Combined Domestic Homicide and Serious Case Review

Concerning Sue, Hayley, Sarah and Daniel

Report by David Ashcroft, Independent Overview Author

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Introduction

1. This is the Overview Report for the Joint Board Review (JBR) commissioned on behalf of Lincolnshire Safeguarding Children Board (now Partnership) and Lincolnshire Community Safety Partnership (formerly Safer Communities Lincolnshire, now Safer Lincolnshire Partnership).

2. The case concerns the murders of Sue, aged 49, and her daughter, Hayley, aged 13, by her daughter, Sarah and Sarah's boyfriend, Daniel, both aged 14 at the time of incident in April 2016.[1] All were of White British ethnicity. The murder of adults, or siblings, by children is a very rare occurrence, and the perpetrators in this case were extremely young[2]. There is little academic research into children who kill, and this case does not fit the most common pattern, which is of boys who kill with guns. Although there were turbulent relationships between the individuals involved, these were not extraordinary or unusual between adolescents and their parents and carers. All four of these individuals are therefore the principal subjects of this Joint Review.

3. Due to the unusual nature of this case and the wish to identify learning for all services and agencies from the circumstances and experience of both victims and perpetrators, it was agreed that this Review would be conducted as a combined enquiry process, meeting the requirements of both a Serious Case Review (in respect of the children involved) and a Domestic Homicide Review (in respect of the domestic nature of the crime resulting in the death of Sue). The Independent Chair of the LSCB commissioned a Serious Case Review and the Community Safety Partnership approved a Domestic Homicide Review. While the case meets the criteria for a DHR, it does not result from a history of domestic abuse or violence within a household, but from a complex set of interactions between family members, and previous exposure to, and experience of, domestic violence for all four principals over a significant period. Equally, the case is not a straightforward SCR where a child is seriously harmed, abused or dies and there is concern about agencies working together. The circumstances of this case are unusual, but there was a strong view that the circumstances of this tragic incident warranted a review of what broader learning could be gained from examining the situation of these families and the engagement of agencies and professionals with them. For this reason, detailed Terms of Reference (ToR) and Key Lines of Enquiry (KLOE) were identified and have been used to frame the individual agency reports or IMRs and will be addressed in this Overview Report. The Terms of Reference and KLOE are included in paragraphs 40 and 41 below.

4. This report has adopted pseudonyms for the subjects and anonymised other key individuals and must be regarded as strictly confidential.

Circumstances of the incident and outline of previous history

[1] These names have been agreed by the Lincolnshire Partnerships to anonymise the victims and perpetrators.

[2] Adams, K. A. (1974). The Child Who Murders: A Review of Theory and Research. Correctional Psychologist, 1(1), 51–61.

5. On Thursday 14th April 2016, Daniel and Sarah were reported missing. Sue did not turn up for work and Hayley was missing from school. On Friday 15th April police officers forced entry to the house where Sarah lived with her mother, Sue and her sister Hayley.

6. Daniel and Sarah were found lying on a mattress on the floor of the lounge. One of the officers asked Sarah where her mother was to which she replied "upstairs". Officers went upstairs where they found the body of Sue in one of the bedrooms. In a second bedroom they found the body of Hayley. Daniel and Sarah were arrested on suspicion of murder.

7. Post-mortem examinations established that the cause of death in respect of Sue was *stab wounds to the neck* and Hayley was *haemorrhage from a stab wound to the neck and smothering*. During initial police interviews Daniel and Sarah stated that they had planned the murders because Sue disapproved of Sarah seeing Daniel and Sarah felt that her mother always favoured her sister Hayley which made Sarah feel left out and depressed.

8. There was a significant and lengthy history of domestic violence in the family backgrounds of both Sarah and Daniel. Sue had fled repeated domestic violence from her husband in 2004, and he had been the subject of several court orders limiting his contact with his children, most recently from 2014. Sarah and Hayley had briefly been in foster care in 2008 after Sue had hit Sarah, although it appears this was a one-off incident and Sue reported it herself. It appears she was depressed and felt threatened - concerned that her ex-partner had moved to live nearby.

9. Daniel's mother had died of leukaemia in 2006 and Daniel had a troubled and episodic relationship with his father, who had convictions for violence and assault, including against his wife. Daniel's paternal aunt was his legal guardian and cared for him and his two brothers after their mother's death but at times found it difficult to manage them.

10. Both Sarah and Daniel had a series of mostly short interactions with services over the previous 4-5 years as a result of concerns about their wellbeing and behaviour. These included referrals to children's social care, CAMHS, targeted youth support, School nursing, contacts with their GPs, counselling and some one-to-one support.

11. They attended the same school who sought to manage their behaviour and interactions throughout this period. Their relationship had started in May 2015 and they went missing together in October 2015. Their relationship was intense, exclusive, and sexual and was a matter of concern to their families. Both Sue and Daniel's aunt and carer appear to have disapproved of the relationship and attempted to restrict the contact between Sarah and Daniel. Sarah took an overdose in March 2016. Sarah and Daniel seem to have both perpetrated and suffered occasional episodes of violence and bullying and had difficult relationships with their peers, but this was not identified as unusual or markedly different from others in their peer

group. Both were intelligent and capable of educational achievement, but this was not fully realised. Daniel was educated away from the main school in a separate facility for several periods from 2014, to avoid permanent exclusion due to his aggressive and inappropriate behaviour towards staff and peers.

12. Sue worked as a lunchtime supervisor at her local primary school and was active with her church and choir. She had sought refuge from domestic violence from her husband in 2004 and moved several times with her two children to avoid contact. She suffered from depression for which she was prescribed medication and at times found it difficult to cope as a single parent. She undertook a course of therapy in 2015 to address her anxieties. She maintained a friendship with the family who had provided foster care for Sarah and Hayley in 2008 and the foster mother later became a work colleague.

13. Hayley was a quiet girl who appeared to have a close relationship with her mother and a troubled relationship with her sister. She was not involved with any direct services herself. She was described as 'bubbly', 'caring, with lots of friends', a child who was not materialistic and who appreciated small things. She was seen as close to Sue - "Mum's shadow".

14. Daniel pleaded guilty to murder and Sarah pleaded guilty to manslaughter and was convicted of murder, in October 2016, and they were sentenced in November 2016 with a minimum tariff of twenty years. During the trial and the early part of this Review process there were restrictions in place on reporting the case and identifying the perpetrators. Following appeal these restrictions were lifted in June 2017. There was considerable press and social media interest in the case from the time of the incident through to the completion of the court processes. Lincolnshire County Council had parental responsibility until her 18th birthday under a Care Order for Sarah following proceedings that concluded in January 2017.

Purpose of JBR2016:

15. The purpose of this Joint Review is twofold:

    To fulfil the statutory guidance for completion of a Domestic Homicide Review (Home Office 2013 & 2016):

    - 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;
    - Identify clearly what the lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
    - Apply these lessons to service responses including changes to policies and procedures as appropriate;

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice
- To fulfil the statutory guidance for completion of a Serious Case Review (Working Together 2015).
- Identify improvements which are needed and to consolidate good practice.
- Translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

16. This Review is not a repetition of the criminal or care proceedings, or of the Inquests. It does not cover all aspects considered by those processes, nor does it seek to challenge or conflict with the evidence and judgements reached under those jurisdictions. However, in reviewing what lessons may be learnt for all agencies from this case it may draw conclusions which place a different emphasis or significance on the knowledge now available and on the decisions made at the time. The purpose of the Joint Review is to identify whether there is learning to improve future practice, and to recommend how this learning can be best shared and implemented in practice. This is different and separate from the processes to establish guilt for a crime or to understand the psychiatric and psychological condition of either perpetrators or victims. This Review cannot be a retrospective assessment of any of the subjects.

Overall Observations

17. **As will be set out in this Report, it is my unequivocal view that no action or engagement with the individuals could have predicted that Daniel and Sarah could or would commit murder. This conclusion was endorsed by the Joint Review Panel when signing off the report. Sarah and Daniel were responsible for the actions they planned and undertook, and for the deaths of Sue and Hayley. There were no actions or interventions by agencies that might have prevented the murders. Their needs during this period did not reach any threshold for intervention that would have removed either of them from the care of their families or led them to be under any form of supervision beyond the day to day care of their families and professional support that was provided to each.**

18. There was no history of physical violence towards the victims perpetrated by either Sarah or Daniel, although each were capable of displaying disruptive and occasionally aggressive behaviour as ways of expressing their anger, anxieties, and worries. Daniel could be violent and verbally abusive with his brothers, at home and at school. Sarah was verbally abusive towards her mother and other adults but did not apparently display physical violence. She was not seen as a disruptive or violent child. Although

of concern, their behaviours were not exceptional for young people in their situation and with their history, and help was offered by a number of professionals over a lengthy period.

19. It is highly significant that Sarah and Daniel had grown up witnessing significant domestic violence and abuse and had suffered loss and trauma as a result. Their separate, but similar, adverse childhood experiences were not appreciated as being as complex and formative as they appear in hindsight. The management and support provided was not always informed by a full awareness of these difficulties, which have now been more clearly identified as a result of this review. There are aspects of the support offered and delivered that could have been better co-ordinated and it is possible that more consistent engagement, that fully acknowledged the severity of their needs and the impact of trauma, might have ameliorated the behaviours that were seen by others and experienced by Sarah and Daniel and their families. This would be the common experience of many troubled teenagers and their families.

20. Sue did receive support during 2015 to address her anxieties which recognised the trauma of her own direct experience of domestic violence and abuse. She found this a positive experience. The impact of these factors on Hayley is more difficult to assess.

21. It is the view of the independent author of the Review that the *extent* of the breakdown of the relationship between Sarah and her mother was not fully recognised by professionals. There is learning from how these families were supported that has wider, useful implications. The profound effects of the domestic violence and abuse perpetrated by his father that Daniel witnessed; the death of his mother; and the challenges his aunt faced in looking after three boys were cumulative adverse experiences that clearly had an impact on Daniel. The significant impact of exposure to domestic violence and abuse, over extended periods and at a young age, on the attachment and behaviours of young people is seen in this case.[3] Loss of a parent through accident or illness is also recognised as having significant implications for young people, and is not always adequately addressed. Daniel resisted attempts to provide him with counselling and bereavement support. He felt that these "talked down to him".

