do with her for some 11 years.

3.41 On 3rd August 2015, the Perpetrator wanted to speak to his grandfather about attending the funeral. The Perpetrator was on his way out for the evening when he unexpectedly went to the Victim's house. It appears that he went into the kitchen on the pretext of getting a drink of water. He returned to the living room and there was an argument between the Perpetrator and the Victim during which the Perpetrator stabbed the Victim in the neck after the Perpetrator made a remark about his sister S2.

3.42 The Victim, while wounded by the attack, managed to call for assistance. He however refused to make a formal complaint about his grandson to the Police. He did however explain what had happened.

3.43 The Victim was admitted to hospital. Over the next few days his condition deteriorated and he died of his injuries.

3.44 The Perpetrator was arrested and charged with his grandfather's murder. In November 2015, he was convicted of manslaughter and sentenced to 3 years imprisonment.

4. Analysis and Recommendations

4.1 It is appreciated that all Domestic Homicide Reviews should be victim-focussed. In this case however, there is little known about the Victim. He was a widower and lived alone. Following the alleged allegation of sexual abuse on S2 the family disowned him and no contact was made for several years. He himself, according to S2's mother, had no contact with his own mother for 11 years. How he spent his days is unknown. There is nothing of any significance contained within the Victim's health records and no suggestion that he disclosed the alleged allegation of abuse to his GP.

4.2 The Report Author and fellow Winston Consultant, Mr Martyn Jones, visited the family at their home and their views are reflected throughout this report. Likewise the Perpetrator has been visited and his views are also considered herein.

4.3 Following the disclosure to her mother of allegedly being sexually abused by the Victim, S2 was seen by Children's Social Care. According to the Mother this contact resulted in a brief visit from a Social Worker that concentrated on agreeing a disclosure document preventing S2 having contact with the Victim. The Mother told the Report Authors that she thought the visit was pointless.

4.4 The Children's Services IMR states that this report should have been dealt with as a Section 47[11] investigation and a strategy meeting[12] held with the Police to agree the way forward, be it a single or joint agency investigation.

4.5 Instead an Initial Assessment[13] was completed on the Direction of the Service Manager. Any assessment conducted under the Framework for Assessment[14] stresses the need to have a full picture of the child's circumstances and take a child centred approach, and should include the child's development and also include any other children and family.

[11] Section 47 of the Children Act 1998 which calls for an interagency investigation into the allegation of abuse or neglect.
[12] Strategy Meeting – an interagency meeting to decide whether further investigation should take place and whether any short-term emergency action is required.
[13] Initial Assessment – The Framework for the Assessment of Children in Need and their Families - 2000
[14] The Framework for Assessment of Children in Need and their Families Dept. of Health 2000

4.6 The Children's Services IMR points out that this assessment did not record any sightings of S2's brothers, who were living at the same address at the time. Nothing is mentioned about the father in the family and he was not contacted and had no input into the assessment. As there was no Section 47 investigation, the Victim was not spoken to by a Social Worker nor was the Police informed of the alleged allegations.

4.7 The Children's Services IMR points out that there was not a consideration of any further assessment either under the Framework for Assessment or in terms of child protection enquiries under S.47 of The Children Act 1989 and the All Wales Child Protection Procedures. No referrals were made to any support services for S2 or family members. There is no reference to health checks being made during the assessment to confirm the extent or presence of the medical issues being described by the Mother for S2.

4.8 Given there was a disclosure of alleged familial sexual abuse, this case should have proceeded via a Child Protection route with initial strategy discussion with Police and relevant agencies. This would have provided a co-ordinated response and shared decision making; by not proceeding with S.47 enquiries there was not sufficient sharing of information with agencies involved with the family.

4.9 During that Initial Assessment process S2 was only seen once by a Social Worker. All other conversations involved the Mother only and no other members of the family were spoken to, thus a holistic picture of the family dynamics was not obtained.

4.10 The Children Act 1989 provides the statutory responsibility for local authorities to carry out enquiries under S.47 where there is cause to suspect reasonable harm of a child who resides within their area. The All Wales Child Protection Procedures provides national guidance around the management and practice of S.47 enquiries.

Recommendation 1

It is recommended that Cardiff Council ensure that all front line practitioners receive training, supervision and support to be able to effectively identify, report and respond appropriately where significant harm or abuse is alleged, including any allegation or suspicion of sexual abuse. Also, that all front line practitioners apply the appropriate thresholds to the management and allocation of cases where there is risk of significant harm as defined by The Children Act 1989 and the All Wales Child Protection Procedures.

