Aylesbury Vale Community Safety Partnership

Domestic Homicide Review following the murder of Philip, who died in March 2018

Domestic Homicide Chair and Author:

Gillian Stimpson, Lime Green Consultancy Services Ltd.

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The Panel would like to express their condolences to the families of Philip, and particularly to the four children of Philip and Eva, who now must re-start their lives without their parents. This has been a sad case to review and the Panel wish the children the best future as they move forward with their lives.

1 DOMESTIC HOMICIDE REVIEW

1) This Domestic Homicide Review examines agency responses and support given to Philip, a resident of Aylesbury prior to the point of his murder in March 2018

2) In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

3) This Domestic Homicide Review (DHR) is being undertaken as there was a relationship between Philip and Eva. They were husband and wife. The review considers agencies' contact/involvement with Philip and Eva from March 2017 to March 2018. This period was chosen as it covered the pertinent period in the lead up to the homicide. Some of the information provided before this period has been used as part of picture building and helping the Panel understand the background of the family.

4) The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and/or abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and, most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

2 TIMESCALES

5) The Community Safety Team Manager was advised of the murder of Philip in April 2018 by Superintendent Metcalf of Aylesbury Local Police Area. A Primary Assessment Document, which is a brief report on the homicide, including a short description of the incident, those involved and their relationship status, was provided by Thames Valley Police. The report explained the relationship between the deceased and the perpetrator. This report was initially shared with Will Rysdale, Assistant Director, Aylesbury Vale District Council who is the chair of the Aylesbury Vale Community Safety Partnership, who agreed that the circumstances constituted a domestic homicide. The Home Office was notified of the homicide and the intention to undertake a Domestic Homicide Review on the 25th May 2018.

6) This review began in July 2018 and was concluded 31st July 2019. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. There was a prolonged delay in the trial due to the pathology report, which impacted on the charges placed on Eva. This then led to a lengthy delay in Thames Valley Police re-writing their Individual Management Review (IMR) to include more relevant information for the Review.

3 CONFIDENTIALITY

7) The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. The pseudonym/s agreed with the family and used in the report to protect the identity of the individual(s) involved are Philip, who is a male, aged 55 and whose ethnicity is White British and who is the victim. The perpetrator is Eva, a female aged

54 and whose ethnicity is White European. Other pseudonyms are used throughout the report when referring to other relevant people who are linked to the review.

- Child 1 of Philip and Eva, aged 22 years, white British ethnicity
- Child 2, aged 20 years, white British ethnicity
- Child 3 aged 17 years, white British ethnicity
- Child 4, aged 14 years, white British ethnicity
- Andrew – elder brother of Philip
- John – Cousin of Eva

4 TERMS OF REFERENCE

The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) 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.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

8) The Review will cover a period of 1 year prior to the homicide but those participating in the Review are to consider contacts and engagement with the victim and perpetrator prior to this and if there is information that would be relevant to the review, that should also be included.

Specific issues to address

- Was there evidence of a risk of serious harm to the victim or the perpetrator that was not recognised or identified by the agencies in contact with them? Was there any evidence which might have raised a homicide concern for the victim or the perpetrator?
- Family, Friends, neighbours, and work colleagues

  a) Whether family or friends want to participate in the review. If so, ascertain whether they were aware of any circumstances which might have led to the homicide of the victim?

  b) Whether, in relation to the family, friends, work colleagues and neighbours it is known that there were or could have been any barriers experienced in reporting abuse.

c) Is there any evidence of controlling or coercive behaviour; being experienced by the victim or the perpetrator? If so, did the victim or perpetrator have appropriate opportunities to report concerns.

d) What, if any, are the legal requirements around the notification to authorities in respect to home education by parents and schools and, if there are legal requirements, were they followed by the family and Buckinghamshire County Council – Education Department in respect to the children in this case?

e) How have these requirements changed over the years since the children were first removed from school in 2006? What does the Buckinghamshire picture look like in respect to the number of children recorded in Home Education and is this likely to be a correct number? What is the general process when a notification to Buckinghamshire County Council is received in respect to a child receiving a home education, including if these processes exceed the national legal requirements?

f) What might the impact of the way the family lived in social isolation have had on the children in the past and of how they move forward?

g) Did the family have any religious beliefs or belong or follow any cult, and if so, did they attend meetings or services, and can this have attributed to their lifestyle choice?

h) Where any agencies had a connection or link with the family, can it be shown that those involved displayed evidence of professional curiosity particularly in respect to their choice about how they lived and raised the children?

i) Was there any implication in respect to the homicide which might be attributed to the family having no access to technology?

Could improvement in any of the following have led to a different outcome for Philip considering:

- Communication and information-sharing between services.

  a) Was there information or were there any opportunities available which might have identified that there was a serious risk of harm the victim, but that was not shared with other agencies?

  b) In circumstances where information or opportunities were available and shared, were they acted upon in accordance with the agencies' recognised best professional practice?

  c) Communication within services – was relevant information about the victim shared and acted upon appropriately within agencies?

  d) Is suitable advice and information available and accessible, including the availability of specialist services, for those who may be at risk of experiencing domestic abuse?

- Does the homicide appear to have any implications or reputational issues for any of the agencies or professionals?

- Does the homicide suggest that national or local procedures or protocols may need to be changed or are not adequately followed or understood?

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

5 METHODOLOGY

9) Once being notified of the homicide the Aylesbury Vale Community Safety Partnership considered the circumstances and, because there was an established relationship between Philip and Eva, it was considered appropriate to notify the Home Office that the Community Safety Partnership would undertake a Domestic Homicide Review.

10) The Panel Chair met with the Senior Investigating Officer (SIO) following the report of the homicide to the Community Safety Partnership. This meeting was useful in providing background information about the family.

11) Letters requesting that any agency being involved with the subjects, along with a chronology template, were sent via email to all the listed statutory agencies along with letters to voluntary organisations within the area that may have had a connection to the subjects of the Review. The letters requested that if there was any agency involvement, then records should be secured. Six statutory agencies had links with those involved in the Review. The Review was unable to establish any voluntary agencies which might have had any links to the family.

12) The IMRs provided by the Services that had engaged with the family were used to support and inform this Review.

13) The Children's and Adults' Safeguarding Boards were aware of the Review and requested that the report is shared once completed. Neither of these Boards carried out separate Reviews but have requested that the final versions are submitted to the Boards to inform their learning.

14) National research was considered and reference to a recent Serious Case Review undertaken by Northamptonshire which concerned home schooling/education was reviewed and these references are recorded in the report.

15) Extracts from the interviews the children undertaken by Police and Social Care were used.

6 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

16) The brother of Philip (Andrew) and a cousin of Eva (John) have been engaging with the Chair through emails; letters and telephone calls. They have been provided with the Terms of Reference, information from the Home Office, support, and guidance leaflet from Advocacy After Fatal Domestic Abuse (AAFDA) and kept up to date with progress.

17) They did not meet with the Panel but engaged through communicating with the Chair of the Panel and initially through the Thames Valley Police Family Liaison Officers.

18) The children of the family have been contacted twice through the Family Liaison Officer by letter from the Chair but to date have chosen not to engage with the Review process.

19) Eva has been written to three times in prison to advise her initially about the process being undertaken and then on the last two occasions to request that she engages in the process. No response has been received from any of the contacts made.

20) The Chair met with neighbours of the family.

21) Neither Eva nor Philip had worked for some time.

22) They had no friends that the Panel could engage with nor did the family engage in any aspect of the wider community.

23) Philip's brother and Eva's Cousin were provided with the report before publication and were advised that permission to only publish the Executive Summary was granted by the Home Office.

7 CONTRIBUTORS TO THE REVIEW

The agencies engaging in the Review are as follows:

- Thames Valley Police – provided an initial IMR which was later replaced by a more detailed Review following the conclusion of the case at the request of the Panel.
- Buckinghamshire Children's Social Care - provided an IMR which covered First Response and the Multi Agency Safeguarding Hub (MASH)
- Buckinghamshire County Council Education Service - provided a report with recommendations to improve the service and an explanation of Home Education and the legal aspects relating to this.
- Buckinghamshire Clinical Commissioning Group (General Practitioner - GP) – provided an IMR
- South Central Ambulance Service – provided an IMR
- Buckinghamshire Healthcare Trust - provided a short note about information they held that did not pertain to the period of the review
- Oxfordshire NHS Foundation Trust (mental health service provider for Buckinghamshire) – confirmed they had not engagement with family
- The subjects of the Review were not known to any other services.

All the information and reports provided were given by staff who were not involved with the subjects of the review or have any direct management of staff who had previous links with the subjects.

8 THE REVIEW PANEL MEMBERS

The following people attended and supported the Review process. In addition to the three meetings that took place, there were numerous exchanges of emails and the sharing of the draft report, action plan and recommendations, between the relevant agencies.

- Gillian Stimpson- Chair – Attended all meetings
- Will Rysdale- Chair - Community Safety Partnership - Attended all meetings
- Chris Oliver, Community Safety Advisor – AVDC Community Safety – Attended two meetings
- Tony Heselton - Head of Safeguarding and Prevent – SCAS – Attended one meeting
- Nuala Waide - Associate Director for Adult and Children's Safeguarding Buckinghamshire Healthcare Trust – Attended one meeting
- Krista Brewer - Safeguarding Adult Lead - Bucks Clinical Commissioning Group – Attended two meetings

- Debbie Johnson - Senior Operational Support Manager - National Probation Service – Attended two meetings
- Mary Buckman - Associate Director of Social Care - Oxford Health Trust – Attended two meetings
- Carl Wilson – Acting Detective Inspector - Thames Valley Police Domestic Abuse Investigation Unit – Attended two meetings
- Amanda Andrews - Head of Service - First Response, MASH & Assessment Teams - Buckinghamshire County Council Children's Services – Attended two meetings
- Julie Murray – Head of Service, Safeguarding Adults, Deprivation of Liberty Safeguards - Buckinghamshire County Council Adult Safeguarding – Attended all meetings
- Denise Edmonds – Head of Service - Aylesbury Women's Aid – Attended two meetings
- Viv Trundell - Educational Entitlement Manager - Bucks CC Elective Home Education – Attended two meetings
- Gillian Attree - Designated Nurse Safeguarding Children and Looked After Children - Buckinghamshire Clinical Commissioning Group – Attended one meeting
- Linda Ricks – Senior Probation Officer - National Probation Service – Attended one meeting
- Claire Knibb – Detective Chief Inspector – Thames Valley Police – Attended one meeting
- Julie Davies - Head of Quality, Standards and Performance - Buckinghamshire County Council Children's Services – Attended two meetings

No one engaged with the Panel or the IMRs has had any direct link with Philip or managed any staff who have been engaging with Philip.

9 AUTHOR OF THE OVERVIEW REPORT

24) The Domestic Homicide Review has been chaired by Gillian Stimpson of Lime Green Consultancy Service Ltd. Gillian has been the Director of the Company since 2015 and has been undertaking Domestic Homicide Reviews and chaired two Serious Case Reviews, one for a baby death and one into child sexual exploitation.

25) Gillian has had previous experience as a Police Officer in the Metropolitan Police from 1978 to 1987 and as Community Safety Manager for Wycombe District Council, from 1993 to June 2015. Gillian currently has no connection to the Community Safety Partnership other than in the undertaking of the Domestic Homicide Review.

26) In 2013 Gillian successfully undertook the Domestic Homicide Chair Certificate, a Home Office funded 5-day training course delivered by AVA (Against Violence and Abuse) accredited by the Open College Network (OCN). Gillian continues to undertake professional development and attended a day's training on the new Domestic Homicide Review Guidance. In addition, Gillian has attended learning events which have included keynote speakers covering specialist support for families, modern day slavery and intimate partner homicide. Lately Gillian has also attended an AAFDA Information and networking event.

27) Gillian has undertaken 4 completed Reviews and is currently involved with 2 further Domestic Homicide Reviews as the Panel Chair.

10 PARALLEL REVIEWS

28) An inquest into the death of Philip was opened and adjourned at Beaconsfield Coroners Court. There have been no further hearings following the conviction of Eva. There are no other parallel reviews.

29) Eva was assessed in custody to see if she was fit for interview by the police. Beyond this point no psychological issue was raised by the defence so no additional assessments were made.

11 EQUALITY AND DIVERSITY

The following protected characteristics were considered

- Age – Eva was aged 54 and Philip was aged 55 at the time of his murder. Both are adults and so no additional consideration in respect to age was necessary.
- Disability – There are no known disabilities for either Eva or Philip.
- Gender reassignment was not a consideration
- Marriage and civil partnership – Eva and Philip were married and living together.
- Pregnancy and maternity – These weren't considered as part of the Review as neither Eva nor any other subject mentioned in the review was pregnant or had been within the last 14 years.
- Race – Eva is a white European (German) and Philip was white and of British nationality. The children are all white British but had dual nationality (British and German). There was no evidence to suggest that their race played any part in the circumstances which led to the abuse and ultimate murder of Philip. There is a suggestion from the brother of Philip that Eva may have suffered racial abuse from patients when she was employed as a midwife, when she first stated working in London. However, this was in excess of 23 years ago. There is no further reference or link to race.
- Religion or belief – The Review has been unable to confirm the religion or beliefs of the family. It is known that in the past they practiced a Christian, bible reading religion, but it became apparent that they chose to stop practicing religion in public. In the past they had attended a Presbyterian or Anglican church. It is not known if they followed any religion in the confines of their home. The brother feels that Eva was brought up in an Anabaptist Swiss/German "Apostolic" denomination, and that they withdrew from the Anglican church because they felt it was too liberal. They appeared to be rejecting being part of what they saw as a fundamentally flawed Christian community. Andrew thinks they came to see their own family as an exclusive church, and he is not sure if their children were baptised into the Christian faith.

  Around 2014, Philip told Andrew during a telephone conversation, that he believed we are living in the "End Times" a quote from Book of the Apocalypse. He may have believed that earning a living was now irrelevant.