22. The cross-Government definition of domestic violence and abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse. While this definition applies to those aged 16 or above, APVA can equally involve children under 16. There is currently no legal definition of adolescent to parent violence and abuse. However, it is increasingly recognised as a form of domestic violence and abuse[4] and, depending on the age of the child, it may fall under the government's official

[3] Nicky Stanley, Khatidja Chantler, Rachel Robbins (2019) Children and Domestic Homicide, *The British Journal of Social Work*, Volume 49, Issue 1, Pages 59–76
[4] Wilcox, P. (2012) is parent abuse a form of domestic violence? *Social Policy and Society* 11(2):277-288.

definition[5]. Adolescent to parent violence and abuse (APVA) may be referred to as 'adolescent to parent violence (APV)' 'adolescent violence in the home (AVITH)', 'parent abuse', 'child to parent abuse', 'child to parent violence (CPV)', or 'battered parent syndrome'. The circumstances of this tragic case offer an opportunity to deepen awareness and responses to this phenomenon for Lincolnshire safeguarding partners.

23. APVA is increasingly recognised nationally by practitioners who work with families across a range of treatment, care, therapeutic and support services. However, it is only very recently that policy has begun to be developed to specifically address the problem. As a result, it is not usually officially documented and therefore does not currently appear in any public records or figures. Evidence of the extent of the problem is therefore piecemeal and developing incrementally[6].

24. Sarah and Daniel were troubled young people with significant disruption in their attachments to family and carers. When concerns about their behaviour were raised there was an overreliance by agencies on the capacity of their families to cope with their behaviour, when both Sue and Daniel's aunt were themselves vulnerable. There was a long and complex history of vulnerability and psychological trauma affecting both families which might have been more coherently recognised and might have received more sustained specialist intervention or support. This case review provides an opportunity to highlight this learning in order to develop better future practice.

25. Although both Sarah and Daniel received support this was not consistently informed by all the circumstances of their situation. It is not possible to state what effect better sharing of insights might have had on the services offered and on the relationships and wellbeing of the subjects. In general information *was* shared effectively between agencies and professionals, and there were a number of different people seeking to help Sarah and Daniel. Sue also received specific services to address her depression and anxiety, but in strengthening her capacity to address the domestic violence and abuse she had suffered, this may have undermined her empathy for Sarah's uncertain and equivocal reaction to her father' reappearance in her life. Hayley was not in receipt of services herself.

26. There is evidence of some persistent and consistent work by a number of individual practitioners with both Sarah and Daniel which helped them in their relationships and behaviour management. However, there were a number of occasions when the problematic circumstances of these young people could have been more critically examined and proactively supported. For both Sarah and Daniel there was a cyclical pattern of incident/concern, referral, limited engagement, closure and then a further incident or concern. Both were subject to the Team Around A Child processes (TAC) to co-ordinate their support, and although Daniel had a Social Care Assessment and was a Child in Need from July 2014 to August 2015 there appears to have been an

[5] Home Office (2013) 'Domestic violence and Abuse',
[6] Condry and Miles (2015) *Uncovering Adolescent to Parent Violence* (Palgrave)

emphasis on managing their immediate behaviours, rather than any curiosity about the underlying reasons for these.

27. This repeating cycle did not encourage a more comprehensive assessment or an appreciation of the cumulative impact on either Daniel or Sarah of their life experiences. Although several workers were able to keep working with each of them for a reasonable period (the Targeted Youth Workers with Sarah (2013-14) and Daniel (2015-16); the School nurse with Daniel (2010-16); the CAFCASS Family Court Advisor with Sarah and Hayley (July 2014 to June 2015)), the overall picture is of a reactive, and at times disjointed, series of interventions. This was not made any easier by the reluctance of both Sarah and Daniel to engage, and the pressures on their carers, Sue and Daniel's aunt, and their lack of confidence and experience in responding to challenging teenagers. The specialist reports completed after the murders for the criminal trial evidence in hindsight that both Sarah and Daniel were young people in need and at risk. This does not mean that their willingness to commit murder was evident or predictable. There is no evidence of any violence, coercion or control displayed by either of the perpetrators towards the victims. Indeed, there was a greater concern about the risks of self-harm for Sarah, and Daniel's aggression and poor behaviour were directed at his siblings and aunt and others as a result of his frustration and anger, not towards Sue or Hayley. There are indications that their own relationship was more volatile in early 2016, and both Sarah and Daniel were seeking both to limit and to maintain a relationship that was at one and the same time mutually supporting and also constraining and troubling. Learning about boundaries was a challenge for each of them. There were elements of coercion and control which fluctuated as their relationship changed. There is a pattern of escalating concerns with Sarah's overdose in March 2016, Daniel's increasing aggression and their deteriorating relationships with family and at school. Daniel's behaviour still illustrated a pattern of abuse and violence within the home and at school, essentially repeating previous patterns of domestic violence and abuse towards family members and carer. There was little exploration of what might be the triggers for this frustration and anger – the support he was offered was symptomatic rather than causal, and there was little recognition of the possible profound effect of his mother's death might have had on Daniel. Equally he was reluctant to consider this himself when help was offered.

28. It is apparent that Sue and Daniel's aunt could have benefited from more support in their parenting roles. To a large extent they were seen as mothers and carers rather than as individuals in their own right, although Sue did receive and benefit from CBT sessions in early 2015. There was support available for them to help with the behaviours in the children they were finding difficult to manage, but this was not always accepted. It is not clear that the particular pressures of caring as single parents were explicitly recognised. It is not clear what assessment of their parenting capacity was ever undertaken, although this would presumably have been assessed when Aunt became the formal carer for her three nephews in 2006 as a result of the care proceedings for this arrangement. It is not clear that her parenting capacity was reviewed later. Both found dealing with teenage children challenging and at times

struggled to adapt and adjust to adolescent behaviour. Aunt had made a life choice not to have children but had assumed parental responsibility for her three nephews after the death of her sister-in-law in 2006. In her interview with me for this Review she stressed that she had felt unsupported in her parenting role: "I was a total novice…I was a fun time auntie and then I got them full-time…I was set up to fail". This is not to suggest that the threshold for formal child protection interventions, or statutory care outside the family, would have been met, but that the cumulative and concerning circumstances for both Sarah and Daniel separately, and especially for their relationship together, should have encouraged a more comprehensive evaluation of their vulnerabilities and needs and of the caring context in each household.

29. Sue found the reappearance of her ex-husband in 2014 profoundly traumatic, and she was frightened and uncertain about his intentions and her children's reactions as result of her earlier experience of abuse. Fear is known as a powerful on-going factor in domestic abuse which can have far reaching consequences well beyond any episodes of actual violence or harm. The coercive control exercised by Sue's husband had a profound effect, which is often underestimated in such situations[7]. Her anxiety and fear were recognised by several of the professionals working with her – notably the CAFCASS Family Court Adviser. She was referred by her GP to the LPFT Steps to Change programme in January 2015 and completed a course of Cognitive Behavioural Therapy (CBT) by May 2015. Although this went well to address her trauma from previous domestic violence and abuse, there is no evidence that practitioners linked her previous history of risk and anxiety when formulating current responses to her family pressures.

30. The DASH[8] assessment tool could have been used to identify the depth and extent of her concerns and to help identify the impact on her parenting, but it is not clear what would have been the trigger for this and it would not have fitted her circumstances exactly. The assessment tool would not necessarily have encouraged the exploration of the substantive issues. The focus on her own parenting capacities may have emphasised her feelings of not being able to cope, as domestic violence and abuse can undermine a mother's confidence by disrupting the child's relationship with her and with the perpetrator using contact arrangements to control the situation – which is evident here.

31. Sue confided some of her anxieties to friends at church, who were personally supportive and also witnessed the distress to her and Hayley caused by their father's unexpected reappearance but did not appreciate the wider safeguarding risks or their own opportunity to make a formal referral or seek further advice from the Diocesan Safeguarding Team as part of a duty of care.

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[7] Stark, E. (2007) *Interpersonal violence. Coercive control: How men entrap women in personal life.* New York, NY, US: Oxford University Press.

[8] The DASH checklist and practice guidance has been developed as a standard tool for identifying risks of domestic abuse, stalking, harassment and honour based violence

32. This Review Report has not been prepared in order to provide a detailed narrative of all the incidents, services and interventions that were offered over a period of more than 10 years. It concentrates on the analysis of the evidence against the Terms of Reference and Key Lines of Enquiry in order to establish what learning can be gained for agencies and partnership working in Lincolnshire. For that reason, it does not provide a step by step account of all the interactions and services recorded in the agency reports but concentrates on the learning for the future. These have been collated and described through the agency reports and chronology that has been used to produce this overview report. Paragraphs 48 onwards provide an outline of the key events.

Methodology

33. The methodology adopted for this Review has been as follows.

- The decision to conduct a Joint Review was made in June 2016, following earlier separate decisions by the LSCB and Safer Communities Lincolnshire that the case should be considered as a SCR and as a DHR. The Home Office and the National Child Safeguarding Practice Review Panel were informed of these decisions.
- An independent author was commissioned to undertake the review in June 2016. Initial meetings drafted Terms of Reference (ToR) and Key Lines of Enquiry (KLOE) which were presented to a scoping meeting of the Panel in November 2016.
- The Joint Panel agreed the Terms of Reference and KLOE, confirmed the process and proposed timeline, and identified those agencies required to submit agency reports. The Panel is chaired by Leila Barron on behalf of both commissioning bodies. The Panel has met on five occasions.
- A briefing meeting for agency report authors and Panel members was held in January 2017 to present the ToR and KLOE, and to establish the requirements for each agency report.
- Agency reports and chronologies were prepared and submitted and were subject to quality assurance and review by the Panel and Independent author.
- The Agency reports were presented to a full meeting of the Panel on 31 May 2017. Revisions were made, and additional information was supplied as a result.
- Access to specialist reports provided for the criminal proceedings or identified in the agency reports was sought and agreed and these were provided for the use of the independent author.
- Invitations to be interviewed were sent to family and friends and these took place where they were requested.
- A draft Overview Report prepared by the independent author was reviewed by the Joint Panel on 1 February 2018. A further revised draft was considered by the Joint Panel on 10th May, and additional information requested.
- Arrangements were made to seek views of the perpetrators and family members. Daniel was interviewed in April 2019 and Sarah in October 2019, and views obtained from members of the families and others. Other members of the families chose not to take up the opportunity to contribute.

- A final draft was considered following these interviews and the collation of all remaining evidence.
- Specialist advice was obtained on the Report from Ceryl Davies who has previously advised Lincolnshire agencies in respect of ADVA and related topics. Detailed discussions were also held around the mental health and CAMHS input to this case.
- Revisions were made to the Overview Report, which was subsequently presented for approval to the LSCP and Safer Communities Lincolnshire, on 5 December 2019.[9]
- The Overview Report, Executive Summary and action plans were submitted to the Home Office for quality assurance and their comments and feedback have been incorporated.
- The Joint Review Report was published.