4.11 There is nothing recorded in the Education IMR to indicate that the Perpetrator reported his feelings towards the Victim to any member of the teaching staff.

4.12 This was also at about the same time that S2 was absenting from school. It is the Perpetrator's recollection that on one occasion he was stopped as he was leaving school by his Head of Year, a male teacher. He challenged the Perpetrator about leaving school, and the Perpetrator stated to the Report Authors, that he told the Head of Year all about the alleged allegation of abuse with his sister and the Victim. He says he was crying at that time and very upset having to reiterate the story to the Head of Year. He said he found that very painful. This meeting is disputed by the teacher concerned who states that that conversation did not take place.

4.13 In October 2014, the School Attendance Officer referred the Perpetrator's case to the Education Welfare Service. His case had been discussed at the Vulnerability Assessment Panel where it was agreed that he would be allocated a Lead Worker for mentoring support.

The disputed meeting between the Perpetrator and Head of Year

4.14 With regard to the Perpetrator, his report was broken down into school term periods with comments about the Perpetrator in each time period:

Year 7

During this year there were 33 entries made. The nature of these entries were as follows: Lateness, rudeness, disruptive behaviour, aggressive towards a teacher and failing to provide homework.

During this academic year the actions that school made in respect of addressing this behaviour included: Phone calls home to (Mother) and a two day exclusion.

Year 8

During this year there were 61 entries made. The nature of these entries were negative approach to learning, reluctant to work, defiance, rudeness, walking away during class and leaving the school site.

During this academic year the actions that the school made in respect of addressing this behaviour included being referred to the Head of Year, behaviour plan, internal exclusion, contacting home.

On 8th May 2012 [the Perpetrator] wanted to leave class and tried to push the class teacher out of the way to get through.

Year 9
During this year there were 14 entries made regarding lateness to registration, negative approach to learning, aggression.

He was off school all week, a home visit was made by the School Attendance Officer (SAO). There was no answer so a calling card was left. Head of KS4 spoke to (Mum) about [him] not attending school. She was described as being very frustrated and wanted school to be "brutal with how we deal with him, so he knows that he's not calling the shots".

4.15 The Youth Mentoring Lead Worker (YMLW) visited the family home on 23rd October 2014, but was not invited in. It is reported that there was a smell of cannabis coming from inside the house and at the time it was presumed that this was the reason why he was not allowed inside. According to the YMLW, the Perpetrator stated that he did not want to be in school and did not want any help. The YMLW terminated contact with the Perpetrator on 25th November 2014 after it had been made clear that no help was going to be accepted by the Perpetrator. Although the presence of cannabis is denied by the Perpetrator, there is no evidence that the YMLW made any referral of this fact to any other agency.

4.16 The SAO tried various options to get the Perpetrator back into school; reduced timetable, allowing him to leave earlier than the rest of the school; but all failed. It is reported that the Perpetrator would get his mark and return home to be with his older sister. The SAO also reported smelling cannabis at the family home on one of their visits, but again no referral made to any other agency. The SAO reported that the Perpetrator was always polite and never aggressive towards her.

4.17 Head of Key Stage 3 reported that she too tried to get the Perpetrator back into school but failed to do so. It is reported that it was known he was aggressive towards his mother and also to other members of school staff that he did not like. One comment that is common throughout these reports is that the Perpetrator was a very capable

student at school. The Perpetrator denies being aggressive towards his family members.

Recommendation 2

Cardiff Council to conduct a review of the referral and continued support arrangements for pupils who have significantly disengaged from school.

4.18 Head of Year commented that, although he had a good relationship with the Perpetrator, he could be very challenging and it was his view that the Mother was unable to control him at home and relied heavily on the school to do so. The school was told that when he was truanting from school he was staying at home looking after his older sister.

4.19 The Head of Year stated that the Perpetrator made no disclosures to him, but according to the Mother, the teacher was told that 'there was a lot going on at home', although it appears that was never followed up. It is reported in the IMR summary that if the Head of Year caught the Perpetrator leaving school at any time apart from the normal time, the Perpetrator would say that he was going home.

4.20 There is clearly some contradiction between the events as described by the Head of Year and the Perpetrator and a request was made by the Author for the Head of Year to be seen again and asked questions specifically around the incident where the Perpetrator says he broke down in tears and also about any occasion that the Perpetrator made any kind of disclosure.

4.21 A copy of a record of interview between the Education IMR author and the Head of Year held on 24th May 2016, was received.