It is a possibility that their religious view may have led to their isolation and created barriers to them accessing services. The Review was, however, unable to establish what their views were.

Gender and sexual orientation – Both Eva and Philip appear to be heterosexual. According to the Crime Survey for England and Wales (CSEW) year ending March 2019:

- an estimated 7.5% of women (1.6 million) and 3.8% of men (786,000) experienced domestic abuse in the last year
- adults who lived in urban areas were more likely to have experienced domestic abuse in the last year (6.0%) than those who lived in rural areas (4.2%)

In 75% of the domestic abuse-related crimes recorded by the police in the year ending March 2019, the victim was female.

Between the year ending March 2016 and the year ending March 2018, 74% of victims of domestic homicide were female compared with 13% of victims of non-domestic homicide.

- In this case Philip was male and so in the minority of victims for this offence. There are fewer male victims of abuse and so that the smaller number of victims may mean that there is more of a lack of awareness of men as victims and fewer resources available to them. In Buckinghamshire men can access support from the SMART IDVA service and there are several helplines, including Mankind and Men's Advice Line UKThese characteristics did not have any impact on the ability of the subjects of the review to access services should they have wanted or needed to. Service delivery by any of the agencies involved was not and would not have been impacted by these characteristics.

12 DISSEMINATION

30) This report has been kept confidential during the Review process. Members of the Panel have had full sight of the report and have actively engaged in the process of compiling the final version, either by attendance at meetings or through email.

31) The Final Overview report will be shared with the Panel. Where an agency has recommendations and learning, the report is expected to be shared appropriately with senior management of the agency with recommendations.

32) The Executive Summary will be shared with the Adult Safeguarding Board and the Buckinghamshire Safeguarding Children's Partnership, along with the Community Safety Partnership.

33) The brother of Philip and the cousin of Eva will be shown the final draft of the report. The children will be contacted through the Family Liaison Officer to ask if they want to see the report. They will be advised when it is published. The Panel is agreed that the anonymised Executive Summary only will be published as the report contains information about the children, one of which remains a child.

34) This review raises important issues around the short comings of checks available for local authorities to make home schooling visits ensuring the safety and welfare of children and the quality of home schooling, and so this report will also be shared with the Department for Education (DfE).

13 BACKGROUND INFORMATION (THE FACTS)

35) Philip lived in Buckinghamshire with his wife Eva and their 4 children. The family were not known to any agency within the timeframe of the review. There was one call to police about concerns for the family's welfare from a neighbour, and a message to Children's Social Care from a family member who was visiting from Canada. The children had had little engagement with the education services, with the two youngest children not having any school record.

36) On the day before the ambulance service was called to the home address, it is suggested that Philip collapsed in the bathroom. The family tried to self-medicate him but without success. The call to the ambulance was made the following morning when it is believed that Philip had been dead for some time as rigour mortis had set in. On arrival the ambulance service inspected Philip for injuries and found head injuries. Eva was asked about the injuries and she claimed they had had a falling out a couple of weeks before and that the injuries were caused by a rolling pin with which she had hit him repeatedly. The Police were called due to the circumstances and claims by Eva; she was arrested on suspicion of murder.

37) The exact date of Eva and Philip's wedding has not been established but they have been married for approximately 23 years. During this time, they had always lived as a couple. Living in the family home were Philip, Eva and their 4 children aged 22, 20, 17 and 14. They had lived at the address in a town in Buckinghamshire for the previous 3 years, having moved from a different home in the same town.

38) A homicide investigation was conducted by Thames Valley Police's Major Crime Unit. On 1st April 2018 Eva was charged with Grievous Bodily Harm with Intent (S.18 Offences Against the Person Act 1861) but this was changed on the first day of her trial when she was arraigned for Murder. During the investigation it was revealed that Philip had 78 visible injuries across his body, which it is believed were inflicted on him since 2015. In the Judge's summing up, Justice Mrs Yip DBE said "Internally, he had fractures to the vertebrae of the neck and the thoracic and lumbar spine, and to both scapulae. There were two injuries to the larynx, indicative of neck compression."

39) She went on to say "Although other mechanisms were suggested to the experts, there can be no sensible doubt that Philip had been subjected to partial strangulation in the weeks before his murder. Philip's ears showed the appearance typically seen in rugby players and boxers, so-called cauliflower ears. Such injuries result from repeated trauma to the cartilage of the outer ear. There was chronic remodelling of the bone across the whole skull, evidencing repeated trauma. Some of that was longstanding. There was also evidence that injury to the skull had been inflicted on more than one occasion within a few days of death, most recently haemorrhage had occurred within 2 days of Philip dying. The pathologist said that he had never seen a case involving so many injuries inflicted over such a long period of time with so much resulting scar tissue."

40) The pathology report to confirm the cause of death and so determine any final charges took a considerable amount of time. The post-mortem finally established that the cause of death was "Sudden death of a 55-year-old man with bronchopneumonia who had been subjected to repeated episodes of significant blunt force injury".

41) The trial took place at Kingston Crown Court, starting on 5th March and concluded on 20th March 2019. The verdict was guilty of murder, and the sentence was life, serving a minimum of 16 years.

42) The Panel is aware of the guidance relating to Domestic Homicide Reviews which suggests that reviews should be concluded within a 6-month timeframe. The Panel wish the Home Office to note that this is an unrealistic timeframe. With several members of the Panel having been involved in multiple domestic homicide reviews, the Panel is keen for a recommendation to be

made for the Home Office to consider a review of the current guidance which is now three years old, and to consider a more realistic timeframe be recommended. Currently, with the guidance suggesting 6-months, this may cause unnecessary distress and concern to families who are advised that this is the current guideline and may then be concerned that this timeframe cannot or is not being met. The Panel consider that a more realistic timeframe is between 12 -18 months.

43) These delays are often caused by delayed trials which mean that the reports cannot be comprehensively completed until after that time. The expectation of speaking with the families in any depth is not currently permissible. This is because the Police recommend that families who may be involved in a trial should not be fully engaged in case anything which may compromise the case is forthcoming during any discussions. It should also be noted that the Panel is frustrated that until the trial is complete, they do not receive the full information about the case until post trial. There is often additional information after the trial, which can lead to a change in report, requiring additional information to be sought and considered.

Panel Recommendation 1 - National

The Home Office reviews the existing Domestic Homicide Review Guidance (2016) particularly the current suggested guidance for the timeframes to complete a homicide review. New guidance should also give more specific guidance to Police Services and other key agencies about the completion of IMRs to ensure they are completed fully from the outset which would assist in speeding up the Review process.

Contributions from Family and neighbours

Brother – Andrew

44) Philip and Andrew were siblings with Andrew being the elder. They were raised on the Wirral. Andrew has been domiciled in Scotland since leaving full time education in the mid 1980's.

45) Asked about when Philip and Eva first met, Andrew explained that they were both tenants of rooms in a shared house in London, probably first meeting in about 1992. At that time Philip was a post-graduate student at the Guildhall and Eva was a midwife, working in London.

46) Philip had been previously married, but it was thought that this was the first relationship for Eva. Andrew explained that he thought that Eva had suffered some racial abuse while working in London and that it may have been from patient's families with whom Eva was working. Andrew was aware that Eva had a somewhat difficult childhood, her mother was single and suffered from mental health issues.

47) Philip and Eva were married in 1995, and the wedding was attended by family. Andrew recalls that it was at a Church of England church near Covent Garden. The wedding was a conventional Church of England service. As Philip was divorced, he was called on during the service to express his sorrow for any contribution he might have made to the failure of his first marriage. Andrew thinks that they were members of the congregation of the church in which they married.

48) When asked about the last time that Andrew saw Philip, he explained that he last saw him and his family in August 2012 when it was their mother's 90th birthday party. This was held at Andrew's home on Skye. Their mother's birthday was a happy event, with the family and most of the neighbours dropping in during the afternoon.

49) Andrew recounts several minor things which stuck in his mind from the visit, including when at dinner in the evening Philip commenced to sing a grace (blessing). The same grace they had been

singing a decade earlier. Andrew felt this was unusual and he stopped him and said his own 'Grace'.

50) Andrew's house has two double and three single bedrooms and he had planned on how the whole family would be accommodated overnight, but Eva "not wanting to be any trouble" insisted on making up pack beds for the children rather than accepting the beds and rooms as he had set them up. It appears nothing could disturb their routine, not even being guests in someone else's house.

51) While they were with Andrew there was a mass shooting in Cockermouth when a taxi driver went on the rampage. Andrew had the BBC news channel on following events, but Philip asked him to turn the television off as he did not want the children to know about things like this. Whilst Andrew could understand his concern regarding the younger children, the oldest ones were 15 and 16 and this seemed overprotective.

52) Andrew had been made aware that the eldest child, then 16, had been put into school to prepare for examinations. An interest in engineering had been mentioned and, as he was about to take his dogs out for a short mid-afternoon walk, he asked the child if they would like to accompany him, hoping to be able to talk about the child's ambitions and potential A level choices etc. Child 2 then asked if they could come, then child 3 had to come and then child 4 (age 6). As a result, it was impossible to instigate an age appropriate conversation with the 16-year-old. Andrew found their language limited in expression as things were largely "nice" but there was no sense of any shade of meaning.

53) Philip did not seem to want his children to visit any of the "attractions" of Skye, such as castles and museums. Andrew thought it was as though he did not want to engage with history or culture.

54) Andrew also went on to explain that his own daughter had given birth out of wedlock and that his daughter had told him she was afraid of meeting her cousins fearing they would not approve of her being pregnant. She was surprised at them being kind and giving her presents for the baby.

55) Andrew was asked if he knew about the schooling of the children. He said that he thought there had been a dispute between Philip and Eva, and the eldest children's primary school, concerning the children being shown age inappropriate videos. Andrew thought the videos were of a sexual nature which had concerned the family. He understood the school had dismissed their concerns out of hand. This led to the children being removed from primary school on moral grounds.

56) Andrew was asked about why he and Philip were estranged, and he felt it was ostensibly because Philip found out that their mother still exchanged Christmas cards with his ex-wife's parents.

57) Philip ceased contact with Andrew in 2014. By December of 2014, the phone line was no longer in use but had been giving fault tones whenever Andrew tried to phone for several months before that. Andrew was aware that during one of the last phone calls he had with Philip, that Eva was listening in on the other phone in the house. Whenever Andrew rang, Eva had always put Philip on the line as quickly as possible.

58) Apparently when a cousin died in December 2011, Philip did not ask for a day off to attend her funeral. He told Andrew that the music centre where he worked would refuse such a request, so he was not prepared to ask.

59) There was a growing sense of distance. Their father had told Andrew in 2005 that he wanted him to have the dining suite on his passing and when their mother could no longer live at home. They were then to share out any other possessions with the remainder going to a sale room.

60) Philip was withdrawing from the family at the time their mother had agreed they should clear her house (2014) when she went into a care home. When Andrew mentioned their father's wishes about the dining-suite, Philip was upset that it had been offered to Andrew without his knowledge and he made it clear that he had wanted it. Andrew's circumstances were such that he would probably not be able to take it and so would sooner Philip had it, but this was not good enough as it then became something he could have only because nobody else wanted it.

61) There were other issues that just seemed to constantly get in the way. Philip told Andrew that their mother did not properly acknowledge his children, which Andrew did not understand. Another example of how the families grew apart was when a Harry Potter birthday card sent to one of Philip's children was interpreted as being about magic and so was evil. In another attempt to find a suitably non offensive birthday card for Eva, Andrew sent an art-deco style picture of a vase with flowers and this was viewed as a crematorium urn and interpreted as Andrew wanting her dead. Eventually the children's birthday cards came back marked "return to sender".

62) Asked about if there were any concerns about Philip and Eva and the family, or if they had expressed any concerns, Andrew explained that their mother who was a retired teacher expressed concerns that the children could not get a full secondary education through home schooling.

63) It also seemed that Philip and Eva were unwilling to go anywhere on their own and were unwilling to go anywhere without all the children accompanying them.

64) There had been no concern about any abuse perpetrated or received by either Philip or Eva, however Andrew was concerned that he found Eva listening in on a telephone conversation he had with Philip. At the time Andrew just thought this was a joint strategy on their part to make sure they both knew exactly what was said. In retrospect, Andrew now feels this fits a pattern of controlling behaviour.

65) Asked about religion Andrew explained he believed they were both in the Anglican communion at the time of their marriage. Philip was raised in the Roman Catholic faith and attended Roman Catholic schools from the age of 5 to 18. As a university student he was involved in the Christian Union. Philip's first wife was raised in and was active within the Methodist communion, and they married in 1985 in the Methodist church. She became a lay preacher and that role appears to have continued during the period that they lived in Lincoln, where she began a relationship with another man- which lead to the failure of their marriage and divorce. Philip severed all his ties with the Methodist communion after the engagement of his first wife to her new partner, when it was published in the English Methodist church magazine.

66) Many years later their mother told Andrew that the planned date of Philip's first marriage was brought forward twice – both times at the instigation of his fiancée. His mother believed this had disrupted his training as an accountant and led him to leave that profession before qualifying. He may have had this in mind when he was determined to "avoid the mistakes of the past" early in his relationship with Eva.

67) Andrew believes that when they first lived in Buckinghamshire Philip and Eva attended the Anglican church. Andrew believes Eva was brought up in an Anabaptist Swiss/German "Apostolic" denomination, and that they withdrew from the Anglican church because they felt it was too liberal. They appeared to be rejecting being part of what they saw as a fundamentally flawed Christian community. Andrew thinks they came to see their own family as an exclusive church, and he is not sure if their children were baptised into the Christian faith.

68) Around 2014, Philip told Andrew during a telephone conversation, that he believed we are living in the "End Times" a quote from Book of the Apocalypse. He may have believed that earning a living was now irrelevant.