34. The members of the Joint Panel are:
    Children's Services Manager, Action for Children (Independent Chair).
    Consultant Nurse Safeguarding and Mental Capacity - Lincolnshire Partnership NHS Foundation Trust (LPFT)
    Named Nurse Vulnerable Children and Young People - Lincolnshire Community Health Services (LCHS)
    Deputy Executive Headteacher of South Lincolnshire Academies Trust School (Bourne Academy)
    Lincolnshire Police
    Children's Services Manager East Lindsey quadrant, Lincoln and West Lindsey quadrant, EDT and CSC - Children's Services
    Designate Nurse Safeguarding Adults, Children and Looked After Children - South West Lincolnshire Clinical Commissioning Group (SW CCG)
    Children's Services Manager: Education Support - LCC, Education
    Service Manager – Children and Family Court Advisory Support Service (CAFCASS)
    Named Nurse for Safeguarding Children and Young People - ULHT (United Lincolnshire Hospitals NHS Trust)

    <u>Advisers</u>
    LSCB Business Manager
    Assistant Chief Legal Officer - Legal Services, Lincolnshire
    Community Safety Manager, Safer Communities
    Adviser on domestic violence and abuse research and practice

35. It was recognised that there are a number of other relevant family members and friends who have played a role in the lives of the four subjects of this review. Information regarding their roles and interactions is contained within the records of the subjects of this review and has form part of the KLOE. Details of the Review have

[9] During the timespan for this Joint Review the Local Safeguarding Children Board (LSCB) has been replaced by the new Lincolnshire Safeguarding Children Partnership established under the provisions of the Children and Social Work Act 2017 and Working Together 2018.

been communicated to all these individuals inviting them to contribute to the Review. Repeated invitations have been extended to participate in the review or provide information for the report. Where these invitations have been accepted their comments and views have been incorporated into this report. Appropriate support and contact arrangements were offered to assist the engagement of family members and other contacts, and arrangements were put in place to allow the participation of Daniel and Sarah while in the secure estate.

36. In addition, a number of staff, workers and those who knew the subjects, was interviewed as part of the agency reports. This evidence has been used as appropriate in compiling this Overview Report.

37. Agency Reports were requested and provided by the following agencies
    - Lincolnshire County Council Children's Services (Social Care and Early Help)
    - Lincolnshire Police
    - Lincolnshire Community Health Services NHS Trust (School Nursing Service)
    - Lincolnshire Partnership NHS Foundation Trust (Mental Health and CAMHS and Steps to Change)
    - United Lincolnshire Hospitals NHS Trust (Acute Hospital Services)
    - CAFCASS
    - Leicestershire County Council (Children and Family Services)
    - Munro Medical Centre (GP Practice)
    - South Holland District Council
    - South Lincolnshire Academies Trust (Secondary School)
    - Diocese of Lincoln (Parish of St Paul's Spalding)

38. These reports were presented to a full meeting of the Panel on 31st May 2017, and further clarification and details were sought as necessary.

39. The Independent author has also been able to review a number of specialist reports on the subjects of the Review. It is important to note that these reports were not available to practitioners during the chronology of the case, except for parts of the specialist psychological report prepared for the court in December 2014.

40. I have also been able to consult the sentencing remarks from Mr Justice Haddon-Cave from the conclusion of the trial in November 2016.

41. Interviews were conducted by me with family members in October 2017 and January 2018 and with Daniel and Sarah in 2019. Notes of these were taken and have been consulted for this Report.

Terms of Reference

42. The following were agreed as the Terms of Reference to be considered by all agencies in their reports

a. To examine whether there were any previous concerns, incidents or indications which might have signalled the risk of violence, or given rise to other concerns or instigated other interventions
b. To consider whether the actions of agencies in contact with both victims and perpetrators were appropriate and relevant to the needs and risks identified at the time
c. To consider whether there were any significant changes in behaviour and relationships that might have indicated increased risk of violence or harm
d. To consider whether appropriate professional curiosity was exercised by those professionals and agencies working with the individuals in the case
e. To consider the interaction between professionals and agencies, and the wider network of community and social contacts
f. To consider the importance of wider community support for situations where agency involvement was low or occasional
g. To consider whether there are training needs arising from this case
h. To consider the management oversight and supervision provided to workers involved
i. To consider whether any issues of diversity, culture or identity were relevant
j. To consider whether there are support or therapeutic interventions that might have been used, and what might be the criteria for accessing these in the future
k. To consider the effectiveness of coping and recovery from trauma and harm for the four individuals and the legacy this may have left
l. To consider how learning from extraordinary or unusual incidents can inform wider systems learning and improvement of local services and interagency cooperation
m. To consider whether there were appropriate policies and procedures in place, whether these were fit for purpose, and to identify any gaps

Key Lines of Enquiry

43. In order to address the Terms of Reference agencies were requested to consider the following Key Lines of Enquiry where relevant.
    i. The extent and impact of exposure of the children to domestic abuse and violence from an early age.
    ii. The extent and impact of Sue's exposure to domestic abuse.
    iii. The attachment of the children to significant adults in their lives including parents, guardians and foster carers.
    iv. The relationships between Sue and her husband and her subsequent partner and how these affected the children, including any subsequent contact with the girls' father following the family break-up and the Court proceedings.
    v. The family background of Daniel, his experience of domestic violence in the home and attachment, including the death of his mother.
    vi. The educational experience of the children, including any exclusion, missing episodes, specialist support offered and any behaviour issues.

vii. The experience of foster care by Hayley and Sarah and the attachment and contacts resulting from this episode.
viii. The relationship between Hayley and Sarah and whether there were tensions and risks observed.
ix. The friendship, employment, social and support networks available to Sue in support of her role as parent, and to support her own emotional well-being.
x. Any relevant history of emotional well-being issues for the four individuals or other close family and carers.
xi. The history and nature of the relationship between Sarah and Daniel and how this was viewed by others, both professionally and by family and friends.
xii. The role of other significant adults.
xiii. The nature and impact of family and individual support and therapeutic interventions, or the absence of these inputs.
xiv. The degree in which Sarah and Daniel were on the edge of other friendship and family circles and the isolation and marginalisation that may have resulted from this, including consideration of their attachment to parents and carers.
xv. Any exposure to social and mainstream media, or other cultural influences that might explain the actions of the perpetrators.

44. In order to ensure that this Overview Report remains focussed and concise it addresses the evidence gathered through the Key Lines of Enquiry and then reaches conclusions against the Terms of Reference set of the Review. This process has been overseen and endorsed by the Review Panel.

45. A comprehensive integrated chronology of the case was compiled from the details supplied by each agency. This included some case history from 2003, but this Overview concentrates on the events from 2013 to 2016. A summary of the key events is set out in paragraphs 50 and following.

Equality and Diversity

46. There is no evidence that any of the nine protected characteristics under the Equality Act 2010 were exceptionally relevant to the circumstances of this case or affected access to services or their delivery. Throughout this Review these issues have been considered and reference has been made in this Report to any relevant implications. As noted in paragraph 2, the perpetrators were very young at the time of the incident and had been engaged in a sexual relationship for some time. The assessment of needs and provision of services were age appropriate for the young people involved. Domestic abuse, violence and harassment perpetuated by men against women were a significant background issue to the family histories of both families, and Daniel's behaviour at time was aggressive towards women. It is unclear whether this was a factor in Daniel using violence to kill Sue and Hayley. The significant long-term impact

of exposure to domestic violence and abuse is considered throughout this Report as it affected all parties.

Confidentiality

47. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication.

48. To protect the identity of the victim, perpetrator, and their family members, the pseudonyms below have been used throughout this report. The pseudonyms for the victims and perpetrators have been chosen by the Lincolnshire Safeguarding Children Partnership, but a member of their family approved the use.

49. The victims: Sue was aged 49 years at the time of her death and Hayley was aged 13 years at the time of her death.

50. The perpetrators: Sarah and Daniel were aged 14 years at the time.

51. All parties involved in this Review were white British.

Dissemination

52. In addition to the families, the following will receive a copy of the review:
    - Members of the Safer Lincolnshire Partnership
    - Lincolnshire Safeguarding Children Partnership
    - Lincolnshire Clinical Commissioning Group
    - Lincolnshire Safeguarding Adults Board
    - Lincolnshire Police and Crime Commissioner
    - Organisations represented on the Review Panel.

Independence

53. David Ashcroft was appointed as the Independent Overview Author of this Joint Board Review in June 2016. He has worked at a senior level in children's services for the past 25 years, including operational responsibility for all aspects of safeguarding and children's social care in a number of local authorities. Mr Ashcroft currently chairs Safeguarding Partnerships in Sheffield for both Adults and Children's and has been the Chair of Norfolk, South Tyneside and Manchester LSCBs. He was for 3 years (2016-19) the national chairman of the Association of Independent LSCB Chairs. He is also an independent member of other Improvement and Children's Partnership Boards. He is an accredited C4EO Sector Specialist in child protection, and an associate member of the Association of Directors of Children's Services.

54. Mr Ashcroft has conducted, as an independent chair and/or overview author and lead reviewer, several SCR, DHR, inspection and investigation assignments. He has undertaken extensive training in review methodologies including the Home Office DHR module and has been an expert adviser to several national projects to develop training and improve standards in reviews and report writing. He has previously completed SCR Overview Reports for Lincolnshire LSCB. He has no managerial connection with the agencies involved in this case or with the LSCB.

55. All the Agency Reports have appropriately identified that their authors were independent of operational management or direct involvement in the case.

Summary of key events

56. This section provides a summary of the key episodes and services that were involved with the subjects for the period 2013 to 2016. It is not a complete chronology of all activities but is intended to provide the necessary background for the analysis and conclusions in this report.

2013

57. In January 2013 there was a Team Around the Child meeting for Daniel's younger brother, who was anxious and stressed as a result of contact with his father. Their aunt admitted that she was struggling to cope with the boys at home. The TAC process was continued for Daniel's sibling to support with boundaries at home and when the boys had contact with their father.

58. During Year 8 (2013-14) Daniel struggled with his behaviour and was involved in a number of incidents which included violence against other pupils, verbal abuse and disobedience. He claimed he was being bullied and picked on. He found it difficult to accept that relationships were reciprocal, and to see that his own behaviour and attitude affected situations. He maintained that he did not think anyone at the School could help him with anything. He received a number of fixed term exclusions. Although the Year 8 team worked persistently with him and sought to build up a relationship with his aunt and carer, Daniel was moved to separate provision at the School to avoid permanent exclusion in May 2014.