4.22 Enquiries with CAMHS who had been involved with both the Perpetrator and his sister over a number of years, revealed that the school was not informed by CAMHS of the fact that both children had received their services. It is not normal practice for CAMHS to contact the school unless education attainment is affected.

4.23 On 16th December 2016, the Author and Mr Jones again saw the Perpetrator. He had seen a copy of the report prior to that date and commented about the list of his misdemeanours making him feel like a 'monster'. He was asked again about the truthfulness of his account regarding the meeting with the Head of Year and he was certain he was being truthful and made the comment that he did not like the Head of Year so why should he choose to disclose to him. He did so, he says, because the Head of Year tackled him as he was about to leave the school.

4.24 It appears therefore, that the variation in accounts cannot be settled, but what is clear is there was evidence that there were problems at home with both children and family life was difficult for them as well as for the Mother. If the Perpetrator is truthful regarding the meeting with the Head of Year, there appears to have been little consideration of the safeguarding for both the Perpetrator and his sister. If however the account from the school is correct, this casts doubt on the truthfulness of the accounts from the Perpetrator and his Mother.

4.25 It is the view of the Panel that it is reasonable to recommend a review of adherence to relevant safeguarding procedures, without judging whether or not there was a failing in safeguarding on the part of the school. This should include all school based staff, not just teachers, and staff who work in other services such as the Education Welfare and Youth Services.

Recommendation 3

Cardiff Council ensures that all education staff, including school-based staff, are aware of and compliant with the All Wales Child Protection Procedures 2008.

4.26 The referral to the Barnardo's Transition Service for S2 did not materialise due to the sick leave of the CAMHS Psychologist for a number of months. S2 was referred by CAMHS so that Barnardo's could pick up the support for her as she approached adult age and therefore out of CAMHS parameters. The plan was for Barnardo's 16–25 Service to cater for her needs. However because of the sickness of the CAMHS Psychologist, S2 was not seen. Was it not possible for another CAMHS Psychologist to see S2 at any time over the 10 month period before the case was closed? S2 was described as possibly suffering from Post-Traumatic Stress reaction, which it appears was not addressed due to the sickness of one Psychologist.

4.27 It is interesting that the Barnardo's Report answers two questions of 'Analysis of Involvement' and 'Effective practice/lessons learned' with the same comment;

> 'N/A due to non-engagement with service'.

4.28 It could be argued that the non-engagement with service was the fault of CAMHS and Barnardo's.

Recommendation 4

Child and Adolescence Mental Health Services examine its working practices and resilience to ensure that children receive appropriate support and care even in the event of staff sickness.

4.29 The Cardiff and Vale UHB IMR concentrates very much on the earlier lives of both S2 and the Perpetrator, details of which have been included in the sequence of events section of this report. The report shows that the Perpetrator was referred repeatedly to CAMHS over a period of time with the full knowledge that previous referrals to CAMHS had not been a positive experience for him and that he had failed to attend or had not been taken on numerous occasions. However, the IMR illustrates positive outcomes for the C&VUHB regarding consistent support that was offered to the Perpetrator and his sister.

4.30 In June 2011, there was a variance of views between the SpR Community Paediatrician and the Consultant Child and Adolescent Psychiatrist as to whether a referral made by the Community Paediatrician to CAMHS in respect of S2 was necessary. In January 2015, Cardiff and Vale of Glamorgan LSCB introduced a Protocol for the Resolution of Professional Differences[15], which sets out a formal framework to resolve such debates, but in 2011, there was no such policy. However there does not seem to have been any discussion between the two professionals regarding their differing views.

4.31 There is evidence that some details of the alleged abuse were given to Housing by the Mother in pursuant of her housing applications. That information was not referred to any other agency especially Children's Social Care.

[15] Protocol for the Resolution of Professional Differences. January 2015 Cardiff and Vale of Glamorgan Local Safeguarding Children Board.

Recommendation 5

Cardiff Council (Housing) review policies, practice and training in the duty of staff to make referrals to other agencies when there is information regarding safeguarding issues, whether concerning children or adults, to ensure that all staff are fully conversant with the referral procedures of both child and adult protection legislation.

4.32 In addition to the Overview report recommendations, individual agencies were invited to make recommendations pertinent to their own agencies.

Individual Management Report Recommendations

Children's Social Care – City of Cardiff Council

Recommendation 1
Practice reviews raised within this review, specifically around the undertaking of Sec 47 investigations and robust initial assessments, will be discussed in a learning event with Children's Services frontline staff of all levels. This will cover lessons to be learnt and act as a means of improving future practice.