69) Asked if Andrew knew of any reason why Eva would abuse his brother, he explained that he thought they were very protective secular Christian parents, living in a post-Christian society. They found their moral and spiritual values increasingly challenged by generational attitude shifts in that society. Andrew thought their concerns were clearly not entirely unfounded as witnessed by the revelations of sexual abuse (of power) in national institutions, including churches and political parties. If they began as protective, they became very protective, then overprotective and ultimately shut themselves off from secular society embracing a simplistic personal interpretation of the bible, with an over emphasis on the historical accuracy of the old testament.

70) Andrew thought that Philip and his family cut themselves off from what they saw as "The World". He thought they both came to subscribe to a very narrow view of Christianity in which they saw all mainstream churches as being misleading, with their view of Christianity developing into a very literal interpretation of the Bible and a rejection of anything or anyone that did not completely agree with them.

71) Eva, from her comments while watching an historical documentary on the hippy movement in America in the 1960's was as much a driver of this as Philip. After the programme she started talking about the Minoans as being one of the pagan peoples who the old testament warned the Jews about. She linked this with nudism and "free love" as in the stereotype of hippies. There seemed to be a narrative about interest in ancient Greek history and archaeology being tied up with paganism in the present day. Andrew thought this was an unhealthy level of interest for any Christian to have. Philip seemed to back up everything she said.

72) Finally, Andrew felt that as the family cut themselves off from society, the dynamic within the family changed as they were without any social/spiritual contacts which meant there was no other point of reference to challenge or help them with any perceptions they had. Effectively "group think" took over. At some point Eva began to physically abuse Philip on many occasions, leading to his health gradually deteriorating. No-one sought external help until he was dead. Andrew does not know why this happened.

73) Andrew has not managed to have any direct contact with the family since the incident.

Cousin - John

74) The Chair was able to communicate via email with a John who is a first cousin of Eva and who lives in Canada. Eva is the only cousin that John has on his mother's side of the family.

75) Eva was aged about fifteen or sixteen when John really got to know her during a time when he lived and worked in Germany. Eva was still in school. They spent many weekends together in church related youth group functions. John lived with his aunt about 20 minutes away and he made weekly visits to Eva and her mum. They took several trips and outings together, including travelling to Sweden with a group of young people. John's impression at the time and looking back is that given the difficult circumstances of living with her mother's mental condition, Eva was very responsible and mature. She enjoyed being with her friends. Her relationships outside the home were a welcome reprieve to the difficult home life that she had. She was a teenager that took life seriously. During his visit in 2003 she certainly gave the impression that she was a very responsible and caring mother of her children. Her home was neat and organized. Nothing stood out as being abnormal in their marriage. Prior to marriage Eva spent time working in Egypt as a nurse living out her Christian faith.

76) John met Philip at their wedding, and during visits. Whilst John did not know Philip well, he came across as a laid back and quiet individual, liking music. He seemed like a caring and responsible father. Over the years when John called and Philip answered the phone, their conversations was generally short but cordial, before passing the phone to Eva.

77) John and Eva's history was normal considering the distance between them. John and his family attended Eva's wedding and visited in 2003 with their children. Eva has been to Canada on several occasions with her family. The relationship became more distant when John's mother died in 2016.

78) John was asked if he knew anything about Eva and Philip's work and about how, if they do not work now, they bought their home. John believes that Eva was a full-time mum and did not know that Philip had stopped working. When Eva's mum died in 2000, John assumed she received her inheritance. She also had a father in Germany who may have helped her buy the house.

79) John explained that Eva was raised in a "bible believing church" like his own, but he could tell when he managed to talk to her through a window on his last visit to the UK, that something changed about her faith. She said, "we don't believe like you." Over the years, following his visit in 2003, when John would talk with Eva on the phone, he had the impression they no longer attended a church or were part of a meaningful Christian community on a regular basis, and had the impression that they were becoming more reclusive.

80) John knew she moved to England and went to a Presbyterian church. John and his family went to their wedding.

81) John explained that their two families met up in 2003 for four days. John and his family visited Eva and her family, and that they all spent most of their time with them visiting and sightseeing and he described it as "normal." Everyone was friendly welcoming, enjoying each other and having lots of normal conversation. Nothing appeared unusual with them, or between the two families.

82) Around the same time, Eva and her family came to Canada and stayed with John and other family members. Everything seemed very normal with their relationships.

83) John became concerned about the family when they did not contact him in any form for about 2½ years, despite many phone calls and a registered letter to their address. This was very out of character and so in 2017, John and his family decided to come to the UK and try to contact Eva and her family. John managed to obtain the address and upon their arrival they went to Eva's home, in June, at 7pm. No one responded to the bell or knocking. They spoke to a neighbour who shared several features with them, explaining that the family keep their blinds closed; they don't go out much and don't answer the phone or door to anyone; that Philip seemed controlling with the wife, Eva, and that Philip's physical and emotional state has dramatically changed over the past 2 years and doesn't work anymore at the age of mid-fifties. The neighbours also wondered if anything was wrong with the family.

84) The neighbour then decided to report this all to the police who came the next day and no one answered the door though both cars were in the driveway. John went back the next day about 10:30am to try to knock again they did not respond. He found an open window and called in, introducing himself and stating he was there from Canada.

85) Eva came to the window and opened the blinds about 3 inches so John could see her. They spoke this way for almost an hour and a half trying to keep the conversation going and getting

information about the family and repeatedly asking if she could come outside to talk and if he could see the children. John felt it was as if she was trying to hide something from him.

86) Eva did not give any information about the family and said he was imposing on her privacy and was upset with the family for not keeping contact. John felt she had lots of blame and was always twisting things. The conversation was very awkward and strange and raised a lot of red flags in John's mind.

87) John explained that Eva's deceased mother had had a mental illness and he was now worried about her possibly having similar issues. He was also worried that the husband may be controlling because the neighbour says Eva won't speak with the neighbour when Philip is around but will say hello if he isn't around.

88) John feels that if Eva doesn't want any more communication with the family that is her decision, though very sad since John is the only close family she has, apart from her ill father and her elderly aunt, both in Germany. Neither of them had heard from Eva in at least two and a half years. John just wanted to make sure that everyone in the house was well.

89) The day after John's visit and brief chat with Eva, he spoke with Buckinghamshire Safeguarding Children's Board (now Partnership) and was advised to send an email to First Response explaining his concerns, which he did. John explained that what he thinks is of the most importance is to find out what, if anything, happened with the email he sent to the authorities raising the concern. To this day no one can tell him if it was read at the time or acted upon in any way and asked that the Chair tries to see where the system may have gone wrong. John says that as he listened and read the news coverage of this tragedy and hears people in authority saying "contact the authorities if there is signs or evidence of domestic abuse" then one should know what happened in this case. He hopes at the end of the day he will find this out. John says he knows it will not bring Philip back or get Eva out of prison but will hopefully help prevent another tragedy.

90) Panel note – It is very unfortunate that after the cousin provided a copy of the email he sent, it was noted that the email address he used or was given was not correct and so was never received by the First Response/MASH team. The email was also copied to the member of staff who advised him of who to contact. The email of this member of staff was a temporary one and the person spoken to and emailed is not employed by the Council and has not been for some time. We are unable to contact this ex-staff member.

Neighbours

91) The Chair met with neighbours of Philip and Eva. They had been neighbours for about 4-5 years during which time neither family had been into each other's homes. They also did not have any conversations with them, other than the occasional hello and once they took in a parcel for the family. When Philip and his family first moved into the home, he seemed to be quite a well-built man. The neighbours were aware of his job as a music teacher as he had taught the neighbour's child. The neighbours described them as reclusive and not mixing with the community. The window blinds in the front of the house were always down, and lights were rarely seen on. The windows were seldom opened, even in the height of the summer.

92) The family and children wore clothing which could be described as more conventional than that which a young person might wear. They lived in a three-storey house and the neighbours thought that they were home tutoring their children, and that perhaps they used the top floor for this purpose. There were often beautiful pieces of artwork hanging in the window. The neighbours believed the children were very bright as with the older children attending school to undertake

examinations, they were at the same school as the neighbours' child. Apparently, they kept themselves to themselves at school.

93) The children could occasionally be heard playing in the garden and seemed to be quite happy. They had a table tennis table in the garden and would play volleyball. The neighbours said it was lovely to hear happy child-like noises when they played. There was never any shouting between them. They were sometimes seen outside but would always be together and perhaps be on roller skates or using their bicycles. It is also believed that they adopted a cat, which they kindly put food out for. One of the children was often seen cutting the grass but with a manual push lawnmower.

94) The family had two cars, both of which could take the whole family out, with both Philip and Eva being drivers.

95) The neighbours felt that Philip may dominate Eva as they considered she only spoke or said hello even if the neighbours spoke to them. Eva occasionally said hello however, if Philip was not there. They also report that on one occasion both families were in their own gardens and that Eva and Philip had bought some plants for the back garden. They recall hearing Eva say she wanted to put the plants in a particular place and that Philip told her he had told her where they were going to be planted, and that was that. They felt he was possibly using controlling behaviour with Eva. The way he said it made the neighbours feel uncomfortable about his treatment of Eva.

96) Over the period of them being neighbours, there was a noticeable difference in Philip's appearance. He had gone from a well-built man to a thin and weak looking person, causing the neighbours to believe he may have cancer or a degenerative illness. In his last days it would take him several minutes to walk from the front door to his car and he seemed to be old and stooping. The neighbours also thought it was strange that Philip, even in the heat of summer was seen outside wearing an anorak and a hat.

97) The neighbours were not sure if they were religious but when they first met them had thought they might be Mormons[1] or Mennonites[2] as they do not use electricity and because they knew Eva was from Germany. The neighbours were not aware of them attending any religious meetings or services.

98) After Philip retired from being a music teacher there was a time when the neighbours were very concerned about the family as it seemed that Philip and Eva did not live at the home for about 10 weeks, however, the children remained at the house. One of the cars disappeared and the other did not move off the drive. The neighbours had wondered if they had gone off on a religious pilgrimage following Philip's retirement. Although the oldest child was probably about 19 at the time the neighbours felt they would not have left their family like that and for such a long time.

99) When Philip and Eva returned, Philip looked quite ill. He had lost a lot of weight and was looking very unwell. He used to have a beard and he had shaved this off. He seemed to be losing his hair and it had become white. He looked emaciated. The neighbours thought he may have a degenerative illness and because of their possible beliefs did not seek medical help.

[1] Mormons - a member of the Church of Jesus Christ of Latter-day Saints, a religion founded in the US in 1830 by Joseph Smith Jr

[2] Mennonites - a member of a Protestant sect originating in Friesland in the 16th century and now mainly located in the US and Canada, emphasizing adult baptism and rejecting Church organization, military service, and public office.

100) In the June before Philip died, a cousin and his family from Canada came over to see them as they had been unable to get in contact with them. They received no response at the house and so called on the neighbours to see if they could help. Having travelled from Canada, and the family would still not engage with them, the neighbour thought it was appropriate to call the police and rang 101 to report his concerns about the family. The female call-handler said she would record the matter and the next day a police officer called on the family. The neighbours went out and spoke with the officer who had said that they did not call on the neighbours as they did not want to identify them. The neighbours said they were not worried about that as Philip and Eva never spoke to them anyway. The officer said she had been banging on the door but there was no reply. Therefore, a card was left to indicate attendance.

101) The next day the cousin managed to speak to the Eva through a window. Eva had said that the children were old enough to decide for themselves if they wanted anything to do with the Canadian cousins. Eva declined her cousin entry into the house. The neighbours were told by the Canadian cousin that he had contacted the MASH[3] and the neighbours confirmed that the police had been notified of their concerns.

102) Later in the year, via email, the neighbours were asked by the Canadian cousin to put a note through the door to say that an aunt had died. The only other communication after that was with them when the funeral arrangements were made.

103) The neighbours are concerned that even when the police did manage to speak to the family following the calls about concerns, that no-one went into the house. The neighbours now wish they had pushed for more to happen.

104) On the day of the incident, Eva knocked on the neighbours' door and asked if she could use their phone, as she did not have one and her husband had died. Two of the children were with her. It was very cold, but Eva would not enter the neighbour's home. She asked the neighbour how to use the phone as she did not know how to call the emergency services. She was very calm and told the 999 call-handler that her husband had died the night before and that they did not try to revive him as she had 'hoped there was life'.

105) The neighbours were still living at the same house when the children returned following the murder of their father. The neighbours believe that social services are doing an excellent job with the children and that they noticed a big change in the children. The neighbours were concerned about the children having to return to the home and even saw them trying to cut the grass, initially with scissors and then with shears, as it had grown so long. They offered to help but it was declined. The neighbours were delighted when they heard music coming from the house and that when the neighbours came to move, they knocked on the door and one of the older children spoke to them for the first time and wished them well in their new home.

Children

106) The Children of Philip and Eva did not want to meet with the Chair or take an active part in the process. Following the murder of Philip, the children were interviewed by both police and worked with social workers.

107) All four children were subject to an assessment and video recorded interview soon after the discovery of Philip's murder. They were also assigned Family Liaison Officers from the Major Crime incident room for the duration of the investigation. The children remained insular and did not

[3] MASH – multi-agency safeguarding hub

supply enough detail to inform a victimology. They did supply fragments of information about their lifestyle which can be summarised as follows:

108) Child 1 described how the family would always eat together and discuss lots of things. They had assisted in the schooling of the younger siblings. They would bake bread and biscuits, go on trips together to places such as Wales, Scotland, and most parts of Great Britain. They had relatives in Germany. The child said they had school friends in the past but as a family they preferred to keep themselves to themselves. The child explained that their father had become more and more distant and did not take part in family activities anymore. He had become hunched over and slept a lot. Since the summer of 2015 he had started to act differently and became unbearable. He had been nasty to their Mum and had no boundaries or respect. He had hit Eva in the face. The Child described how he would set the family against each other. He had pushed the children around and that Mum would hit him with the rolling pin, and he would then have more respect. They had spoken together as a family to try to sort it out.