59. In June 2013 the School raised a Cause for Concern about Sarah, with a subsequent referral to Children Services which resulted in an Early Help Assessment. A Targeted Youth Support Worker (TYSW) was allocated to work with Sarah and sustained a positive relationship with her over the next 12 months. This work identified that Sue was worried that Sarah felt that her mother did not love her. Sarah felt that she was not given freedom by her mother, and the incident when she was hit by Sue in 2008 and the subsequent period of foster care were seen as key triggers in their difficult relationship. Sarah now recalls that she felt she did not fit in at secondary school – she did not belong to a particular friendship group and struggled to make new friends as she was shy and was anxious meeting new people. She liked English and Geography and loved learning. Sarah now says that she felt too scared to admit that she needed more help and that she was struggling in her relationships with peers and with her mother and tended to let problems build up inside.

60. Counselling was identified in 2013 as part of the targeted youth support to address Sarah's feelings about what had happened when she came into care. Sarah recorded at the time that she hated her mother, wished she had been born into a different family and felt jealous of her sister "when she gets all the fuss". As work continued with the TYSW this added to the evidence of the feelings of alienation and distrust felt and articulated by Sarah. In early September Sarah alleged to her TYSW that her mother had assaulted her again following a disagreement – it does not appear that this was followed up or resulted in either a discussion with her mother or any formal

investigation. This should have been done especially as the earlier incident when Sue had struck Sarah, and triggered the period in care in 2008, was highly significant for Sarah's view of her mother (see paragraph 110 below). Sarah felt supported by the foster carer she had been placed with in 2008, and with whom she stayed as a family friend on subsequent occasions, stating on at least two occasions that she would like to live with her permanently. There is a consistent picture that Sarah constructed of herself as the outsider, separated from her mother and sister, she felt unloved and isolated. She did not feel that she had trusted people in her life and talked to her teddies and her pets to find solace. Her account suggests that her mother's reactions could be quite controlling and arbitrary, and that Sue could be erratic in her behaviour, especially when she was not on medication. Sarah felt that she was "walking on eggshells" much of the time.

61. Sue was concerned about the influence of a particular school friend with whom Sarah planned to run away. When she did so on 24th September the TYSW was able to persuade her to return. This was a positive intervention. The TYSW attempted to ensure that she listened to both Sarah and her mother separately as well as together, and recognised that Sue found dealing with Sarah difficult and that her attempts to manage Sarah could sometimes be counterproductive. Sarah started on a Counselling course in October 2013, and the counsellor contacted the TYSW with her view that it seemed that Sarah was viewing the TYSW as a secondary attachment figure, and that attachment issues needed to be handled carefully – as changes and endings were proving difficult for Sarah. This was an acute observation but it perhaps underplayed the positive opportunities to engage with Sarah that this worker had achieved.

62. During this time Sue was increasingly involved with helping with the Church and related groups. This was clearly an important social support for her. It is not clear what other support networks she had.

63. During this period there is evidence of both Sarah and Daniel (who had not yet met) feeling isolated and marginalised at school and within their family situations. Both displayed challenging behaviour and found it difficult to develop and sustain relationships. Both were uncertain that they could rely on help and support from others. This form of behavior is evidenced as part of the often unhealthy and abusive relationships between teenagers who have both witnessed domestic violence and abuse, and had difficult experiences, e.g. being in care; bereavement; or significant disruption to caring arrangements.[10]

2014

64. Sarah continued with one to one support from the TYSW during the first half of 2014 – and this relationship was seen as positive by all. The TYSW was sent a thank you card by the family in July 2014 when the case was closed. Sarah had maintained her involvement with the Counselling and other support, including the Time to Talk

[10] Wood, M., Barter, C., & Berridge, D. (2011) *standing on my own two feet: Disadvantaged Teenagers, Intimate Partner Violence and Coercive control.* NSPCC.

support group at school, as part of the Petite POISE scheme (improving self-esteem and self-confidence) and as a Young Inspector, reviewing children's services. When the TYSW and Sarah reviewed the situation in April Sarah said she was getting on better with Mum, but that she was worried by the reappearance of her father. She saw her mother's rejection of any contact with her father but was uncertain of her own reaction – she was aware that she did not have a father figure in her life and wanted to see him. At the point where she appeared to have made some progress this new situation raised fresh challenges for her own emotions and for her relationship with her mother. In May the TYSW reported in supervision that Sarah had a tendency to see herself as a victim and was saying that the counselling had not really been helpful. Her resilience was still fragile. The closure of the case in July 2014 by the TYSW was perhaps in retrospect premature when Sarah, and her family, were confronting new challenges due to the reappearance of her father.

65. Sue and her children had continued their links to the Church since starting to attend in 2013 and became involved in its activities and worship. They were all baptized and confirmed in May 2014. When Sarah left the choir this removed an activity in which all three had been involved. Sue and Hayley remained involved in a number of church activities.

66. Sue's husband, from whom she had fled domestic violence, after a long gap of nine years, sought renewed contact with Sue and his daughters in April 2014. Following a number of incidents of harassment and persistent attempts to contact her, which distressed her and the children; Sue involved the police and sought a non-molestation order. Sarah recalls that her mother felt that she looked more like her father than did her sister, and that her mother said Sarah was like him. This increased the uncertainty for Sarah in making sense of the complex relationships and emotions involved and her perception of being separate from her mother and sister. Sarah and Hayley's father undertook not to contact Sue for 12 months from June 2014. A private law application for contact with his daughters resulted in safeguarding checks, the involvement of CAFCASS, and the appointment of a Guardian for the subsequent court process.

67. This Family Court Advisor (FCA) recorded that Sarah presented as a sad girl who was lonely and needed a great deal of reassurance. She was concerned for Sarah's well-being and was concerned that in wanting to see her father Sarah was trying to fulfill a need that was not met by her mother – being loved, valued and noticed. Sarah recalls that she wanted to get to know her father, who had not been part of her life – she may have hoped this would bring about a better relationship between her parents, as she recognised that her mother was profoundly scared and worried about the reappearance of her father. Hayley described a very different relationship with her mother and was clear that she did not want to see her father as he had hurt her mother and her older half-sister. Hayley said she did not have a good relationship with Sarah.

68. The FCA was concerned that Sue's husband had little insight into the impact of his behaviour on the children and was concerned about how he would deal appropriately

with contact. An expert report was recommended, and this was commissioned by the court to assess both parents, Sarah and Hayley. This report was submitted in January 2015.

69. The FCA continued to work with the family and saw both Sarah and Hayley separately – the girls' wishes and feelings were reflected in her report to court. Sarah confirmed at one point that she would like some contact with her father, although she found the letters he sent difficult to comprehend and found that it was difficult to establish appropriate boundaries. She then changed her mind about contact. Sarah also disclosed her feelings towards Hayley – she had hated Hayley when she was born and was jealous of the attention she felt Hayley received from her mother. Hayley was clear that she did not want to see her father and also reported that she found her relationship with her sister difficult. Sarah recalls that when she met her father with Daniel for a meal in 2015 he was over-attentive and she did not feel comfortable with him. Daniel stepped in to tell him to 'back off'.

70. Daniel's aunt had been diagnosed with cancer in early 2014 and was finding it increasingly difficult to cope with the three boys in her care. There were growing concerns about her health, that she felt intimidated and could not control the boys who were constantly fighting, and that she had little support from her own family network. When these concerns were raised in May the School were advised to complete an Early Help assessment and set up a TAC meeting. It is not clear that there was any exploration of how the boys were reacting to the news of this illness when they had lost their mother to cancer a few years previously. In June there was a referral from the School to Children's Services over concerns about the boys' behaviour, and the lack of supervision when in the care of their father. The boys were reporting that they were using blow torches and petrol to set tyres alight, when their father was variously said to have witnessed this or to have been drunk and asleep rather than supervising them. A social care assessment as children in need was started. The initial Child In Need (CIN) plan recommended a programme of support with family work, work between the siblings and with their father on his care and supervision, plus a Family Group Conference to look at support and respite for aunt. The FGC did not take place until October and does not appear to have been effectively followed up or engaged many of the extended family or friends.

71. The CIN assessment in July/August recorded that the boys' father "preferred to use a stick for punishment" and that he was unwilling to support his sister in their care. This was challenged, but the situation was complex and any real focus on support for these children feels diffuse. The assessment concluded that the boys' father could not give adequate supervision, yet it was agreed that he could take them on a canal trip for three weeks during August to give Aunt some respite. This was a confusing message for all concerned which did not resolve the tensions between aunt and father or set consistent expectations for acceptable care and behaviour.

72. Daniel reported that he felt the odd one out with his brothers and that as a result often got angry and sometimes violent. His brothers and father confirmed this – "he

sticks out like a sore thumb" and said that Daniel did not want to join in with them. During at least two meetings, it was noted that Daniel sat with his aunt while his brothers sat with their father. It does not appear that the boys' father had a parenting assessment since his release from prison for violence against the boys' mother. The School nurse, who had worked with Daniel for several years, raised with the social worker this historical information. It is not clear whether any risks of violence towards Aunt were considered.

73. On the canal trip Daniel ran away from the boat as he said he did not feel safe and his father was drunk. He went several miles into Northampton town centre and was returned by the police to Aunt's care. His father did not report him missing. There is no record that a strategy discussion took place to determine whether this incident raised any safeguarding issue or whether the context of domestic violence and abuse should be considered.

74. Through the autumn the brothers continued to be Children In Need, presenting challenging and at times violent behaviour to each other and others. There was a particularly high level of concern about the youngest boy which may have meant that Daniel's needs were not recognised so clearly.

75. During 2014 Sarah made some progress in addressing her feelings of isolation and low self-esteem. However, this work came to an end in July, when the reappearance of her father, and the conflicting emotions this prompted, raised fresh issues for her relationship with her mother and her sister and for her own resilience.

76. Daniel experienced increasing isolation from his siblings, and his relationship with his father was severely compromised by the lack of care and supervision shown by his father. Although continuing to be on a Child in Need plan with his brothers, it is not clear that the attempts to negotiate stronger and more consistent family support, to support his aunt, or to manage the conflicts in the family, resulted in any significant improvement for Daniel. Daniel continued to experience and perpetuate aggression as a means of coping with these concerns and uncertainties, a pattern that he had experienced from a very young age in witnessing his father's serious violence toward his mother. The impact of witnessing domestic violence and abuse is well established as a significant and long-lasting factor[11]. There was no comprehensive assessment of the impact of this domestic violence and abuse.

2015

77. The comprehensive psychological report on the family was completed in December 2014 and provided to the court and CAFCASS. It informed the FCA's analysis of the family and her recommendations to the court. Her view was that the family was fragile and that Sue's husband lacked the capacity to change, and that in so far as

[11] Mullender, A, Hague, GM, Imam, I, Kelly, L, Malos, EM & Regan, L (2002) *Children's Perspectives on Domestic Violence*. SAGE Publications Ltd.