Recommendation 2
Periodic internal audits by a Quality Assurance Officer of a random selection of Child Protection and Child in Need cases is recommended to ensure correct procedures are being followed and decision making is robust in future.

Health – Cardiff and Vale UHB

Recommendation 1
Cardiff and Vale UHB conduct a review of referral guidelines to Children's Services for A&E Dept at UHW regarding young people up to 18 years of age who present with overdose and or disclosures of sexual abuse and ensure the safeguarding consideration record is completed in every case.

5. Lesson Learned

5.1 The analysis of the circumstances of this tragic death as outlined above, indicate that there were identified shortcomings within agencies and between agencies. As a result of this review improvements have been made with the introduction of the Multi-Agency Safeguarding Hub, supplemented by the Cardiff Family Advice and Support Service, which together ensure that families receive the right help at the right time and, where necessary, cases can be escalated for a partnership safeguarding response that includes Education, Children's Services, Adult Services, Police, Health and third sector specialist partners. These services are also supported by improved safeguarding procedures and training for all staff.

6. Views of the Family

6.1 The Mother, her sister and S2 were seen at a very early stage of this Review process. Their views have been incorporated within this report. The Mother was angry at the inaction of the school when the Perpetrator allegedly disclosed his reason for leaving school and returning home. She was also very angry at the initial Social Worker who came to the house as a result of S2's disclosure of alleged sexual abuse by her grandfather.

6.2 The Mother made comment about the delay in her reporting the alleged allegation of sexual abuse. She stated that she was more concerned about the effect of making a complaint would have on S2, who feared that once she had disclosed, her experiences would have been common knowledge especially at school and she would have been the brunt of further abuse from class mates. The Mother explained that once S2 had told her about the alleged abuse, she cut off all communication and contact with the Victim and made sure than none of the children in the family had anything to do with him.

6.3 Once the Mother had made contact with Children's Social Care, which was at a time when S2 was undecided if she wanted to make a formal complaint for the reason set out above, she had expected a more robust response from the Social Worker, rather than leaving it to S2 to decide. She is of the opinion that S2 should have been reassured about information sharing and details being made public which may have convinced S2 to make that formal complaint. She is also disappointed that the Social Worker did not consider the alleged allegation against the grandfather serious enough to involve the Police.

6.4 According to the Mother, the Perpetrator was frequently walking out of school to go home to bed. He had, it is reported by the family, been awake during most nights outside his sister's bedroom, guarding her and keeping her safe since he had learned of the alleged incident with the grandfather. He was consequently too tired to attend school and would leave the school premises between lessons and go home to sleep.

6.5 The Perpetrator was written to as part of the formality of the Review process and after his conviction he requested to see the Report Authors. His mother was aware of the meeting with the Authors and although the Perpetrator was offered the presence of his solicitor he was content to be seen without but in the presence of staff from the secure unit he was resident at.

6.6 He was seen on 20th May 2016. He said that he was not happy with Social Services regarding the alleged abuse allegation made by his sister:

> 'They treated her like an adult although she was only 13 years old' and
>
> 'They did not explain anything to her'

6.7 He said that he knew something was wrong with his sister as she was losing weight and then she took an overdose of a mixture of slimming pills and painkillers. After she was discharged from hospital he had walked into a conversation between his sister and his mother about the sexual abuse. He said that his sister was afraid that it would be made public and his mother was being protective towards her.

> 'I did not want my sister to harm herself again. I used to stay awake at night to keep an eye on her. I used to get some sleep around 5.00am before school.'

6.8 The Perpetrator explained how he had been caught by the Head of Year leaving school and on being asked for an explanation, he had broken down in tears and disclosed the alleged abuse of his sister by the Victim.

6.9 The Perpetrator explained that he would have to walk past the Head of Year's office to leave school and the teacher asked him where he was going and he told him 'going home'. He said the teacher was not happy with him and called him into his office and asked him why his mother was letting him go home so he told the teacher about the abuse.

> ‘I was crying and I was upset. Two months absenteeism from school, school letters to the house. I was under pressure and mum was under pressure.’

6.10 He explained that he and his sister were both in a Faith School.

> ‘Nothing was done about anything. I told them about my problem.’

6.11 He said that he told the teacher that his sister had tried to kill herself and she stated that her grandad had abused her.

> ‘He just sat there. He let me go home. I was 15 years old at the time. I would not have told that teacher that again. If I had known he was not going to do anything I would not have told him’.