109) Child 1 explained that they went to a local Junior School from reception to part way through year 4, and was then home schooled, until for year 10 and 11 when they attended a local secondary school switching for year 12 and 13 to another school.

110) Child 2 described how they had a good childhood. Philip stopped working in 2015 and Eva had not worked since Child 1 had been born. Since then they lived off their savings. Child 2 had completed science 'A' levels. The family would eat together and have discussions. They baked bread and cakes. Their mother had tried to interest them in lots of different aspects of life, i.e. plants, cooking, politics, history etc. Child 2 said that she had been home schooled for a little bit by their mother. Child 2 liked to sew and had been making curtains. They had been planning to make the house nice. The Child described how one of the siblings liked making things from wood and reading history. Child 2 had a good relationship with their mother who had never been violent towards the children. They had gone out on family trips including one to Kew Gardens. Philip did the household chores. They had no visitors and no friends. She explained that Eva's mum had died, and Eva did not have contact with her father.

111) Child 2 gave more detail about how things had been between their parents and within the family in recent years. The child explained that their father had started to be violent towards their mother around 2015-2016. There would be arguments over his ex-wife. Child 2 stated that Philip had been emotionally cruel and violent towards their mother, leading their mother to have to defend herself. Child 2 described how Eva hit him with a rolling pin. The Child thought their father was declining mentally and said it was as if he was not present anymore. In recent years he had become indifferent to everything. He had lost his appetite and started losing weight. The Child was surprised at this as their mother cooked good dinners. Philip never said he was in pain. He was sleeping more than normal. He had become unwell in the past but had got better again.

112) Child 2 said their father had a bad experience about 10 years ago when he went to hospital following an asthma attack. He had an injection. The Child stated there was no religious reason for him not liking hospital or not seeking medical help. It was based on this bad experience.

113) Child 2 said they went to a local Junior School from reception to year 3, and was then home schooled, until for year 11 when they attended one secondary school for year 12 and 13 and then attended a different secondary school.

114) Child 3 described how the family would talk together at mealtimes, they would learn things from books (e.g. science). The Child would knit and sew and did woodwork with one of their siblings. The family used to go on trips out such as the butterfly farm and to museums. The Child explained how their father was a music teacher until 2015 but left his job as things started to change at work and as colleagues left. The Child knew that their father had a brother and their mum was an only child. The Child said that their father liked to listen to music. Child 3 said they had never attended school and had been home educated.

115) Children 3 and 4 met with intermediaries for a pre-interview assessment.

116) Child 3 told the intermediary they liked walking, swimming, and inline skating, and that when they went to Germany, they would stay in their 2-bedroom flat and would go on excursions. The Child confirmed they had been home schooled learning Science, Maths and Spanish. The intermediary asked how she would be able to know in interview if Child 3 was feeling sad and the Child said "I don't know. You'd have to know me quite well".

117) The Social Worker said from her work with Child 3 that they thought the way the Child reacted it was possible they could have autism. The Social Worker said the Child seemed to be sitting right on the spectrum (referring to ASD – autistic spectrum disorder).

118) Child 4 described how their father had started hurting and throwing their Mummy about in 2015. He described how Philip was provocative toward their mother and would bring up things from his first marriage. Their father had a change of personality. The Child's mother would hit Philip with a rolling pin and that Philip had fallen down the stairs in June (2018). The Child explained that their father's injuries were not healing. The Child had a good relationship with their father.

119) Child 4 said they had never attended school and had been home educated. When they were asked about their GCSEs the Child said they was planning to take them this year.

120) (The following is a verbatim transcript of an email from the children's Social Worker to the FLO) "During my visit to Child 4 they acknowledged that their mother hit their father, however the Child justified this by saying that when she did this it was because their father had provoked her. I asked Child 4 how their father had provoked her, they shared that their father would talk about strange dreams, naked people. Child 4 reported that their mother was always trying to protect them from their father's influences, they commented that their father was trying to set the children against their mother. Child 4 reported that they had not been aware of these influences until their mother had told them. I asked Child 4 to consider what kind of relationship they thought their parents had. Child 4 shared that there were always times when it was

strained, the hitting had occurred more recently. Child 4 stated that the violence would be over quickly, their mother would then explain to them and their siblings why the violence had been necessary.

121) Child 4 stated that their parents would sometimes sleep in the chairs in the lounge, other times they would sleep in the chairs in their bedroom. Child 4 reported that there were occasions when they all slept in chairs, describing how their father would often wake at 4am. Child 4 stated that they were early risers.

122) Child 4 described that they had been happiest in 2015, when the family visited Germany. The Child has also enjoyed a recent family visit to Kew Gardens. The Child then added that it had been nice to walk around without being watched, when I asked them why, they thought they may be watched he stated that they are a large family and that they may look odd walking around the estate where they live".

123) Child 4 had taken their exams in English and Maths and was waiting for the results, which should come in January, and that they were now studying hard for their science.

124) The review notes that the two younger children spoke in much less detail and often gave vague answers during their interviews. All 3 of the younger siblings gave consistent accounts of how they discovered their father unwell on the night of his murder, their attempts to revive him and what they did after he died. They thought their father would get better as he had done in the past.

125) Child 1 was not involved in the attempts to revive their father as they had felt unwell and had gone to their room.

126) It was explained to Andrew (brother of Philip) how the children did not seem to understand why he would want to see them. The children had indicated that the relationship between their father and Andrew had not been good. They were aware of arguments taking place via the telephone. Andrew described their relationship becoming strained and mentioned arguments over greeting cards being misinterpreted.

127) To give an insight into the children's lives, extracts of their diaries were translated from German into English.

128) Child 1
Spoke of learning Latin, feeding the cat and fish, playing piano and of painting the WC along with listing the food eaten.

129) Child 2
Recorded list of food eaten; of seeing three cats in the garden; cleaning the house; shopping in Tesco and Lidl and buying a plant in Lidl.

130) There were no diary extracts for Child 3

131) Child 4

The extracts from this diary included daily updates on the weather and wind including information about the clouds and temperature. The child listened to Austrian radio specifically mentioning the Koralm railway tunnel including height and measurements. Also listed was the food eaten; of using a pair of shears to cut the front lawn and of putting up a small greenhouse. The child spoke of changing their bookshelves around all day and of cleaning their room; of playing badminton and going shopping one day. The child also spoke of a cordon in the road on one day as containers were taken away from a show home nearby. The child also spoke of painting the cloakroom and of sleeping in a chair for the night.

14 CHRONOLOGY

132) The family had lived since November 2014 in a large new build, 5 bedroomed, three floored, detached house on an estate. It was privately owned by the family with no mortgage.

133) Neither Philip nor Eva worked at the time of the murder. Philip used to be a music teacher working in schools, but this changed to working from a single base with students visiting a local Music Centre. He had not worked since 2015. It is believed they lived off their savings (mainly through inheritance.) Eva was a stay at home mother and acted as the children's teacher, although she had trained as a midwife previously. They had inherited money from a family member who had died. Whilst they did not work it does not appear that there were any financial issues for the family and that they appeared to be living off the inheritance. There was no evidence of financial abuse being identified in the review.

134) The eldest two children attended a local primary school from 2004 – 2006. They then attended a secondary school in the town to study for GCSEs in in academic years 11/13. The two younger children were always home schooled and not known to education services.

135) The children were not known to any services other than outside of the Review period when they were known to a GP practice. The oldest child was seen in 2014 for a minor illness and treated appropriately with no necessary follow up required. The 2nd child was seen in 2004 for back pain and referred for physiotherapy but this was later declined. There is no clear indication of where the children were born, other that the youngest being at Stoke Mandeville. This child was taken to the surgery for routine vaccinations in 2005 but did not attend any follow up vaccinations in 2006. In May 2008, the youngest received boosters of diphtheria, tetanus, pertussis, polio, and haemophilus B. During this appointment Eva was informed that the youngest child's immunisations were incomplete. Eva agreed to MMR vaccine being given but said she would make a further appointment. There is no evidence this happened.

136) The family appears to have withdrawn from the community and their extended family. Indeed, Philip has a brother in Scotland who tried to contact him when their mother was ill. She subsequently died but Philip nor the rest of the family replied to any contact. Eva has a larger dispersed family, but she stopped connecting with them. It was reported by a branch of the family in Canada, (a cousin) who came over in 2017, that they arrived and tried to visit the family, however they were refused entry at the door.

137) The house, at the time of the police entering the property, was cluttered with belongings but there were also areas, such as the children's rooms that were tidier and seemed well used. The

children each had a room in the house which are described as being full of traditional crafts, such as knitting and woodwork. Whilst not identified as hoarders, the family did not appear to throw anything out. The downstairs living space and master bedroom were more cluttered. The kitchen and dining room were used as would normally be expected. Although cluttered the house did appear that it was cleaned regularly, and it was not disordered. The children appeared to have been brought up in an environment which seemed to be a rather old traditional style. There was little technology in the house as there were no phones, tv, computers etc., but there was a radio. The children have been brought up in a conditioned environment which could be viewed as an old traditional style.

138) The children did not mix with other children. The family went out to shop but lived very frugally. They owned two cars. Other trips out appear to have been for educational purposes, such as Kew Gardens where they had recently been for Eva's birthday.

139) On the day of Philip's murder, it appears he had been unwell and was struggling to breathe and was in the bathroom. He did not like seeking medical attention. He was a sufferer of asthma but when he attended hospital in 2005 with an exacerbation of his asthma symptoms, it is suggested that he did not like the medical assistance received and possibly discharged himself. The short report from Buckinghamshire Healthcare (NHS) Trust (BHT) referring to this attendance at hospital does not suggest he discharged himself, but he left at 3.30am, leaving by his own transport.

140) Philip had become unwell. The family were trying to home treat him using items such as Vicks VapoRub[4]. He was in the bathroom on the floor when the ambulance crew arrived. It is claimed that he said he did not want to seek medical assistance. It is reported that he died on the previous day at 7pm, however, Eva did not seek any medical assistance for Philip that day. Her first contact was going to the neighbour's house to ask them to call for an ambulance at 7.30am the following day. Philip and Eva did not have a phone; hence the request was made to the neighbour to call. Eva called for an Ambulance. South Central Ambulance Service (SCAS) notified the police due to the injuries to Philip's head. Eva was arrested soon after police attended as there were obvious injuries to Philip.

141) It seems that at some point after 2015, when Philip stopped working and bought the property, that they currently lived in their lifestyle changed. The Panel has been unable to establish what might have been the catalyst for this. It is possible that Philip was regularly abused by Eva, who, it is believed used to hit him over the head and back with a rolling pin and a hairbrush. A neighbour suggested that Philip used to be an overweight man who, since 2015, had become about half his original size and appeared to be barely able to walk.

142) The family had lived in the town for many years and the children were born in the town.

143) There is very limited engagement with the family, indeed the only statutory agency involvements were in June 2017 when the Police were called by a neighbour of the family after a visiting cousin of Eva's, who currently lives in Canada, had been so concerned about the lack of contact with the family they made a trip to visit them. However, the family member was refused entry at the doorstep. This resulted in the relative being concerned about the family and so he attempted to contact the local Children's Safeguarding Board (now Partnership) to find out how to report his concerns. The neighbours called the Police to see if they could check on their welfare. This proved difficult but after a few days an officer did manage to speak to Eva and the children in

[4] Vicks VapoRub is an ointment which is used to relieve nasal catarrh (inflammation of mucous membranes in the nose and throat), congestion (a blocked nose), sore throat and coughs due to colds.

their garage, where she saw them on a visit to try and speak to the family. Whilst Eva went to get Philip the officer spoke with the children. The family suggested they did not answer the door to the family member as they did not want to speak with them. There were no concerns raised by either Philip or Eva with the officer about their welfare, but the officer was concerned about the emotional well-being of the children because of the family's lifestyle choice and so made a safeguarding referral. See Appendix A for Occurrence Report

144) This referral resulted in enquiries being made by the Multi Agency Safeguarding Hub (MASH) which established the family were not known to any universal agencies including a GP or schools. Despite this the case was assessed by the Team Leader as there being no role for social care at this stage and a letter was sent to the family to this effect.

145) The only engagement the Ambulance Service had was following the call from Eva when she rang for an ambulance, following Philip's murder.

146) There had been no engagement with any Education services or schools since 2016 when the eldest child left education, following attendance at a secondary school. For the two youngest children there was no engagement with state education at all.

147) None of the family had been seen by their GP since 2005. Letters had been sent to Philip about an NHS check, screening for bowel cancer and having a flu jab, but these offers were never taken up.

15 OVERVIEW

15.1 Thames Valley Police

148) The first contact Thames Valley Police had in connection with the family falls outside the scope for the review. It is referenced as it related to Philip and his brother, whom had not been in contact with each other for some time. Their mother had died and Philip's brother was unable to contact the family to advise them of their mother's passing. Despite calling at the address and leaving a message for Philip to contact the Police, he did not respond. It is thought that at the time the family may have been in Germany.

149) The next, and only other engagement with the family was in June 2017, when a welfare call was made to Thames Valley Police from a neighbour. This was instigated because of a visit from some relatives of Eva who had come over from Canada. The relatives were concerned about Eva's welfare as they had not been able to get in touch with the family for some time. During the call, the neighbour also expressed their concerns about Eva being controlled by Philip; that the children were home schooled and that the curtains were always drawn. This resulted in the Police trying to speak to the family but having to make several attempts to do this. Eva and the children were seen in the garage of the family home where they were tidying it up. Eva seemed evasive and although being asked if she felt she was controlled by Philip she said she was not and did not disclose any concerns about him. There were no safeguarding concerns or domestic abuse issues raised or indicated by either Eva or Philip.

150) The children were all spoken to by the officer when Eva left them to find Philip. They responded that they are home schooled, although the Child 1 responded that she does not go to school. When asked if they go to work, Child 1 stated that they were on a gap year doing/learning "Household duties", although going to work is something they planned to do in the future. The Officer reflected that this appeared to be an odd comment from someone of a young age and with their mother being reluctant to provide any details, this behaviour appears unusual. The children

were asked how they find home schooling and whether they enjoy it, in which Child 3 stated it gives them more time to study from home.