Sarah was looking to him to fill a hole left by the lack of attachment to her mother, this was making matters worse. She recommended only indirect contact with father.

78. The report identified that Sarah was a child in emotional turmoil with an avoidant attachment to her mother. Family therapy was strongly supported to address this. Hayley was seen to have a conforming personality, with high anxiety and loyalty to her mother. Sue was described as having low mood, but no mental illness. She had a dysfunctional relationship with Sarah and self-defeating and dependent personality traits. Father was assessed with a chaotic and reckless lifestyle. He lacked insight into the impact of his behaviour, and the report concluded that he needed long term psychotherapy, with which he was unlikely to engage. His emotional difficulties presented a further challenge to Sarah's poor attachment.

79. The report was prepared for the court and CAFCASS but there was not permission for it to be shared in full as their father had objected to this. However, the conclusions did inform the on-going work of the FCA and were the basis for her continuing concerns about the family. It was permitted for part of the report to be shared to inform the referrals by the GP.

80. Following the psychological report, Sue contacted her GP on 16th January to request family therapy as recommended. The GP made three separate referrals to the Lincolnshire Partnership FNHS Foundation Trust[12] (LPFT) Single Point of Access (SPA) for Sue, Hayley and Sarah requesting further family therapy and CAMHS support. Separate referrals were made on the advice of the SPA. Extracts of the report were attached in detailed support of these referrals, including the suggestion of cognitive behavioural therapy (CBT) for Sue. The difficult relationship between Sue and Sarah was highlighted by the GP. These were clear and appropriate referrals which recognized both the separate individual and the collective needs of the family. The GP included a reference from the report, "In simple terms depressed parents can place their children at risk of emotional harm through affective deprivation, neglect and inconsistency parenting". This was an important marker for CAMHS.

81. There is no evidence that the CAMHS referrals reached the service from the single point of access and no action proceeded for the recommendation of systemic family therapy. Sue did complete nine sessions of CBT through the Steps to Change (S2C) programme, ending in May 2015. In her initial assessment she disclosed that she had a strained relationship with her daughter, Sarah, and that *"due to the ongoing custody battle she has been feeling stressed, tired and irritable"*. During these sessions her on-going worries about contact with her ex-husband and her historic experience of domestic abuse were recorded, as was the impact this had on Sue's levels of depression and anxiety. This prompted the inclusion of Eye Movement Desensitization and Reprocessing (EMDR: an integrative psychological approach proven to be effective for the treatment of trauma) as part of the course. Although there were ups and downs through her sessions Sue felt that she had gained from the

[12] LPFT are the providers of mental health, CAMHS and related specialist services for the area.

therapy overall and felt better able to cope as a result. In the discharge letter to her GP the success of her treatment was attributed to her motivation and commitment.

82. An assessment specifically addressing the risks of domestic violence and abuse might have provided a basis for informing other agencies of the risks perceived by Sue, but the assessment and risks remained contained within the therapy environment. For example, in session 6 of her CBT Sue is recorded as declining to work on trauma due to external stressors. It was not recorded or explored what these external stressors were, nor could she identify the positive choices she was making. At this time she was continuing to be subject to further harassment from the father and was attempting to support Sarah with her own CAMHS interventions, and minimize the contact that PE had with the girls.

83. On 11th February Sarah handed notes to a teacher at School which raised concerns. Sarah wrote *"I feel trapped, sad, lonely and depressed and also I feel no one cares. I cry a lot. I tried to remain strong but I can't fight anymore. I'm tired and alone. No one understands except K (school friend) because she feels the same way. Also this is my suicide note."* Sue was contacted and requested to make an urgent appointment with her GP. It appears Sarah and a friend had planned to take an overdose but did not do so. Sarah and her mother saw the GP who telephoned the crisis team as an urgent referral, but was advised that Sarah was too young to be eligible for the service. Sue was advised to take Sarah to A&E and the GP faxed an urgent referral to CAMHS, when the GP also mentioned the January referral previously made.

84. CAMHS assessed that the referral met the criteria for a Tier 3 assessment (for severe or enduring mental health problems) and an appointment was offered. The Family Court Advisor provided support and advice to Sue, Sarah and Hayley about dealing with their emotions and this situation. A detailed CAMHS assessment was completed on 25th February with Sarah and her mother. This was an appropriate and speedy response. The assessment judged that Sarah was not at immediate risk of self-harm or suicide and no risk to others was identified. At the second session on 13th March Sue advised that Sarah's mood had improved since she had 'got herself a boyfriend'. This is the first reference to her relationship with Daniel in any records. Sarah reported that she had fewer suicidal thoughts but continued to feel "lonely, depressed and trapped". A CAMHS care plan was agreed.

85. It appears that Sue accompanied Sarah to these appointments, so it is not clear to what extent there was an opportunity to explore with Sarah her feelings about her relationship with her mother. Because this sequence of CAMHS interventions was triggered by the suicide note in February, rather than by the issues of attachment referred by the GP in January, it is not clear that the wider context for Sarah's behaviour and emotional wellbeing were recognized.

86. Sarah attended face to face sessions at CAMHS Tier 3 on 13th March and 2nd April. At the second session the clinician notes that Sarah was increasingly uncomfortable and quieter – Sarah was advised to explore these feelings at home. This advice may have

underestimated the extent to which home was a focus for Sarah's anxieties and worries. At this time CAMHS provided assessment and treatment for 9 common mental health disorders of childhood. CAMHS was not commissioned to provide assessment or treatment for children and young people who had behavioural problems without associated mental health disorder. Tier 2 clinicians worked with mild to moderate mental health problems and Tier 3 used a team approach to address moderate to severe or complex mental health disorders.

87. On 16th April Sarah attended her GP, with her mother, stating she felt depressed and suicidal. Sue had found notes in her bag all mentioning suicide. The School had also been concerned that Sarah might be contemplating suicide and that she was concerned about Daniel with whom she had started a relationship. Sarah did not feel that counselling sessions were working, and "she would not mind leaving her mother and little sister behind if she was dead" and "she did not feel safe or loved in her home". Her feelings towards her mother were changeable and unstable – but this volatility was not fully appreciated as each service responded to the presentation it saw in isolation.

88. The GP advised that she attend A&E as the Mental Health Crisis Team could not help due to her age. Sarah's mother said that she was unable to take her to A&E, but she had a CAMHS appointment due the following day. Sarah was seen on 17th April and a psychiatric assessment with the consultant was arranged for 24th April. This identified a number of the issues which affected Sarah, including the impact of the contact with her father, her suicidal thoughts, shyness and isolation. As Sue accompanied Sarah to this appointment it is not clear how far the nature of their relationship was explored. It is also not clear if the impact of her new relationship with Daniel was assessed. It appears that the consultant psychiatrist was aware of the original GP referral and the recommendation about family therapy, but no safeguarding concerns were raised, and no risks to others were recorded. The CAMHS worker who had seen Sarah on 17th also discussed the case with the consultant psychiatrist and enquired whether a period of in-patient care would be appropriate as a means of gaining a fuller assessment of Sarah's needs[13]. This was not felt necessary and there is no opinion on this option in the letter from the psychiatrist back to the GP.

89. In writing to the GP following these appointments CAMHS stated that the relationship between Sarah and her mother "was not great". This might appear to be a simplified view of a complex and changing situation. In her two episodes of CAMHS care Sarah presented as a girl who struggled to openly share her thoughts and feelings and who looked to her mother for support when talking to CAMHS. However, she had directly and openly written a letter to her teacher about her worries, which is unusual and illustrates the degree to which she wished to receive some form of support. This may have disguised the stresses in her relationship with Sue. These tensions had been well recognised in 2013 when Sarah was working with the Targeted Youth Support Worker.

[13] An acute in-patient unit for young people who are experiencing acute or complex mental health difficulties and their needs cannot be met by a community treatment package of carer.

Throughout her care and treatment CAMHS maintain that there was no indication of the risk of Sarah becoming alienated from her mother and sister. While it is correct that there were no signs of significant aggressive behaviour from Sarah, or risks to others, the CAMHS assessment did not give sufficient weight to the unusually strained relationship between Sarah and Sue. Other practitioners working with them had already identified how important this dynamic was (see paragraphs 53-57 above).

90. When Sarah was seen with her mother on 29th April by the CAMHS worker, Sue shared that Sarah did not feel that the relationship with this worker was a positive one, as she preferred to be seen by a female clinician. Sarah also wanted the CAMHS appointment to be in school. This was possibly, in my view, an expression of Sarah's desire not to have all the appointments in the presence of her mother – although this is not evaluated in the CAMHS record. Sarah now recalls that she was scared and anxious, and that she did not say how she was actually feeling. She retrospectively wished that she had sought more help independently. As Sarah did not have a severe and enduring mental health illness, which would have indicated Tier 3 support, she was offered individual sessions with a female practitioner at Tier 2, who would see her at school. This response was sensitive to Sarah's wishes however it does appear that the presenting issues were largely as communicated by Sue rather than by Sarah.

91. In fact a further appointment date was not arranged until July as contact could not be made by phone, and the appointment with the Tier 2 worker took place on 19th August. This was a four-month gap since Sarah had last been seen by CAMHS – during which time her father had intervened in her life; the court had decided on future contact (twice yearly indirect contact and a Non-molestation order until Sarah's 18th birthday); she had continued to indicate suicidal thoughts; and she had started her relationship with Daniel. Sarah was seen alone for the majority of this reassessment, which was appropriate, and she reported some improvements in her mood and situation. Sue realised that Sarah needed to be allowed responsibility and independence; Sarah reported that she did not feel "left out of the triangle at home between her, mum and sister". At a final appointment on 23rd September Sarah reported that she found school stressful and that she was worried about the relationship with her boyfriend ending. She said that things were OK at home, and that she wanted to see her father. She did not feel that she needed to see CAMHS anymore.

92. During April, May and June her father repeatedly attempted to make direct contact with Sarah – including seeking to give her a mobile phone for her birthday and visiting the house. This breached the court order, and this controlling behaviour was a cause of considerable anxiety to Sue. The FCA remained in contact with the family and also advised father that he should not seek to ignore the court orders. Towards the end of the year Sarah appears to have changed her mind about whether she wanted some level of contact with her father, but it is also clear that he attempted to present her with a view of himself, his past actions, and how he felt he had been treated by Sue, that was one-sided. This reinforces the extent to which his actions were part of his emotional and controlling behaviour towards Sue and Sarah.