6.12 He said that he saw the teacher a few times afterwards but he did not mention anything to him. ‘He did not ask about my sister or me’.

> ‘I think he should have told someone. If I had told my cousin she might have done something’.

6.13 The Head of Year, according to the Perpetrator, stated that he was aware of his sister having problems with her attendance at school, but after hearing the whole story about the Perpetrator and his sister no action was taken. As a Faith school, the Perpetrator felt then, and still does feel, that more ought to have been done by the teacher, in terms of referring the matters to the necessary authorities or ensuring that he had some degree of pastoral care within school.

6.14 According to the Perpetrator and his mother, the school let both the Perpetrator and S2 down badly in failing to act positively about their respective problems and that his absence from school once he had got his daily registration mark was not investigated properly.

6.15 He explained that he had a female cousin working at the school at that time who was a teacher although he did not speak to this person about his problems.

6.16 A support worker at the Secure Unit where the Perpetrator was resident provided the Authors with a written report of a conversation that he had had with the Perpetrator that reiterates all of the facts set out above.

6.17 According to the Perpetrator, he had repeated this explanation on numerous occasions during the investigation and during enquiries into the death of the grandfather at the subsequent criminal proceedings and to his care workers at the secure unit.

6.18 On 4th November 2016, a Panel meeting was held to which the Mother and an AAFDA representative were invited. There was a general discussion about the Review process about which the Mother expressed her view that issues had been identified that could have been handled better and she was satisfied that actions were to be put in place in an attempt to prevent similar actions arising again.

6.19 The Perpetrator was seen again on 16th December 2016 at the secure unit. He had seen a copy of the draft report and agreed that it gave a true account of the events as he saw them. He commented that the misdemeanours at school had been blown out of proportion and he could not understand why the Head of Year was being untruthful about the day he alleges disclosing his domestic problems.

7. Conclusions

7.1 This is a case of a young man who took his own action against his grandfather who had allegedly sexually abused his sister in the past. This split the family and caused a rift that only manifested due to the Victim's insistence in attending his own mother's funeral, much to the disapproval of the rest of the family. Fearing the Victim would attend the funeral and thereby upset his sister and the rest of the family, the Perpetrator visited the Victim's home, he says with no intention to cause harm or injury to the Victim. However, an argument started between the Victim and the Perpetrator during which the Perpetrator stabbed the Victim who died later from his wounds.

7.2 The alleged sexual abuse of S2 was disclosed and the Mother says she sought help and assistance from several agencies. Eventually Children's Social Care became involved but because S2 was unsure at that stage about making a complaint for reasons set out above, little action was taken other than to decide that this was to be a single agency referral and therefore opportunities to involve the Police and for the Victim to be interviewed were lost. S2 could have been reassured by the Social Worker about the process but she was not. Had this matter been referred this would have likely managed the situation better for both the Perpetrator and his sister and the school would have been informed.

7.3 Barnardo's and CAMHS did not provide S2 with the Transition Service that was required due to the sickness of a Psychologist. It appears there was no attempt to provide another Psychologist to take on her case.

7.4 Had these issues been addressed in the recognised manner that child protection guidance and legislation requires, it is possible that a full investigation into the actions of the Victim may have taken place and agency involvement would have been more robust including a plan of care to protect S2 whose vulnerability may have been recognised.

7.5 The Panel are of the opinion that there ought to have been proper robust action by agencies with regard to the concerns raised. There were opportunities missed by Children's Social Care and the family GP to consider safeguarding of S2 and the Perpetrator. If the alleged disclosure to the teacher is correct, there were no safeguarding considerations. It must be stressed however that the teacher does not accept that this happened. Because the original disclosure of abuse by the Victim was not progressed according to procedures, the risk he posed to the rest of the family and other children was not assessed.

7.6 It is appreciated that the Victim's voice in this case cannot be heard. There is little known about him. The alleged allegation of the abuse of his granddaughter was never put to him, so it is not known what his views of that allegation were.

List of Recommendations

Recommendation 1

It is recommended that Cardiff Council ensure that all front line practitioners receive training, supervision and support to be able to effectively identify, report and respond appropriately where significant harm or abuse is alleged, including any allegation or suspicion of sexual abuse. Also, that all front line practitioners apply the appropriate thresholds to the management and allocation of cases where there is risk of significant harm as defined by The Children Act 1989 and the All Wales Child Protection Procedures.

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Recommendation 3

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Recommendation 4

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