151) The officer attending was concerned about the children's emotional well-being and so completed a Child Protection (non-crime) incident form and completed an ABCDE [5] risk assessment. This was assessed by the MASH and referred to Children's Social Care. On this occasion it was assessed that there was no further role for the police. There is no additional information held on police systems to indicate any action taken by other agencies.

152) The final contact with the family was because of the call from the ambulance service to the family home following the murder of Philip.

15.2 South Central Ambulance Service - SCAS

153) SCAS had no previous engagement with the family until the day of the call to Philip who had been taken ill in the bathroom. The Service received a call from Eva from a neighbour's home at 07.32. During the call Eva revealed that Philip had died last night and that an ambulance was not called then.

154) On arrival the double manned crew went into the house and were taken to the bathroom where they found Philip, lying on his left side on the floor in the recovery position. His head was resting on blanket or dressing gown folded like a pillow there were no lights in the bathroom, so the room was dark. The crew had to open a blind for light. There were no signs of life visible.

155) The crew noted some injuries to Philip's head and asked Eva about them. She stated they had "fallen out" about two weeks before and she hit him over the head with a rolling pin repeatedly. Eva said that Philip did not seek medical attention and did not want to. The family had not been in contact with any health care providers since moving home 3 years ago. Eva stated that he had not re-registered at a Surgery. Eva said he had mild asthma and that he did not use drugs or alcohol. The crew did not recall if there were any previous injuries evident other than the head injuries noted. The Review Panel asked SCAS if there were any evident injuries to Eva, but the crew did not recall any.

156) The children were present, quiet, and staring whilst the crew were there. One of the children said that it happened the previous night between 7 and 8pm. Eva said that Philip developed rattling breathing and was vomiting and coughing and that one of the children attempted mouth to mouth resuscitation.

157) The crew confirmed that life was extinct and asked their Control Room to call the Police where it was confirmed that they were on their way to the property. On arrival the police declared the house as a crime scene and Philip was left in situ. The crew left at 09.34.

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[5] **The ABCDE model** was devised in 2013 following research carried out by the University of Central Lancashire (UCLAN). Initially it was an assessment tool purely for mental health issues. However, several forces including Thames Valley Police, are now using it to assess a wider spectrum of vulnerability.
The tool consists of 5 areas:
Appearance – what you see including physical indicators of vulnerability.
Behaviour – how the individual is presenting and if this is in keeping with the situation.
Communication – what the individual is saying and how they say it.
Danger – whether the individual is in danger and whether their actions put themselves or others in danger.
Environment – where they are situated and whether anyone else is there.

15.3 Clinical Commissioning Group - GP

158) There was no involvement with the family during the period of the review. Prior to the period of the review there had been no direct contact since 2005.

159) The practice had tried to engage with the victim on several occasions between January and March 2016, with letters being sent inviting Philip to make an appointment for a 'NHS Health Check' on 3 separate occasions but no appointments were made. The NHS Health Check is a health check-up for adults in England aged 40-74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes, or dementia. Adults in the 40-74 age group are invited to attend every 5 years, attendance is voluntary.

160) 2010 Philip had declined a flu vaccination at the GP Practice and had also declined to engage with GP consultation. In 2015 the practice was informed by the hospital that Philip had not responded to an invitation for bowel screening. It has been verified that the surgery had the correct addresses for the family and so letters would have been correctly addressed.

161) There was no direct contact with Eva, but the practice had been informed that she had not attended for routine breast screening in 2012 and 2015. Her occupation is not recorded in the GP records.

162) The children in the family were rarely seen. In 2014 (when Child 1 was nearly 18 years of age) they were seen in a GP clinic for a minor ailment which was treated appropriately and no follow up was needed. Child 2 was seen by a GP in 2004 (when 6 years old) with back pain and a referral for physiotherapy was made which was later declined by the family.

163) The youngest child was brought to the practice for the start of routine vaccinations in 2005. These were never completed with Eva saying she would book a further appointment, but there is no record of this having happened.

15.4 Buckinghamshire County Council – Children's Social Care

164) Prior to this Review, Children's Social Care had one safeguarding contact relating to this family. This contact was a Child Protection Occurrence received from Thames Valley Police in June 2017 because of the concerns expressed by the neighbour, following the attempted visit by relatives of Eva and of the refusal of the family to communicate with them.

165) The local safeguarding procedures did not require Thames Valley Police to complete the Multi Agency Referral Form (MARF), which is the usual trigger for progressing contacts and referrals in First Response[6].

166) The family were aware that the Police had completed a referral and at this time had requested that any contact be via letter. A letter requesting the family to contact Children's Social care was sent. A couple of attempts were also made by telephone on a number provided by health. Neither of these efforts were successful.

167) MASH checks without consent were initiated as no response had been received from the letter. The Assistant Team Manager notes that education and health have no information, the GP stated they had not seen the family for years, and the children are not registered at school. She

[6] [6] First Response is the team which takes details of concerns about a child or young person. They assess each referral and ensure that the referral reaches the appropriate team for assistance in a quick and efficient manner. https://www.bucksfamilyinfo.org/kb5/buckinghamshire/fsd/service.page?id=ohzME0tA-qA

made the decision to close the referral because in her view the concern raised by the neighbour 'does not seem substantiated in any way' and they were of the view 'that at this stage there is no role for social care at this time'. This is further considered in the Analysis section of the Review.

168) It has now been established that an email expressing concerns about the family was sent to BCC by the Canadian Cousin, but it was never received as there was an incorrect letter used in the email address.

15.5 Buckinghamshire County Council – Education

169) The children were not known to the Education Service for the period of the scope for this Review. The children all had some home schooling. Indeed, only Child 1 and Child 2 had attended any schools within the County. Child 1 and Child 2 both attended an Infant and junior school in the local town. For Child 1, they attended primary education from 2001 to 2006; and for Child 2 they received primary education from 2003 to 2006. After these periods they did not receive a secondary education until it was time to sit examinations and so for Child 1, they attended two different schools, the first between 2011 and 2013 and then moved to another school until 2015. Child 2 attended the same schools but from 2013 to 2014 for the first school and then to 2016 for the second school.

170) Neither Child 3 nor 4 attended any schools. Child 4 was not known to the education service.

15.6 Buckinghamshire Healthcare (NHS) Trust – BHT

171) There are no records held for any members of the family, other than one report in 2004, of Philip attending a hospital with an acute asthma attack. He was at the hospital for a few hours and after treatment Philip left the hospital in the early hours of the morning via his own transport. There are no records to show if Philip discharged himself or was discharged by the hospital.

172) There were no other engagements with the family by any other known services.

16 ANALYSIS

16.1 Thames Valley Police

173) Following the call by the neighbour to police in June 2017, after the visit of the relatives from Canada not being happy about the family not wanting to talk to them, the call was classified as a "fear for welfare" call. The neighbour also added his own previously unreported observations of what he perceived to be possibly controlling behaviour by Philip towards Eva. The neighbour also referred to the family living an isolated existence but that the neighbour had never witnessed any harm or neglect towards either adults or children.

174) The incident was correctly classified and graded as a 'by arrangement' commitment as there was no suggestion of any immediate threat to anybody involved. Consequently, there were several unsuccessful attempts to contact the family over the next four days. It is entirely possible that they may have chosen to not answer the door on these occasions as they had done so earlier with the relative.

175) There were several attempts by officers to contact them over the next few days. None of the officers reported anything untoward at the address that would increase the level of concern. At

no point did anybody report concerns that would escalate the situation to a scenario where officers might consider using their powers under Section 17 of PACE[7].

176) During these periods when it was not possible to resource this enquiry the log was updated accordingly, and risk assessed by the duty sergeant[8]. In each case it was recognised that the welfare check needed to be carried out but there was no new information to demonstrate an increased level of concern.

177) The enquiry was allocated to an Investigation Hub (IHub) officer[9] who did manage to make contact 4 days later when she located Eva and the children in the garage adjoining their address. There is no suggestion that the children and Eva were living in the garage or otherwise being held there against their will. When spoken to, Eva was reluctant to engage but the attending officer eventually gained a rapport with Child 2 who seemed to understand the reason for the visit.

178) Other than not speaking to the children individually to give each the opportunity to make independent disclosures, the officer complied with operational guidance with regards to child protection and domestic abuse by separating parties and enabling the voice of the child to be heard. It is difficult to see how a single crewed officer could have done more to separate the various parties.

179) The attending officer discussed the matter with her supervisor and decided to create a Child Protection occurrence in June 2107, within which the officer completed her ABCDE risk assessment of the children denoting concerns about emotional abuse. This report was forwarded to the MASH for onward referral to Children's Social Care. This was an appropriate course of action as no substantive offences were uncovered.

180) The attending officer was interviewed about her attendance and she felt that she dealt with the incident correctly based on the information available to her at the time. She was happy to attend the incident as a single crewed officer as it was a by arrangement commitment that had been dragging on for some time.

181) She was satisfied that she gave the family members adequate opportunity to express any concerns to her. Whilst she did not split the children up, they communicated freely with her once their mother had gone inside. During the officer's visit she did not witness any evidence of domestic abuse and as such did not see the need to complete a DASH form. She did not ask DASH based questions other than to address the suggestion of controlling behaviour which she saw as the other specific concern that had been raised by the original call.

182) Within the ABCDE assessment submitted, the officer referred to the family as making 'odd' comments. This view was based on Eva's initial evasiveness; the fact that the children had to

[7] First Response is the team which takes details of concerns about a child or young person. They assess each referral and ensure that the referral reaches the appropriate team for assistance in a quick and efficient manner. https://www.bucksfamilyinfo.org/kb5/buckinghamshire/fsd/service.page?id=ohzME0tA-qA

[8] Whilst the incident attendance escalation policy normally only applies to Immediate & Urgent Attendance incidents this was good practice to notify a patrol Sgt when the incident was un-resourced

[9] The Investigation Hub (IHub) forms part of the current Operational Model employed on Local Police Areas. The model consists of police officers divided between Emergency Response Teams (ERT) and Investigation Hubs. The former would normally attend incidents, complete initial enquiries before handing any ongoing investigation to the IHub. The model allows for IHub officers to attend incidents in support of their ERT colleagues in times of peak demand.

reassure Eva and encourage her to communicate with the officer; as well as Child 2 who made comments about their gap year activity which was "to learn domestic duties".

183) The Officer's main concern was the emotional wellbeing of the children and so recorded a Child Protection incident. This was based on her view that there was a potential for emotional abuse if this alternative lifestyle was being imposed on the children. She described a family that, whilst unusual, just wanted to keep themselves to themselves. Her gut feeling was that the lifestyle was potentially unfair and damaging to the children who amongst other things were being denied contact with other young people. It was not that there was domestic abuse taking place.

184) When Philip came out of the house to speak with the officer it did not raise any concerns in the manner that he presented himself. The officer's impression was Eva did not want her to enter the house albeit she was not specifically denied entry and did not request entry. The officer saw no reason to enter the house as the concern was for Eva who she had already managed to talk to on her own and she had managed to see the whole family who appeared to be well.

185) The call had raised two areas of concern, the first of the welfare of the whole family and the officer was happy that they were all alive and well. The second concern was about the possible controlling behaviour of Philip, and by speaking with Eva and the children there was no evidence of this or any other form of domestic abuse, with both Eva and the children being asked separately but all with a negative result.

186) On speaking with Philip, the officer did not have any concerns about him being the victim of abuse and so she did not seek to speak to him away from the others. The officer did discuss with her supervising sergeant, the possibility that that the family's lifestyle could have been based around religious beliefs, although there was no mention or discussion of this with the family.

187) The Panel consider the officer acted correctly and that although it took four days to eventually see the family, appropriate efforts were made, and regular reviews of the circumstances and risk level took place. At no stage did any further information become available that would have increased concern and prompted officers to use legislation to force entry into the property. In line with the Operating Model an IHub officer was allocated to the enquiry to assist the emergency response team when they were unable to resource it.

188) The Police Review looked at the initial response up to the point when the body of Philip was seen by police officers and a crime scene established.

189) This incident came about because of a call from the ambulance service who had previously been called by Eva and were already on scene at the home address. It was graded as an urgent attendance commitment which was an appropriate response.

190) When the officers arrived and liaised with the paramedics, they made the correct decision to deal with the death as 'unexplained' securing the property as a potential crime scene. When the information came to light from Eva admitting that she had assaulted Philip, she was arrested, which is the correct procedure.

191) An experienced staff member from the Contact Management Team[10], reviewed the Command & Control logs and is of the opinion that both the call about welfare and the call about the death of Philip were graded and classified correctly at the point of call. The staff member stated that the

[10] Contact Management replaced the old Control Room & Enquiry Department (CRED) which is the department that receives calls from the public and dispatches police resources to deal with incidents

TVP escalation policy[11] is intended for calls that cannot be resourced rather than those that cannot be resolved (in this instance because officers could get no reply at the address).

192) The policy was, however, applied to the first call about welfare when Patrol Sergeants were made aware of the inability to contact the family and were asked to review it. This kept the commitment in view during periods when it could not be resourced. Contact Management staff and local sergeants reviewed the log whilst it remained unresolved.

193) For the calls relating to the death of Philip, the experienced Contact Management member of staff suggests that it could have been considered for upgrade to an immediate response. The initial call to police was made by the SCAS Emergency Operations Centre (EOC) as the caller had stated that the person had died the night before but that no emergency services were called at the time. The attending SCAS crew then sent a further message to police as they had found Philip dead on arrival. The Contact Management Officer considered that the urgent attendance was still an appropriate grading. A change in response category would not have made any material difference to the response as officers and a supervising sergeant were on scene promptly. The Review feels that the update from SCAS, made 4 minutes after the initial call, made little difference to the police response, as officers had already been dispatched and arrived on scene 10 minutes after the subsequent update.