93. During 2015 Daniel continued to experience difficulties with school, with anger and in his relationships with his brother, father and aunt. His aunt contacted the CIN social worker in Children's Services on 19th March concerned about managing Daniel's strong emotions, his self-esteem and seeking to encourage positive activities. A request for targeted youth support was made. Daniel's behaviours continued to be challenging, and his aunt was feeling unable to cope. She found it difficult to reconcile the view that social care thought that his father's care was suitable for Daniel, despite known risks, with her own reluctance to tolerate his continuing poor behaviour. It was recorded that she felt let down by agencies and that Daniel was now the prime focus of his aunt's frustration where previously it had been his siblings. Aunt stopped attending the CIN meetings in April. Her conflicted responses and Daniel's own reluctance to engage with the help offered, meant that the support was not always able to be consistent and sustained.

94. Both his aunt and Daniel did not want social work involvement in their lives – they felt they "did not do anything anyway". Attempts to explore wider family help with respite, or to get Daniel's father to provide care were largely unsuccessful. It is not clear that continuing concerns about father's drinking and capacity to provide safe supervision were followed up; resulting in mixed messages about what was acceptable or safe. Daniel continued to be violent – smashing a door with a cricket bat and breaking the garage door to get his bike out. He went missing or was absent from school. All this reinforced his violence and abusive behaviour and his attempt to exert control in the home. He continued to be offered support by the Targeted Youth Worker and the School nurse. As a result of a joint visit by children's social work and early help, arrangements were made for him to engage with local activities which he did not take up.

95. There is no record whether, with Daniel displaying patterns of aggressive and violent behaviour at home, his aunt was considered as a potential victim of direct personal violence. There is no evidence that Daniel directly threatened her, but she was increasingly desperate about managing his behaviour and he was violent in the house – damaging property and breaking doors. There is no doubt that Daniel's behaviour was threatening and a means of expressing both his frustrations and anger. It would have shown professional curiosity to ask whether this meant that aunt was the victim of violence even when it was not directed directly at her person.

96. On 1st April Daniel's GP referred him to CAMHS, referencing his "long-term behavioural problems at school and home", noting that the School was providing special schooling and that social care were involved. The referral says that his "mother (sic) was worried about the aggression Daniel was displaying toward his brother and that she believes he is depressed". Daniel did not engage with CAMHS - he felt he did not need the support - and his aunt was unable to bring him to either of the two appointments offered for Tier 2 support. Daniel was discharged unseen at the end of May, and the CAMHS worker contacted the Targeted Youth Worker because of concerns from his aunt that Daniel was violent to his younger brother and

that they had fought with household tools. The School nurse, who had worked with the family over a long period, reminded colleagues at a Child in Need meeting in May about the long history of domestic violence perpetrated by father. A change in Daniel's attitude toward females was reported at this time – showing a lack of respect – although the reasons for this were not clear and this was a contrast with his previous behaviour towards both his aunt and the School nurse. It was then, and continues to be, standard practice that if a young person does not engage with CAMHS this is reported back to the GP.

97. It is believed that Sarah and Daniel started their relationship in April 2015, and increasingly saw each other as a refuge from the pressures and anxieties they felt, and as an alternative to the professional help that was available. They have both commented that they saw their relationship as helping to resist what they felt was 'outside interference' or professional help. By the time of a CIN meeting on 25th August the view was that Daniel was making some progress, that his girlfriend, Sarah, was a good and calming influence, and that the brothers were getting on better.

98. In contrast Sue raised at an early stage her concerns about Sarah's contact with Daniel – she felt they were spending too much time together and saw the relationship as "good girl – bad boy". Sue was reported to have been concerned that it became a sexual relationship. Both Sue and Daniel's aunt discouraged them from spending time together away from the rest of their respective families and were uncomfortable about staying over. Their attempts to regulate and control this perhaps only increased Sarah and Daniel in their determination to support each other and to reject attempts to manage or control their behaviour.

99. It was agreed at the Child In Need meeting on 25th August that Daniel would step down to Team Around the Child. It is clear that Aunt was equivocal about social care involvement, stating that she had had no support over the years. She agreed to work with TAC but said that work with Daniel needed to be at school if it was to be effective. Daniel saw his social worker at school in early September. He said that things were better, that he was spending more time with Sarah, and not much with his aunt, and that he would work with the Targeted Support Worker (TYW) but did not want other services. He is recorded as "closed off", but that were no immediate concerns. There was an initial TAC meeting on 1 October and Daniel's case was closed to Social Care. Daniel continued to behave poorly in school, resulting in further exclusions and also truanting with Sarah.

100. On 13th October Sarah and Daniel were reported missing by Sue to the Police, School and Children's Services. They were believed to have gone off on cycles and taken food, winter clothing, a tent and sleeping bags with them. They had camped and then found a caravan but ran out of food and were found by police on 17th October after a report from a member of the public. They told police officers that they had gone off together because they believed that their families would not allow them to see each other anymore. It appears that Daniel had asked his aunt if Sarah could stay over and was told only if they slept in separate rooms. Both parents viewed

the relationship as detrimental for their child. The agencies' response to this incident was appropriate and followed agreed protocols.

101. A worker from Barnardo's saw both Sarah and Daniel for return interviews. Daniel did not want to engage as he stated that he did not want to get Sarah into trouble. In Sarah's interview she voiced the same concern, but she did share some of her views. She appeared to be concerned that her (older) step-sister had, she believed, mental health issues and that her mother suffered from depression and that therefore she might have similar mental health problems, despite her GP telling her "she was not that bad". She had wanted to die in the past but "everything had changed now she had met Daniel: she has something to live for". She said they had run away out of the blue – "it was the stress of everything". In a later interview with the TYW, Daniel said that he was pleased they had run away because it now meant he was allowed to see Sarah. He didn't care if people were worried.

102. School were asked to complete an Early Help Assessment (EHA) in late October as a result of this incident. Daniel was already under the TAC process and Sarah was now also supported in this way. The Targeted Youth Worker continued to work with them both jointly and separately through the following months, seeking to address their relationships, consent, sexual health, risky behaviours and anger management. This was a consistent and positive process that responded appropriately to Daniel and Sarah's varying moods and levels of engagement, but also sought to maintain a focus in improvement and encouraging positive thoughts, keeping safe and avoiding risky or disruptive behaviours. Daniel's behaviour in school continued to be challenging and he was at times excluded. He was not prepared to accept plans either for separate provision or for reintegration to mainstream teaching. Neither Sarah nor Daniel was consistent in their engagement and their relationship fluctuated. It would appear that Sarah found Daniel's continuing disruption at school difficult to handle. At the point of the Early Help Assessment Sarah described her relationship with Daniel as "good…she helps him keep out of trouble and get on better both at school and at home, particularly with his younger brother". Sarah says that is because she keeps him calm which makes her feel good.

2016

103. Both Sarah and Daniel were seen by a counsellor employed by the School in February 2016. Daniel did not engage meaningfully. Sarah talked more fully about her feelings and her relationship with Daniel. She stated that the relationship had changed from *"being happy and wonderful to stressed frustrating*". She described that "*when she met Daniel for the first seven months she did not feel like committing suicide, she felt she could talk to him, she felt safe with him. They were totally opposite but that was the attraction. He was strong and protective and eager to stand up for her, fighting and not being scared. She was there to support him with school work, not getting into trouble and doing the right thing*". He responded to her and "*made the right choices and this made her feel special and happy. More recently she was not able to support and help him as she is not in the same classes and this is making her*

feel anxious and stressed...they make each other feel down". Sarah felt she was doing better at school and could talk to people there, but preferred not to. It would appear from this account that their relationship had reached a stage where Sarah was more passive and attempting to defuse and manage Daniel's behaviour.

104. This seems an insightful and largely accurate understanding of her relationship. It appears to describe both the investment and the rewards that Sarah felt from her relationship with Daniel but also the increased anxiety. The anxiety of managing his behaviour was increasing, particularly as Sarah was demonstrating evidence of wanting to commit suicide again. If her situation had been viewed as consequent of DVA – with controlling and coercive behaviour from Daniel - this might have picked up as part of the volatile nature of their relationship.

105. During this period Sarah was also attending group POISE session on building her confidence and self-esteem, through which she recognised some improvement in her mood. However, her emotional state remained fragile and she repeated feelings of wanting to commit suicide. Daniel was continuing not to engage at school and a potential alternative education provision was being considered. It is less clear how Daniel felt about Sarah, although it appears he was clear that he saw their relationship as a means of establishing his independence from other ties and responsibilities.

106. By early 2016 Sarah and Daniel were at times finding their relationship difficult. A joint session with the TYW in February was terminated to allow them to talk alone as they had previously been arguing, and a few days later they were arguing and upset in the street and a police officer took them to home where Sue was happy to look after them and sat them down to discuss their feelings.

107. At a further TAC meeting on 4th March there was a more positive picture. Daniel's has been reintegrated into school and was helping his aunt to redecorate at home. He was looking at possible alternative education provision and it was agreed that 1:1 sessions would continue but that these would be separate as Sarah and Daniel would now be at different schools. Overall there was felt to be improvement in Daniel' home situation.

108. Sarah was absent from school and seen leaving with Daniel and was admitted to hospital from Daniel's home with an overdose on 17th March. She had taken the tablets following an argument with her mother and sister and had texted Daniel and met up with him. Daniel was felt to have acted responsibly in then contacting Sue and alerting her to the situation. Sarah is reported as feeling useless and that her relationship with her mother was poor. It appears that Sarah found her mother's attempts to manage her contact with Daniel by arbitrary command, and her unwillingness to discuss matters or reach a compromise on her behaviour, difficult to accept.

109. Sarah was seen by 2 CAMHS practitioners on the following day in hospital (not a mental health setting). Sarah reported unhappiness and suicidal thinking over the

previous year and that in the last two months she had been feeling more anxious. This contrasts with her presentation at the POISE sessions and in one to one sessions with the TYW and School counsellor. What is striking in this period of late 2015 through to April 2016 is how changeable, and at times conflicting, was the presentation that both Daniel and Sarah made to family, professionals and each other. Although each incident was responded to, there does not appear to have been any occasion to step back and look at these changing patterns of behaviour, and to evaluate what the contrasting statements and actions that both Sarah and Daniel were exhibiting indicted about how they were feeling.

110. On 10th April there was an incident at Daniel's home. Daniel had asked his aunt to pick him and Sarah up that evening in order to prevent him hitting a girl who was going to hit Sarah. (It later emerged that Daniel had assaulted this girl on the previous day during an argument between her and Sarah outside McDonalds.) Daniel's aunt was intending to drop Sarah off home, but Daniel said she could stay out to 23.30. Sue then called to say that Sarah was meant to be home at 20.00. Sarah and Daniel barricaded themselves in his room. Subsequently Aunt made it clear that Sarah was not welcome at her home.