194) There are no recommendations for Thames Valley Police.

16.2 South Central Ambulance Service (SCAS)

195) The only engagement with the family for SCAS was the incident they were called to when. The actions of the Service have been reviewed and found to be within the Service's practice guidelines. There were no service delivery or care issues identified. There are no recommendations for SCAS.

16.3 Clinical Commissioning Group - GP

196) There was no contact with the family during the period of scope for the Review. Prior to the review period there was little engagement from the family with the practice. Medical treatment of the children several years earlier was appropriate and on-going referrals were made. The lack of engagement from both the victim and alleged perpetrator in routine health screening would not be have been considered as unusual. The national uptake rates for NHS Health Check is less than 50% and for breast screening is approximately 70%. Appropriate attempts were made to invite the family for these screening programmes.

197) Child 4 did not receive all their routine vaccinations as they did not have their MMR[12] immunisations. In 2006, the National uptake of the MMR vaccination was only 84% (currently 91%) and whilst vaccinations are recommended, they are not compulsory, therefore parents have a right to choose whether to have their children vaccinated. There was an appropriate discussion with the mother about the vaccinations, but she did not make a further appointment for them to be given. This would not have been considered as unusual or concerning.

198) There are no recommendations for The Clinical Commissioning Group.

[11] The Escalation Policy enables Contact Management staff to escalate any un-resourced commitment via their own line supervision and to supervisors on Local Police Areas (LPAs) to ensure that incidents are attended. Each level of escalation involves a higher-ranking officer and a wider search for resources.

[12] MMR- Measles, Mumps and Rubella

16.4 Buckinghamshire County Council – Children's Social Care

199) Following the contact from Thames Valley Police in late June 2017, Social Workers in the First Response Team wrote to the family to establish contact in early July 2017. A telephone call was made to the family using a number provided by health as there had been no response to the letter. Following no response to a second telephone call the following day, MASH checks were undertaken by Children's Social Care without consent as the family could not be contacted via telephone or letter.

200) The MASH checks established that education and health had no information on this family - the GP stated they had not seen the family for years and the children were not registered at school. There had been no safeguarding concerns raised by other agencies. The Team Manager was of the view that although the police report suggested mother's demeanour was not what they expected 'there were no disclosures'.

201) The Police saw the children and did not express any immediate safeguarding concerns. The view of the Team Manager who reviewed the contact and work undertaken in MASH was that the concerns raised by the neighbour did not seem substantiated. The Team Manager's decision was that at this stage there was no role for social care. A letter was sent to the family advising them that Children's Social Care would not be taking any further action.

202) The Manager could have been more curious and considered arranging a visit to the family, given that no universal agencies (including GP and school) had seen the family for some time, and the family had refused to open the door to another family member. In addition, it was pointless to try and contact the family via telephone when it was recorded by the Police in their occurrence log that the landline in the home was not working, and Eva told the Police officer that she did not have a mobile phone.

203) With the family not being in contact with a GP and the children being home schooled, this should have triggered the Team Manager to consider what might have been going on in the home and what life might be like for the children. A visit to the home to see the children and family; consider if and why Eva may be suffering any level of paranoia (the word paranoia was used in BCC paperwork and was not used in the police report and it is thought that the social worker completing the paperwork interpreted this from the Police referral and information from the neighbour) would have offered a window into family life and an opportunity to establish if any support was needed and if the children were or could be likely to be at risk of harm or significant harm.

204) Whilst there was no indication or evidence at this time (June 2017) that domestic abuse was occurring within this family, a visit to the home would have offered an insight into family life and could have revealed, through talking to the children individually and also talking to the family, what the relationships were like between the different family members and if there were any indicators or signs of domestic abuse, including coercive control. The Officer who made the decision that there was no role for Children's Social Care at this time and closed the referral, could not be interviewed as they no longer work for BCC.

205) It is acknowledged by Social Care that practice standards at this time were not at the required standard, as reflected in the November 2017 Ofsted Inspection Report. The improvement plan in place has seen changes in MASH which is ensuring there is a greater consistency in compliance with expected practice standards. These improvements are highlighted in the May 2019 Ofsted monitoring letter. Alongside this, the service has undertaken work to improve the sharing of

learning from local and national serious case reviews which have relevant lessons in this case about the potential safeguarding risks where children are home educated.

206) As part of the Review process the Panel requested that further investigations were made to see why there did not appear to be any reference to the email sent in June 2017 by the cousin in Canada which set out his welfare concerns about the family. There was no record of this being received and once a copy of the email had been shared with the Service by the Panel Chair, it was established that the email address used was incorrect with a 'c' being used in the word 'response' instead of an 's'.

207) The Panel felt there should be consideration given for reports or disclosures from members of the public to have a telephone option available. This should require the agency responding to the call to gather a certain level of information before asking for an email to be sent. This would minimise the likelihood of missing reports and of being able to follow up if no email is received. The system of emailing is not always accessible and there should be a way to ensure that this is an easy process to report concerns with an option other than email. A review of how referrals are sent in to Children's Social Care has been undertaken in the last year and the on-line Multi Agency Referral Form (MARF) has been reviewed. This was developed in conjunction with a range of partner agencies and took on board their feedback. The MARF can be accessed on the safeguarding partnership website. This has improved referrer feedback and guides the referrer to provide sufficient information so that timely decisions can be made.

Recommendation 1 - for Buckinghamshire Children's Social Care

Processes in MASH and First Response will be reviewed by the Head of Service to ensure staff have due regard to the potential risks that home schooling and lack of engagement with universal services may have on the safety and welfare of children.

16.5 Buckinghamshire County Council – Education

208) The Education Service had little to no engagement with the children and family and certainly none for the period of the review as the family chose an Elective Home Education for the children. Elective Home Education refers to a child being educated at home following a decision by their parent to educate them outside the school system.

209) Recorded Home Educated children have increased in Buckinghamshire from about 300 registered in 2013 to 600 in 2018. With no current requirement for a child to be registered as being home educated the actual number could be higher. At present the only responsibility is placed on a school to notify the education department when they are aware that a child previously in school has left to be home educated. Therefore, this does not pick up any child who never enters the education system.

210) Local authorities have no statutory duties in relation to monitoring the quality of home education on a routine basis. However, under Section 437(1) of the Education Act 1996, local authorities shall intervene if it appears that parents are not providing a suitable education. This section states that:

211) "If it appears to a local education authority that a child of compulsory school age in their area is not receiving suitable education, either by regular attendance at school or otherwise, they shall serve a notice in writing on the parent requiring him to satisfy them within the period specified in the notice that the child is receiving such education."

212) Local authorities have no powers to enter the homes of, or otherwise see, children for the purposes of monitoring the provision of elective home education. Parents are not required to register or seek approval from the local authority to educate their children at home.

213) Elective Home Education is a topic currently being discussed at a national level. The Department for Education produced new guidance in April 2019 the first since 2007. In addition, the Department launched a consultation which closed on 24th June 2019 entitled "Children not in School"[13]. The consultation is based around four themes:

- the introduction of a duty on local authorities to maintain a register of children of compulsory school age who are not registered at schools of a specified type;
- the introduction of a duty on parents to provide information to their home local authority if their children are within the scope of such a register;
- the introduction of a duty on education settings attended by the children on the register to respond to enquiries from local authorities about the education provided to individual children. The settings in scope would not include those providing supplementary education outside school hours;
- the introduction of a duty on local authorities to provide support to home educating families - if it is requested by such families.

214) Buckinghamshire County Council's Education Service responded to the consultation but in hindsight regretted not suggesting that a child being home educated should be seen in their home environment which would be an added welfare safeguard.

215) Buckinghamshire County Council Education Service had already strengthened its approach to home educated children and developed more robust systems to track and identify children not in receipt of full-time education. It is worth noting that the youngest child would not have been identified through this strengthened approach as they had never attended an educational setting. Neither parents had committed an offence by not notifying the authority.

216) It is hypothesised due to the current educational attainment of the school aged child, that if an assessment had been carried out it would have met the suitability threshold in respect to the education provided by parents. The youngest child is now at grammar school and had therefore attained a level of education which has given them a good foundation. Parents can provide evidence of the education being undertaken by their children without access to the child or the home.

217) There is no right to see the child or the home environment. It is also hypothesised due to the nature of the family's approach to life they would not have granted access to the home and therefore the ability to assess whether there were safeguarding concerns for the children would have been diminished. The Review Panel considers that there is a weakness in the consultation and suggest that the responsibility to allow the Education Department to see the child in the home environment should be added. By including an additional responsibility on Local Authorities to see

[13] https://consult.education.gov.uk/school-frameworks/children-not-in-school/supporting_documents/EHE2019consultationpaperv9.5.pdf

the child and their home environment the ability to safeguard their education and welfare would be increased.

Panel Recommendation 2

The Department for Education, as a minimum, implement changes to the Elective Home Education guidance following their Children not in Education consultation, which places a duty on parents to register their child with their Local Authority when home educating

Panel Recommendation 3

The Elective Home Education guidance following their Children not in Education consultation, should add giving Local Authorities the right to see the child and their home environment to further safeguard children.

218) There have been several serious Case Reviews which refer to home education and home schooling. Most recently a review in Northamptonshire called 'Overview Report - Child Ab by Moira Murray – October 2019'[14] which highlighted that, whilst it is currently a parent's right to elect to home educate their child, the sanctions for not complying with the local authority requirement to visit the child's home, interview the child, see the child's work and provide information concerning the programme of work produced by the child, are limited. This review made the following recommendation:

> The Child Safeguarding Practice Review Panel are asked to consider the issue of Elective Home Education and hidden children, which is a national issue, with a view to undertaking a future thematic review.

16.6 Buckinghamshire Healthcare (NHS) Trust – BHT

219) With there being no engagement with the service since 2005 when Philip went to hospital with a severe asthma attack and the service correctly treated him and notifying his GP following his discharge, there is no further analysis of this incident. There are no recommendations for Buckinghamshire Healthcare Trust.

17 ADDRESSING THE TERMS OF REFERENCE ANALYSIS

Specific issues to address: -

- Was there evidence of a risk of serious harm to the victim or the perpetrator that was not recognised or identified by the agencies in contact with them? Was there any evidence which might have raised a homicide concern for the victim or the perpetrator?

220) There was no direct evidence available to any of the services involved with the family, nor to the family and neighbours which might have suggested that there was a serious risk of harm to the victim or the perpetrator. The neighbours suggested that they thought Philip may have dominated Eva, but this was based purely on the fact that Eva rarely spoke in the presence of Philip but may say hello occasionally if she was on her own. There was no indication that Eva was abusing Philip. The reports from the neighbours suggest that Philip had lost a significant amount of weight and was seen wearing a hat even when there was warm weather, and that his health seemed to have deteriorated considerably whilst they had been neighbours. However, despite this, it was not suspected that Philip was being abused by Eva. There was no evidence that Eva was abused by Philip. There was reference from Child 4 who mentioned that their father was

[14] http://www.northamptonshirescb.org.uk/about-northamptonshire-safeguarding-children-partnership/scr/childab/

"hurting and throwing their mummy about" in 2015. The child described how Philip was provocative toward their mother and would bring up things from his first marriage. Their father had a change of personality and his mother started hitting him with a rolling pin. Eva would have been capable of seeking assistance had there been abuse albeit that this would have likely been by verbally reporting to a service due to the lack of technology available to the family.

221) From the evidence established as part of this Review, Eva used physical abuse to control Philip. Their isolation and his dishevelled appearance are indicators which might have indicated that there was a problem at home but as the family did not engage with any services or with friends, family, or neighbours this was not overtly evident.

222) There was no visit or further investigation by BCC Children's Services, once they had a report of concerns about the family, and following the Police raising the safeguarding concern about the emotional well-being of the children. A home visit and discussion with all parties may have revealed further information about lifestyle and may have identified any concerns about the health and welfare of all the members of the family.

223) It was unfortunate that the email sent to First response/MASH by the cousin in Canada, which contained concerns about the family, was sent to an incorrect address and therefore was not received by Buckinghamshire County Council. This email would have given extra strength to the concern following the police visit.

- Family, Friends, neighbours, and work colleagues

a) Whether family or friends want to participate in the review. If so, ascertain whether they were aware of any circumstances which might have led to the homicide of the victim?

224) The brother of Philip and the cousin of Eva have both been keen to participate in the Review. In respect to the brother, he provided a full account in response to questions asked by the Chair and requested that the review consider the referral to Buckinghamshire County Council's Children's Service, which he considers was not acknowledged, acted on or feedback given to the cousin. He also asked for several other areas, including the Education Service in respect to the cutting of music services and the impact that has had on education. This being outside the scope of the Review he has been advised that this will not be covered by the Review and if he wishes to take this further it has been suggested he contact the Education Service direct.

225) The cousin of Eva had been genuinely concerned about the family and had even flown over from Canada to visit the family as he was so concerned about their welfare. Despite this concern and the fact that he reported these concerns to the Buckinghamshire First Response team, there had been no suspicion that a homicide was likely. He had been more worried about Eva's mental health and was keen to regain contact and a family relationship with Eva and her family. They had no suspicion that Philip was being abused. He is also keen that this Review considers his report to Children's Services.

b) Whether, in relation to the family, friends, work colleagues and neighbours it is known that there were or could have been any barriers experienced in reporting abuse.

226) Nothing in the Review has led to there being any indication that there might have been any barriers to any of the family reporting abuse. There were limited opportunities for the family learning how to report abuse or how to seek support, as there was no telephone, computers, or other way of finding out where to report such concerns. All the family would have been able to go to a police station or to the local authority to report any concerns, although this may have been difficult as it seems they were rarely apart.

227) The Panel is mindful that existing policies and strategies relating to domestic abuse, and particularly the Buckinghamshire Domestic Abuse Strategy 2018-2021[15] has its number one priority as "Help prevent domestic abuse from happening by raising awareness and challenging attitudes and behaviours which foster or tolerate it." Specifically, the actions to support this priority include working with wider community groups and building their awareness around domestic abuse.

c) Is there any evidence of controlling or coercive behaviour; being experienced by the victim or the perpetrator? If so, did the victim or perpetrator have appropriate opportunities to report concerns.