111. On 12th April a TAC meeting for Sarah was held at the School, attended by Sarah and Sue, the School and the TYW. At supervision following the meeting, although a further TAC meeting was planned for the end of May, the TYW reviewed the case and began to consider closure and to start discussion with the family and agencies to see if this was supported.

112. On 14th April Sarah and Daniel were reported as missing by aunt as she had found a note saying that Daniel was "not going to school - will be back later". She believed he had probably climbed out of the window and was meeting Sarah. The police recorded them as absent and reviewed the situation later in the day. Aunt suspected that Daniel might return after the curfew for Sarah of 20.00. She called at the house twice later in the day and got no answer, and the incident was graded as missing by the police at 21.06 that evening. The following day, the School called the TYW to say that Daniel was not in school; neither were Sarah or Hayley with no explanation which was unusual. Sue was also not at work – again with no explanation. At 12.00 on 15th April officers forced entry to the house and found Sarah and Daniel lying on a mattress in the lounge and the bodies of Hayley and Sue in bedrooms upstairs.

Analysis against Key Lines of Enquiry

113. The following sections provide an analysis of the evidence collated under the Key Lines of Enquiry from the agency reports, interviews and expert reports identified above. They attempt to draw out the key points of learning rather than replicate all the evidence collected. In some cases key lines have been combined as the story they tell covers a range of points.

Impact of domestic violence

114. It is clear that all three children and Sue were exposed to domestic violence and abuse over a substantial period and that this is likely to have had a profound effect on them.[14] This is documented in police, children's social care and health records from 2003 onwards. It is also documented in the CAFCASS involvement with the family. Domestic violence and abuse was present over a long period within the family, including extreme violence (the use of a horse whip) by the boy's father towards his wife. Specialist reports and assessments concur that there was a significant impact on all the subjects. The extent to which Sarah and Daniel's relationship also had elements of coercion and control is examined in later paragraphs (157ff).

115. Daniel and his brothers witnessed several severe assaults by his father on his mother in 2003-4, as is clear from police records and for which he had been convicted. As a result, the brothers were on a child protection plan from January 2005 (when Daniel was 4 and a half) before returning to the care of their mother in 2006. There were major concerns about father's violence and aggression and mother's ability to safeguard the children. Daniel's mother died after a period of illness in 2006 and he went to live with his paternal aunt. Although Daniel remained in touch with his father on an episodic basis in future years, he several times reported that he did not feel safe with him. His aunt used physical chastisement with him and his siblings in 2011. He fought with his brothers emotionally and physically and had experienced and used violence as a means to resolve differences or to assert his independence, but this was never seen as exceptional for a young man described, like many of his peers, as "a stroppy, difficult teenager".

116. Sue fled from her husband due to domestic violence in April 2004, seeking refuge with her children and moving nine times to avoid discovery and contact. According to her this violence was witnessed by her children and perpetrated against herself, her older daughter and Sarah. There is evidence of coercive and controlling behaviour from her husband as well as physical violence. He alleges that Sue was violent towards him, but this is not substantiated with clear evidence. He was the subject of a Harassment Restraining Order from January 2005 to 2008. After a gap of nearly 9 years without contact he renewed attempts to make contact with Sue and the children. Following the proceedings in 2014-15 the court ordered twice-yearly indirect contact and a non-molestation order was made until Sarah's 18th birthday in 2019. Sarah recalls now that she had never seen her mother so scared as when her father called unannounced at the house in 2014 and that she felt extremely upset at the time.

117. It is clear that Sue feared for her own safety and did not want her children to have contact with their father and that these circumstances contributed in some part to a

[14] Stanley, N., Miller, P., Foster, H. R., & Thomson, G. (2011) Children's Experiences of Domestic Violence: Developing an Integrated Response from Police and Child Protection Services. *Journal of Interpersonal Violence*, 26(12), 2372–2391.

long history of depressive illness and associated anxiety. The exact details of the abuse she experienced are not fully recorded, but clearly had a lasting impact. This is not unusual as domestic violence and abuse is often hidden and not disclosed. It does appear to have included actual physical violence, emotional abuse and controlling and coercive behaviour, and was repeated when father reappeared in her life in 2014.

118. This affected her confidence and undermined her ability to parent Sarah and Hayley, and in 2008 she admitted that "she had lost it" and hit Sarah in the face. This appears to have been occasioned by her fears that her ex-husband had moved to live nearby, although the exact trigger or reasons for the incident are not recorded. Sue self-referred to Children's Services and a section 47 enquiry and joint investigation with the police was undertaken. Sarah and Hayley were placed with local foster carers in January 2008 with their mother's agreement under section 20. She acknowledged that she was struggling to care for her daughters in the aftermath of her separation from the father and with the fear that he had recently moved to live closer.

119. This episode resulted in the two girls entering foster care for five months and a very short period of in-patient psychiatric treatment for Sue. Sue maintained regular contact with the girls, got to know the foster carers and the case was closed in November 2008 after the children had returned to her care in May. Although the outcome from this episode appeared positive with the family reunited, I believe that this marked a decisive rupture in the relationship between Sarah and her mother that continued to resonate over the coming years. Sarah continued to refer to what she saw as a fundamental breakdown in trust, and a physical assault which demonstrated to her that her mother loved Hayley more than her. The fact that Sarah and Hayley adopted different emotional strategies to cope with their mother's anxiety only reinforced the separation between them. This episode was referred to by both Sue and Sarah when they had counselling and therapeutic sessions in 2014 onwards and clearly had affected them both. Hayley's comments in the EHA on October 2015 about help for her mum to deal with Sarah were apposite.

120. There is a solid research basis for the risk of harm to a child's physical, emotional and social development from exposure to domestic violence, although no causal links. Children are better able to cope with these effects when they receive consistent support to acknowledge the impact of their experiences and are able to develop long term relationships with adults they can trust.[15],[16]

121. A study looking specifically at children exposed to Intimate Partner Violence (IPV) in children under the age of 6 found that "*without intervention, young children may be at risk of developing relatively stable maladaptive cognitive patterns, thereby*

[15] Thornton, V. (2014) Understanding the emotional impact of domestic violence on young children. *Educational & Child Psychology*, *31*(1), pp.90-100.

[16] Howarth, E., Moore, T.H., Shaw, A.R., Welton, N.J., Feder, G.S., Hester, M., MacMillan, H.L. and Stanley, N., (2015) the effectiveness of targeted interventions for children exposed to domestic violence: measuring success in ways that matter to children, parents and professionals. *Child Abuse Review*, *24*(4), pp. 297-310.

heightening their risk of subsequent developmental psychopathology."[17] Megan Holmes suggested that little is known about the longer-term consequences of early exposure to IPV. In her study she suggests that, as early experience provides the foundation for later development, children exposed as infants or toddlers are likely to experience worse negative outcomes over time. She also consider the negative effects of poor maternal mental health and suggests that children exposed to IPV aged three or younger may have been exposed at a critical time in their development which can affect later development of aggressive behavioural problems.[18] In 2017 Horn et al. considered post-traumatic stress disorder in children exposed to IPV and suggest that early instances of trauma are potentially riskier and more detrimental than trauma experienced later in life and may have, "*specific and detrimental effects on children's biological, developmental and physiological responses."*[19] There are descriptions of Sarah's uncontrollable tantrums and hyper vigilance in keeping her mother in her sight aged 4. It certainly suggests that she was traumatized by exposure to domestic abuse early in her life at a key developmental stage. Daniel was similarly exposed to witnessing violence towards his mother, who then died prematurely from cancer, at an early age. The impact of both children of loss and trauma is clear. The Psychologist's report concluded that it appeared that Sue had herself a childhood characterized by neglect, physical and emotional abuse. He drew a parallel between Sue's withdrawal, avoidance and shyness as a child, and Sarah's similar presentation. This pattern may indicate that Sue had reduced capacity to provide the resilience and support that Sarah required, particularly when her father reappeared on the scene, and when Sarah was starting a new and intense relationship with Daniel.

122. The severity and possible impact of the exposure to domestic violence was not fully explored for any of these children, except in the psychological assessment of the family undertaken in 2014-15, when Sue's husband was seeking renewed contact with his children. This detailed report informed the court decisions on contact, and also the continuing work by the CAFCASS practitioner (FCA) to oversee these arrangements but did not prompt a referral to children's services despite the significant risks and additional needs that it identified. It appears that the Family Court Advisor intended to ask the School to make a referral to TAC (i.e. for formal early help and support) in February, but there is no evidence that this was done. Although worried about Sarah's well-being, she felt Sarah had a good enough relationship with her mother and could go to her for support. I believe this was an optimistic judgment and that there was evidence that the relationship between Sarah and her mother was problematic from at least 2008. This is not to suggest that their relationship was exceptional between a mother and her teenage daughter or that it might lead to violence but is in the

[17] Developmental changes in threat and self-blame for pre-schoolers exposed to intimate partner violence (IPV) / Miller, Laura et al. (2014*) Journal of Interpersonal Violence* 29(9), pp.1535-1553

[18] Holmes, Megan R. (2013) The sleeper effect of intimate partner violence exposure: long-term consequences on young children's aggressive behavior *Journal of Child Psychology and Psychiatry* 54:9 pp. 986–995

[19] Sarah R. Horn, Laura E. Miller-Graff, Maria M. Galano & Sandra A. Graham-Bermann (2017) Posttraumatic stress disorder in children exposed to intimate partner violence: the clinical picture of physiological arousal symptoms, *Child Care in Practice*, 23:1, pp. 90-103

context of the other stresses and past history that both had experienced.

123. This review also highlights the challenges of understanding domestic violence and abuse in the context of parenting for troubled adolescents and the complex ways in which relationships can be manipulated. The complexities of recognizing and understanding the impact of domestic violence and the possibility of child to parent violence and aggression has been part of training programmes and practice development in Lincolnshire as a result of learning from this case.

124. The recommendation from the Psychology report that the family would benefit from therapeutic work together was not taken forward coherently. A referral to the mental health trust for family therapy was made by the GP, but does not appear to have been received by CAMHS. Sue accessed CBT on an individual basis and found this helpful. Following the School's urgent referral when Sarah handed in a suicide note in February the GP secured a prompt CAMHS appointment within two weeks, but it appears Sarah only attended two individual sessions and was stepped down to Tier 2 in April and discharged from CAMHS in November 2015. The CAMHS worker agreed to attend the initial TAC meeting in November but informed the School that the CAMHS case would be closed as there were no mental health issues. The detailed assessment of Sarah and her family contained in the psychology report could have been the prompt for a coherent and inclusive offer of support, coordinating the insights from CAFCASS, Children's Social Care, the School, CAMHS, but this did not materialize, and Sarah had little sustained support through 2015, when she was perhaps particularly vulnerable, until after she and Daniel went missing in October. It is perhaps not surprising that she found refuge in this new relationship, thus reinforcing its exclusive nature. It is important to note that the report was commissioned by the court and was not therefore available directly to the agencies working with Sarah and her family who did not have sight of the full report – only the referrals prompted by its conclusions.