228) The only evidence that would have been evident of any controlling or coercive behaviour by either Philip or Eva was identified by the neighbours. They report that they felt that Philip may dominate Eva as they considered she rarely spoke or said hello even if the neighbours spoke to them. Eva occasionally said hello however, only if Philip was not there. They also report that on one occasion both families were in their own gardens and that Eva and Philip had bought some plants for the back garden. The neighbours recall hearing Eva say she wanted to put the plants in a particular place and that Philip told her he had told her where they were going and that was that. They were unhappy about the tone he used and felt he was possibly controlling. The way he spoke to Eva made the neighbours feel uncomfortable about his treatment of Eva. There was no suggestion or indication of controlling or coercive behaviour when the police officer met the family.

229) As part of Andrew's (brother of Philip) input to the Review, he, in hindsight, reflected that whilst there had been no concern about any abuse by either Philip or Eva, he was concerned that he found Eva listening in on a telephone conversation he had with Philip. At the time Andrew just thought this was a joint strategy on their part to make sure they both knew exactly what was said. In retrospect, Andrew now felt this fitted with a pattern of controlling behaviour.

230) The Panel considers that, although no-one or any agency had recognised coercive controlling behaviour, it may have been occurring, but as the family lived in isolation evidence was not available to prove this was taking place. This will have impacted on the children who are likely to have to have been a mutually supporting group as they had no other friends or relatives they could confide in. The family were not only isolated from the community but by the lack of any form of technology and were isolated from the wider world. With the children having been brought up in such isolation, they may not have known what kind of behaviour might be expected between parents. The level of control exerted in relation to home education meant the lack of the opportunity for the children to mix with their peers resulted in missed benefits that could have presented.

231) In addition, Philip suffered 78 recorded injuries, which were inflicted over a lengthy period. The children were aware of these assaults and the deterioration of their father's health, brought on by, in no small part, the regular physical abuse he endured. The children witnessed this abuse and so it is possible that they did not know it was wrong and may have accepted it as normal behaviour. It is unlikely they would have known how to, or felt empowered to, complain about inappropriate behaviour or of how to protect their father from abuse.

232) From information provided in the Police IMR, post-conviction, there is evidence of the children speaking to the TVP Family Liaison Officer and a children's social worker, about their family life.

[15] http://www.buckinghamshirepartnership.gov.uk/media/5016677/Domestic-Abuse-Strategy-2018-2021-FINAL.pdf

During these conversations, the eldest child spoke of how things had changed from around 2015, acknowledging how Eva had started hitting Philip with a rolling pin, saying that she was provoked as Philip would bring up things about his first marriage. Apparently, Eva would explain to the children why hitting Philip was necessary and that she was provoked. One of the younger children spoke of Eva trying to protect them from their father's influence and commenting that Philip was trying to set the children against their mother. There were times when family life was strained, and the hitting had occurred more recently. With the lack of community engagement and the isolation of the family as a whole; with either or both of the adults controlling the children by isolating them from young people of their own age or from attending school, they may have had no understanding that this type of behaviour is not acceptable or right.

233) The Panel has been made aware that work has been carried out across the County following the introduction of the offences relating to coercive and controlling behaviour, but that this has been in respect to professionals and does not appear to have covered much public awareness raising. It is also important that consideration is given to the affect that this type of behaviour has on children where coercive and controlling behaviour takes place.

234) The Panel considers that it is advisable for the County Domestic Violence Strategy Group to undertake public awareness raising. It is important that those who suffer coercive and controlling behaviour can recognise it and so seek support and assistance. Furthermore, that the Strategy Group ensures that future professionals training in respect to coercive and controlling behaviours, includes information about the impacts that this type of behaviour has on children who live with a controlling parent or parents. The Panel therefore make the following recommendations:

Panel Recommendation 4 - Local

- The Buckinghamshire Domestic Abuse Strategy Group undertakes public awareness raising about coercive and controlling behaviour. As a minimum there should be an action appended to the current action plan which lays out a publicity campaign around coercive control using existing media platforms.

Panel Recommendation 5 - Local

- The Buckinghamshire Domestic Abuse Strategy Group ensures that any future professionals' training in respect to coercive and controlling behaviour includes awareness raising and recognition of the impacts that there might be on the children who live with a controlling parent or parents.

d) What, if any, are the legal requirements around the notification to authorities in respect to home education by parents and schools and, if there are legal requirements, were they followed by the family and Buckinghamshire County Council – Education Department in respect to the children in this case?

235) Local authorities have no statutory duties in relation to monitoring the quality of home education on a routine basis. However, under Section 437(1) of the Education Act 1996, local authorities shall intervene if it appears that parents are not providing a suitable education.

236) Local authorities have no powers to enter the homes of, or otherwise see, children for the purposes of monitoring the provision of elective home education. Parents are not required to register or seek approval from the local authority to educate their children at home.

237) The youngest two children had never attended school and so would not have been notified to the service. Indeed, the Service was not aware of the existence of the youngest child but was

aware of the third child but that the child had never been in any formal education setting. They were aware of the elder children who had been in education as primary aged children and then returned to education as they came to take examinations for GCSEs. The correct procedures were followed by the Education Services.

e) How have these requirements changed over the years since the children were first removed from school in 2006? What does the Buckinghamshire picture look like in respect to the number of children recorded in Home Education and is this likely to be a correct number? What is the general process when a notification to Buckinghamshire County Council is received in respect to a child receiving a home education, including if these processes exceed the national legal requirements?

238) Home Education has increased in Buckinghamshire from about 300 registered in 2013 to 600 in 2018. With no current requirement for a child to be registered as being home educated this could be higher. At present the only responsibility is placed on a school notifying the education department is they are aware that a child previously in school has left to be home educated. This therefore does not pick up any child who never enters the education system.

239) This may change if there are legislative changes following the recent "Children Missing Education" consultation.

240) In the view of the Panel this would be a very welcome and important change in the process and will offer much more protection for children in respect to their education and welfare. By including an additional responsibility on Local Authorities to see the child and their home environment the ability to safeguard their education and welfare would be increased.

241) At present the local authority follow the guidelines called Elective Home Education - Departmental guidance for local authorities. This was first published in 2007 and in 2013 The latest edition of these guidelines was issued in April 2019[16]. The two eldest children were known to the service and had been in and out of education at various times and so had been on the Education Services records. For the youngest two children, they were not known to the service at all.

f) What might the impact of the way the family lived in social isolation have had on the children in the past and of how they move forward?

242) The family had no social interaction with the community and the children did not have any friends or communicate with anyone outside of the family. They will have lacked any peer engagement, support or friendships which will have enabled them to have a socially active life. Instead they lived in social isolation within a house of only family members. With no technology in the house the children will not have had the opportunity to learn skills including social skills and information which would help them as they moved into adulthood and eventually venture away from the family home and seek employment.

243) The only support mechanism for the children will have been them mutually supporting each other, but with none of them having a window on life in the outside world, they will have been very restricted in the support and advice they could offer each other. They will have lacked social skills that might be expected of young people of their age. This isolation was also extended to their

[16]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/791527/Elective_home_education_gudiance_for_LAv2.0.pdf

wider family, with the children not being able to socially interact with their grand-parents, or other wider family members.

244) Research about the impacts that coercive and controlling behaviour has on children shows that

> The isolation that children lived with because of perpetrators'/ fathers' controlling tactics severely limited children's opportunities to create resilience-building relationships with non-abusive people outside their immediate family. The multiple benefits that positive experiences with grandparents, friends or in after-school clubs can give to children's social skills, confidence and development were therefore denied to these children. [17]
>
> ….. findings indicated that perpetrators'/fathers' coercive control often prevented children from spending time with their mothers and grandparents, visiting other children's houses, and engaging in extracurricular activities. These non-violent behaviours from perpetrators/fathers placed children in isolated, disempowering, and constrained worlds, which could hamper children's resilience and development and contribute to emotional/behavioural problems. [18]
>
> Based on the known overlap of domestic violence with coercive control and child maltreatment, we can anticipate that coercive control extends to children in a sizable proportion of cases. Even when children are direct targets, we consider them "secondary" victims. This is not because the harm they suffer is "collateral damage" or of secondary importance—it is not—but rather because the children are almost always being harmed when, why, and how they are to subordinate the mother. [19]
>
> All children in relationships where abuse occurs are harmed to some extent ([20]Fong, Hawes, & Allen, 2017).

245) The children were home educated, and it seems to a good standard as the older ones achieved passes in the examinations they sat when returning to school to take them. The younger ones are now undertaking schooling and appear to be progressing well. This will stand them in good stead as they move forward with their lives. These standards are good, considering that the education must have come from book research and their parents' knowledge and input into their education.

246) They are now being fully supported by teams within Social Care and the feedback from a family member who has been able to re-connect with the family following years of Philip and Eva refusing to connect with him has been positive. The children will need ongoing support as they adjust to a totally different lifestyle as they have now been left with no parents to support them. The children will learn how to communicate with their peers, how to look after themselves and about technology which will ultimately help them secure good jobs and a secure lifestyle as they move forward. They are currently all living together and progressing well.

g) Did the family have any religious beliefs or belong or follow any cult, and if so, did they attend meetings or services, and can this have attributed to their lifestyle choice?

[17] Emma Katz – 2015 Beyond the Physical Incident Model: How Children Living with Domestic Violence are Harmed By and Resist Regimes of Coercive Control

[18] Callaghan et al 2018 - Beyond "Witnessing": Children's Experiences of Coercive Control in Domestic Violence and Abuse

[19] Stark and Hester 2018 - Coercive Control: Update and Review

[20] Fong, Hawes, & Allen, 2017 A systematic review of risk and protective factors for externalizing problems in children exposed to intimate partner violence. Trauma, Violence, & Abuse

247) There is no evidence of the family currently following any religion or cult. They no longer attended any religious meetings or gatherings. It seems from the information provided by their families that in the past they had followed a Christian, "Bible reading religion", but it is unclear why they chose to stop being practising Christians and attend church. It is therefore not possible to assess if this change of religious beliefs or following contributed to their lifestyle as we are unable to confirm if the family started following another religion or cult.

h) Where any agencies had a connection or link with the family, can it be shown that those involved displayed evidence of professional curiosity particularly in respect to their choice about how they lived and raised the children?

248) The only agencies that there was any meaningful engagement with the family over the last year were Thames Valley Police and Children's Social Care, following the raising of the concern by the Canadian family. The police officer who was eventually able to speak to the family was satisfied that the children were not in any imminent danger but that there was an emotional well-being concern about them. There did not appear to be any concern about either Eva or Philip. The officer saw the family in the garage and did not go into the house. She spoke to the children separately as a group when Eva went indoors to find Philip. A Child Protection (Non-crime) occurrence was created & Children's Social Care notified via the MASH. An ABCDE risk assessment was completed within the NICHE template including "Voice of the child" section. The officer's overriding concern was the emotional wellbeing of the children hence the recording of a Child Protection incident. This was based on her view that there was a potential for emotional abuse if this alternative lifestyle was being imposed on the children. This was because the children gave slightly unusual responses to the officer, such as the older child was learning how to do household duties in her gap year. Had the meeting taken place in the house, there might have been more cause for concern, but the officer had spoken separately to Eva before she went to find Philip and did not disclose any concerns.

249) In respect to Children's Social Care, after having had the concern raised by the Canadian family and then also when the Child Protection (Non-Crime) occurrence was completed and submitted to the MASH, the way this concern was handled was not satisfactory. Despite the Service being made aware that they family did not have a home or mobile phone they rang what we believe was an old number for the family. The research revealed that the family was not in contact with a GP and the children were being home schooled. This should have triggered the Team Manager to consider what might have been going on in the home and what life might be like for the children. A visit to the home to see the children would have offered a window into family life and an opportunity to establish if any support was needed and if the children were or likely to be at risk of harm or significant harm. This lack of appropriate action showed an absence of professional curiosity about why a family should have no contact with a GP and have children who are home schooled. Indeed, the youngest child was not even known to the Service.

i) Was there any implication in respect to the homicide which might be attributed to the family having no access to technology?

250) It is not possible to accurately assess whether the lack of technology might have had any impact on this case or indeed if the lack of technology might have been a trigger for the homicide or the ability to report concerns and possibly raise an alarm. In the times we live it is difficult for many people to understand how people exist without technology. There are still people who do not use technology as part of their everyday life, be that the internet, television radio or phones. The Office of National Statistics for 2018[21] revealed the following:

[21] https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2018

- In 2018, 90% of adults in the UK were recent internet users, up from 89% in 2017.
- 8.4% of adults had never used the internet in 2018, down from 9.2% in 2017.
- Virtually all adults aged 16 to 34 years were recent internet users (99%) in 2018, compared with 44% of adults aged 75 years and over.

251) Research on how many households have TVs in the Uk revealed that as at March 2018, statistics from the Broadcasters Audience Research Board (BARB)[22] show that around 95% of UK are licensable.

252) Both these sets of facts put Eva and Philip in the small minority of households that do not have access to the internet or to a TV. The Panel feels that the lack of technology was not in itself a trigger to the homicide or abuse suffered by Philip.

- Could improvement in any of the following have led to a different outcome for Philip considering:

Communication and information-sharing between services.

a) Was information or were there any opportunities available which might have identified that there was a serious risk of harm the victim, but that was not shared with other agencies?

253) There was no information available that might have identified that there was a serious risk of harm to Philip. However, had the initial report of concern from the Canadian family been thoroughly investigated it may have revealed a different story which might have led to information being shared with other services who may then have been able to act to help the family.

b) In circumstances where information or opportunities were available and shared, were they acted upon in accordance with the agencies' recognised best professional practice?

254) The Police correctly share the safeguarding concerns with Buckinghamshire County Council Children's Social Care which was in line with their professional practice guidelines.

c) Communication within services – was relevant information about the victim shared and acted upon appropriately within agencies?

255) There had been no professional engagement with the family for several years. This included no GP attendance, which is the service that generally may have had an engagement with most people. This therefore means that it had not been possible to share or act upon information shared by engaging services.

256) The Police submitted a safeguarding concern to the County Council's Children's Services about the emotional well-being of the children, but CSC could have been more curious following this report. The officer allocated the concern closed the case because they could not get hold of the family and there was no supporting evidence. The officer did not consider that the fact the children were not known to universal services including a GP and should have been a cause for concern. As a minimum a visit should have been arranged. This non-action is a failure of Children's Services to investigate.

d) Is suitable advice and information available and accessible, including the availability of specialist services, for those who may be at risk of experiencing domestic abuse?

[22] https://www.tvlicensing.co.uk/about/foi-licences-facts-and-figures-AB18

257) Buckinghamshire has good networks and support systems for providing information about domestic abuse; how to report abuse; and support services. Information is easily accessible in a variety of forms from services including Thames Valley Police; each of the District Councils in the County; The County Council; Women's Aid; Buckinghamshire Family Information Service and Citizens Advice. Each of these sites contain helpful numbers and contacts for advice and support, including support lines and services for men who are suffering abuse. It would be possible to report or talk to someone at each of these agencies by either calling, sending in an email request or by visiting the agency.

- Does the homicide appear to have any implications or reputational issues for any of the agencies or professionals?

258) There do not appear to be any implications or reputational issues arising from this review which would affect any of the agencies or professionals involved.

- Does the homicide suggest that national or local procedures or protocols may need to be changed or are not adequately followed or understood?

259) Whilst there are no national procedures or reputational issues that have been identified for the homicide, the analysis has identified that there is a concern about families who choose to 'home educate' and that, unless the child has been in the school environment at some time during their school years, the education department may never know of the existence of these children. The 'Children not in School' Consultation may go some way to addressing some of these issues.

260) It is acknowledged by Social Care that practice standards at this time were not at the required standard, as reflected in the November 2017 Ofsted Inspection Report. The improvement plan in place has seen changes in MASH which is ensuring there is a greater consistency in compliance with expected practice standards. These improvements are highlighted in the May 2019 Ofsted monitoring letter. Alongside this, the service has undertaken work to improve the sharing of learning from local and national serious case reviews which have relevant lessons in this case about the potential safeguarding risks where children are home educated.

18 CONCLUSIONS

261) This Review has identified that this is an unusual set of circumstances which has meant that a family is almost invisible to the main statutory and universal services, including a GP. A family that had been functioning in a more conventional style for some years and then suddenly, for reasons we are unable to establish, then chose to remove themselves from society. They removed two children from education and did not enter two more into any school; no longer sought medical assistance, although clearly it may have helped Philip who seemed to have several health problems. They chose to no longer have any modern technology, except for a radio. Where they had in the past had a telephone, they no longer used one.

262) The withdrawal of the children from education and the non-attendance at any educational establishment for one of the children meant that they had become virtually invisible to the education services.

263) They stopped contact with their families, indeed on a couple of occasions they were notified of deaths in their families, but they did not acknowledge these notifications. One of the notifications included the death of Philip's mother. Their extended families were genuinely concerned about why they no longer chose to communicate with them and ultimately the Canadian cousin of Eva travelled to the UK to try and establish if the family were well.

264) When an alarm was raised by Thames Valley Police, following the call to police by a neighbour, the response from Buckinghamshire County Council, First Response and MASH should have been more curious. This was perhaps the only opportunity for an intervention to have been made and because it was not sufficiently investigated or any degree of professional curiosity applied, and it was closed with no further action.

265) The Canadian cousin of Eva sent a lengthy email of concern to the First Response email address, but this was never received by the Service as an incorrect address was used. It is very unfortunate that this occurred as, had the Service received the email, even if the family did not respond to a letter sent by the Service, undoubtedly a visit to the home would have been made.

266) The long-term and consistent physical abuse on Philip by Eva led to a long and painful period of possibly 3 years where Philip received significant injuries. he did not present to health services and so was not treated by any medical service for these injuries. Ultimately this led to his collapse in the bathroom and, even at this time, no medical assistance was sought for him until the following day, when an ambulance was eventually called, by which time he had died.

267) This is a very sad case which has left four young people without their parents and now, not only having to cope with this loss, they are having to re-build their lives and learn how to live in a 'normal' society. The feedback from the Canadian cousin is that he has been very impressed with the work that has been provided by Social Care following this sad incident and that he has now been able to re-establish links with the children and been able to visit with them and take them out.

19 LESSONS TO BE LEARNT

268) As most services did not have any involvement with the family, through the family's choice there are not many lessons to learn about the case, except for Buckinghamshire County Council Social Care – MASH and First Response; Education Service and Thames Valley Police.

269) Buckinghamshire County Council Social Care – MASH and First Response - a visit to the family should have been arranged given that no universal agencies (GP and school) had seen the family for some time, and the family had refused to open the door to another family member. In addition, there was no point in trying to contact the family by phone as the police had already reported that did not have access to a phone.

270) The home schooling of children and the absence of contact with the family GP should have triggered consideration being given what might have been going on in the home and what life might be like for the children. A visit to the home to see the children, consider if and why Eva may be suffering any level of paranoia (the word paranoia was used in BCC paperwork and was not used in the police report and it is thought that the social worker completing the paperwork interpreted this from the Police referral and from information from the neighbour) would have offered a window into family life and an opportunity to establish if any support was needed and if the children were or likely to be at risk of harm or significant harm.

271) An improvement plan in place has seen changes in MASH which now ensure there is a greater consistency in compliance with expected practice standards. Alongside this, the service has undertaken work to improve the sharing of learning from local and national serious case reviews which have relevant lessons in this case about the potential safeguarding risks where children are home educated.

272) Thames Valley Police - followed the correct procedures and raised a safeguarding concern Buckinghamshire County Council Children's Service's.

273) The standard practice in MASH is to provide feedback to the referring agency. The revisions to the statutory safeguarding guidance (Working Together 2018) include that referring agencies should take responsibility to seek feedback if they do not receive this direct from Children's Social Care.

274) This means that it becomes the enquiring agencies' responsibility to enquire about a referral should they need to, and it would not be the receiving agency's responsibility to report back. In this case the cousin from Canada reported a concern but had not been able to establish if the concern was received or indeed acted upon. It was unfortunate that the concerns reported by the cousin were not in fact received by Social Care as an incorrect email address was used. The cousin states that he did not receive an 'Undelivered' message, following the incorrect email address being used. It is appreciated that in a case like this, the person reporting will not be advised of the progress but an acknowledgment without any case specifics being shared seems to be reasonable and reassuring to the concerned person.

275) Buckinghamshire County Council Education Service - had developed systems where reports are run from a database before this case was highlighted. These reports identify any young people where a school base has been closed as the young person is going to be Elective Home Educated but the school have not followed the correct procedure of completing an Elective Home Education Form. Retrospective reports have not been developed.

276) There continues to be a need to ensure that staff and schools are aware of their responsibilities for Elective Home Education Guidance and procedures.

277) Further work is needed on the reports to ensure they are analysed in a timely manner to identify any young people who are not on a registered school base or an Elective Home Education base. This will include reports to include children on the data base for whose education base was closed before they become statutory school age.

278) The Service will also devise an external training programme to ensure all partner agencies are aware of Elective Home Education guidance and inform the Local Authority if they are made aware a child is being home educated

20 RECOMMENDATIONS

Recommendation for Buckinghamshire **Children's Social Care**

Processes in MASH and First Response will be reviewed by the Head of Service to ensure staff have due regard to the potential risks that home schooling and lack of engagement with universal services may have on the safety and welfare of children.

Panel Recommendation 1 - National

The Home Office reviews the existing Domestic Homicide Review Guidance (2016) particularly the current suggested guidance for the timeframes to complete a homicide review. New guidance should also give more specific guidance to Police Services and other key agencies about the completion of IMRs to ensure they are completed fully from the outset which would assist in speeding up the Review process.

Panel Recommendation 2 - National

The Department for Education, as a minimum, implement changes to the Elective Home Education guidance following their Children not in Education consultation, which places a duty on parents to register their child with their Local Authority when home educating

Panel Recommendation 3 - National

The Elective Home Education guidance following their Children not in Education consultation, should add giving Local Authorities the right to see the child and their home environment to further safeguard children.

Panel Recommendation 4 - Local

The Buckinghamshire Domestic Abuse Strategy Group undertakes public awareness raising about coercive and controlling behaviour. As a minimum there should be an action appended to the current action plan which lays out a publicity campaign around coercive control using existing media platforms.

Panel Recommendation 5 - Local

The Buckinghamshire Domestic Abuse Strategy Group ensures that any future professionals' training in respect to coercive and controlling behaviour includes awareness raising and recognition of the impacts that there might be on the children who live with a controlling parent or parents.

Recommendations Education Service - BES

Recommendation 1 - BES

Continue to ensure schools and staff are fully informed of Elective Home Education Guidance and procedures (Schools Web is to be kept up to date). Regular bulletin article reminding schools of their statutory responsibility

Recommendation 2 - BES

Reports are analysed in a timely manner to identify any young people for whom we do not have a registered school base or an Elective Home Education base. Reports to include children on the data base for whose education base was closed before they become statutory school age.

Recommendation 3 - BES

Devise an external training programme to ensure all partner agencies are aware of Elective Home Education guidance and inform the Local Authority if they are made aware a child is being home educated.

20 GLOSSARY OF ACRONYMS

AAFDA	Advocacy After Fatal Domestic Abuse
AVA	Against Violence and Abuse
BCC	Buckinghamshire County Council
BES	Buckinghamshire Education Service
BHT	Buckinghamshire Healthcare NHS Trust
CCG	Clinical Commissioning Group
DASH	Domestic Abuse, Stalking and Honour Based Violence
DfE	Department for Education

DHR	Domestic Homicide Review
EOC	Emergency Operation Centre
ES	Education Service
GCSE	General Certificate of Secondary Education
GP	General Practitioner
IMR	Individual Management Review
MARF	Multi Agency Referral Form
MASH	Multi Agency Safeguarding Hub
MMR	Measles Mumps and Rubella
NHS	National Health Service
NICHE	Police records management system
OCN	Open College Network
PACE	Police and Criminal Evidence
SCAS	South Central Ambulance Service NHS Trust
SIO	Senior Investigating Officer
TVP	Thames Valley Police

Appendix A -

OFFICIAL DOCUMENT Redacted Police Occurrence Log

Child/Adult protection

#REPORTING OFFICER. No FYI Closed

Log entry: Type of risk present to child: Physical: No Emotional: Yes Sexual: No Neglect: No Comprehensive summary (include the ABCDE vulnerability assessment tool to detail):

Appearance: Children were clean and fully clothed

Behaviour: The behaviour of the family appears very odd. xxxxxx, related to a FFW for the female xxxx and 4 children (the report describes how the fear for welfare came to light after the Canadian relative's visit) Upon OIC's attendance at the H/A on xxxxx around approximately 16.30rs, there was 1 adult female (xx) and 4 children (xxxxxxx) inside an open garage located to the left hand side of the H/A. As it is not clear which house the garage belongs to, OIC asked which house they were from? xx was reluctant to give OIC any details when asked and despite explaining OIC's attendance, xx was still reluctant. Xx came across as evasive and acting odd, despite her husband (xx) being inside the house. OIC explained several times as to why OIC required the full details of everyone for the FFW, in which when her xxxxx understood, xx provided her details, although still reluctant to do so. xx was asked for a contact number, but she stated for a letter to be sent. She advised their landline was not working and that she did not have a mobile phone. xx was asked about the family member attending her H/A, in which she stated they were not welcome and xx does

not want anything to do with them. This was later confirmed by xx, who stated it was xx's cousin who turned up unannounced at their H/A without contacting them first and came all the way from Canada. Due to this they did not answer the door to the cousin. The family want to keep themselves to themselves and do not want any contact from the cousin. xx was asked away from xx about any controlling behaviour from her husband, but she denied any controlling behaviour or domestic issues. The children were asked the same while xx went to ask xx to come outside but stated there was no controlling or domestic issues with their parents.

Communication: Children gave their names to OIC in the presence of their mother. They were also communicating with OIC when spoken to - this was during the time xx went inside their H/A to ask their father xx to come outside and speak with OIC when it was requested.

Danger: Unknown

Environment: Unknown, OIC spoke with occupants within the garage at the side of their house, which the children and xx were cleaning out.

What are the views/reaction of the parents/carers? As mentioned in "behaviour" above. Due to xx's evasive behaviour on providing her details, OIC does not believe she would consent to a child protection CRI. OIC has spoken to her line manager about the family's behaviour and both Sgt and OIC believe a CP CRI would be appropriate. OIC believes it would be best for the family to be spoken to by someone in plain clothes rather than uniform. It appears an officer attending their H/A came across as a bit of a shock to them, which was confirmed by the children, as they are not used to it.

Body worn video available to view? (If so where located) N/A

What did the child say to you? (Voice of the Child) Children were asked their details while their mother was present. The children gave their full details without any hesitation unlike their mother. While their mother was inside their H/A, OIC asked what school the children go to. They responded that they are home schooled, although xx responded that she does not go to school. When asked if xx goes to work, xx stated that xx's on a gap year doing/learning "Household duties", although going to work is something xx plans to do in the future This appeared to be an odd comment from someone of a young age and with their mother being reluctant to provide any details, this behaviour appears unusual. The children were asked how they find home schooling and whether they enjoy it, in which xx stated it gives them more time to study from home.

Police actions carried out: Child protection CRI

Were Police Protection Powers considered/precluded and why? N/A

Has the child(ren) been relocated? No. If yes details of the person the child(ren) is with now. Name: Address: Telephone number: Relationship:

Were any substantive offences identified? No Child/Adult protection identified? No

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