125. Sue benefited from her course of CBT, but Hayley was not included in any programme and there was little work which supported the whole family. Sarah continued to feel herself isolated from her mother and sister, increasing her feelings of rejection and exclusion.

Attachment to and contact with significant adults

126. The psychologist's report provides a detailed analysis of the attachment issues for Hayley and Sarah. It concluded that Sarah had an anxious avoidant attachment to her mother and that she felt adrift within the family. It viewed her as a child in some emotional turmoil with a worrying psychological profile. The view was that Hayley's attachment to her mother was more secure; although she showed symptoms of anxiety and nervousness and that she had developed a conforming aspect to her personality as a means of parent-pleasing. These were significant assessments by the psychologist and supported by the FCA's work with the family, which highlighted real and long-standing concerns and could have resulted in a referral to Children's Services

and a full family assessment and consideration of Sarah's needs as a Child In Need although not in immediate risk of harm. If this analysis had been available to practitioners in subsequent months, it is possible that it would have informed a better appreciation of Sarah's behaviour, and a more complex analysis of the family dynamics. The continuing attempts by father to make contact in defiance of court orders and professional advice only prolonged the concerns and the conflicting emotions prompted for Sarah. The Family Courts have increasingly recognized the importance of protecting children and partners from the possible impacts of continuing contact with perpetrators of domestic violence and abuse.[20] His behaviour had many of the characteristics of persistent coercion and control often seen in cases of domestic violence and abuse.

127. Instead, the evidence of Sarah's possible suicidal ideation from the School, and the subsequent referral to CAMHS from her GP, although appropriate and timely, distracted attention from the whole family dynamic. When Sarah only attended six CAMHS sessions between February and October 2015, with a significant gap due to the summer holidays, the opportunity for a more comprehensive approach slipped by. What is clear is that the difficult relationship between Sarah and her mother was identified at an early point (at least 2013) and continued to be reported by a number of practitioners as a matter of concern, although the relationship fluctuated and changed, and at times both said that they were getting on better. A consistent engagement with this root cause might have enabled both Sue and Sarah to establish a better relationship. Conflict between mother and daughter in teen years is not unusual, but again the psychology report had suggested that this was deep-seated and required specialist help, and both mother and daughter had been exposed to considerable trauma over a lengthy period.

128. Specialist reports for the trial on Daniel note his experience of insecure attachment and childhood trauma. He witnessed severe violence from a young age, had been rescued from a house fire by his brother, seen the break-up of his parents' relationship, and when his mother was unable to provide adequate care, he was removed to foster care, separately from his brothers. He had a number of different foster placements. His mother died when he was 5, and he was then cared for by his aunt who at times found this difficult. There was a history of challenging and aggressive behaviour with his brothers and with his aunt. Bereavement is understood to have significant consequences for children, particularly when support is not provided.[21], [22]. The School nurse who worked with him for nearly 7 years was of the view that some counselling work around loss and bereavement would have benefitted Daniel. His aunt repeatedly declined to allow him to be referred until 2012, 6 years

[20] See the Revised Practice Direction 12J issued by the President of the Family Division in October 2017.
[21] L. Rolls & S. A. Payne (2007) Children and young people's experience of UK childhood bereavement services, Mortality, 12:3, 281-303

[22] Akerman R. and Statham J. (2011) Childhood bereavement: a rapid literature review of educational and psychological outcomes and the effectiveness of interventions. Report to the Department of Education and Working Paper in Childhood Wellbeing Research Centre,

after his mother's death.

129. All this suggests concerns about the strength of Daniel's attachments, and his capacity and resilience to manage, regulate and express his emotions. He lacked the close and secure relationships with primary caregivers that provide the main opportunity for children to acquire these skills, although his aunt provided some stability and he particularly enjoyed it when he was able to stay with her on his own when his siblings were with their father. He enjoyed her company and she showed him physical affection with cuddles before school. In her evidence to this Review his aunt was resolute in her love and attachment to Daniel. As with Sarah there was no point at which a more comprehensive assessment was made of this complex history, but rather a series of interventions and support, which while appropriate in themselves responded to the Daniel's symptoms rather than the root causes of his behaviours.

130. In 2011 there was concern about Aunt's use of physical chastisement, and her ability to cope with the children. She is reported as threatening to send them back to foster care unless they behaved. In early 2015 she was rejecting help, but threatened that she might hit the boys to force social care to intervene.

131. Daniel had a difficult and conflicted relationship with his father, influenced by his father's heavy drinking which resulted in a lack of care, supervision and nurturing. In early 2014 Daniel was under stress when he was being bullied at school, his aunt was ill with cancer, and he was being hit by his brother. At times he said he was having fun with his father and liked to see him. But in August 2014 he ran away from his father during a canal holiday – this trip took place despite a Child In Need assessment which had concluded that Daniel's father could not provide adequate supervision. Daniel reported several times that he did not feel safe with his father.

132. Daniel showed marked behavioural and discipline problems at primary school – he disliked authority and was physically aggressive to staff. The antisocial and at times violent behaviour continued at secondary school where he was the subject of short-term exclusions for a range of defiant, aggressive, non-compliant and disruptive behaviours. This led to his placement in the specialist provision within the School from March 2015. Despite attempts to reintegrate him to mainstream school he remained disconnected from school and his peers.

Involvement of Sue's husband and the girls' father

133. He had not been in touch with the children for nearly ten years when he made contact in 2014, although Sue had been frightened of his reappearance in her life throughout this period – and he was a largely unknown individual to Sarah and Hayley. Their knowledge of him was largely informed by their mother's views. The court-ordered psychological report concluded that father had a chronic history of instability and dysfunction in his behaviour, lifestyle and relationships. He blamed his wife for the break-up of their marriage and for denying him access to his children – a view he

repeated strongly when interviewed for this Review. The expert report confirmed the assessment of the CAFCASS Family Court Advisor who felt that the dangers of direct contact with him outweighed any potential benefits until the relationship between Sarah and her mother improved and Sarah was more psychologically stable and emotionally robust. Neither Sarah nor Hayley wanted contact and wrote to the court to that effect, and in February 2015 a contact monitoring order stipulated indirect bi-monthly contact. Within a week father had sent Sarah his old mobile phone and SIM, and subsequently sent her a card, blaming Sue for the fact that he could not see Sarah and encouraging her to make direct contact with him. This fits a common and recurring pattern of controlling behaviour.

134. Father saw no reason to comply with the court orders limiting contact – in his interview he repeated his view that his rights as a father overrode the court decision: "They have a right to have me and I had a right to have them". He blamed Sue entirely for the breakup of their relationship and the loss of contact with Sarah and Hayley – he alleged that she was violent and had lied about him. He conveyed this view to Sarah through his letters and attempts at contact with her in 2015, which can only have added to the confusion and uncertainty in Sarah's mind about her feelings for her parents, and her place in their affections.

135. Father's attempts to contact Sarah undoubtedly increased the tension between Sarah and her mother. Hayley was clear and consistent that she wanted no contact with her father, but Sarah appears to have been less certain. Father went to the family home to give Sarah a birthday present of a watch within days of being told it was not appropriate to do so, and he subsequently met with Sarah and Daniel in person in August 2015, and Sarah recalls that she felt very uncomfortable with his attempts at physical contact and was left very unsure of how to deal with his presence.

136. With Sarah's equivocal response to her father and to contact, these actions can only have increased her emotional turmoil. They also allowed Daniel to reinforce his role as Sarah's protector and sole point of refuge.

The effectiveness of interventions and support

137. Both Sarah and Daniel were offered a number of interventions and support, but these resulted in contrasting outcomes and were not always coordinated between agencies. Hayley was unknown to specialist services and Sue received some help with her anxiety and distress. Several workers persisted in their efforts to get to know these families and to provide support but there were no indications that there was a risk of harm to Hayley or Sue. The context of repeated and persistent domestic violence and abuse – and the long duration of the effects of this – was not fully appreciated by those who worked with or knew these families.

138. In June 2013 Sarah was referred to Children's Services by her school. An Early Help assessment was completed by school which identified that Sue loved Sarah very much but was worried that Sarah felt that her mother did not love her. Sue felt that Sarah

mistrusted her. The School expressed concerns that Sarah was not dealing well with more dominant friends at school, including a friendship with another girl at school who told Sarah exaggerated stories about her own life, which awakened some difficult memories for Sarah. At the time Sarah was staying with her ex-foster mother, and both her ex-foster mother and her family were noted to be a substantial support to Sue and her daughters as they had little in the way of support from their own extended family. The case progressed to Team around the Child.

139. Sarah was allocated a Targeted Youth Support worker (TYW) who undertook effective direct work with Sarah over the following months using a variety of tools and sessions, encouraging her to join a support group (Time to Talk), to attend a POISE (Programme of Improving Self Esteem) group starting in September 2013 and to undertake 1:1 work around feelings and emotions. However, despite repeated statements from Sarah that she hated her mother, that she wished to be part of another family, felt jealous of her sister who she felt was loved by her mother more, the extent to which this relationship had broken down was not fully assessed. In my view there was a tendency to view each succeeding transaction, whether positive of negative, as defining the issues to be dealt with, rather than a more curious assessment of underlying causes.

140. This pattern continued through 2015 and 2016. Both Sarah and Daniel were offered and received a range of support, and there was a considerable effort through school and the TYW to build a trajectory for improvement and greater resilience. However, this remained fragile and perhaps relied too heavily on the reported feelings of Sarah and Daniel at each stage or presentation, rather than analysing more critically the conflicting emotions and behaviours that were apparent. Given the significant and lengthy history of low mood, anxiety, subsequent self-harm and volatile behaviours I believe it is reasonable to consider whether a Child In Need assessment should have been started in March 2016. Although Sarah's presenting issues were not as extreme as some young people. A social care assessment is not just a gateway to social care services, but is also a means of bringing social work insight to complex and multi-faceted cases. It would have also been an opportunity to bring together the disparate understanding from other services. Previous episodes of intervention for both Daniel and Sarah had not enabled sustained improvement in their presenting risks, and at this stage it was clear that their relationship itself was a further complicating factor for them, and for those seeking to care and support them. The purposeful sharing of information about Sarah and Daniel, with regard to their risks of harm to themselves, might have strengthened the joint understanding of their individual situations and the complicating factor of their relationship and behaviours. However, this is a matter of judgment, and although of concern, their individual and joint behaviours were not the most extreme nor did they present any consistent evidence of a risk of significant harm. There is nothing in the previous history that indicates that either was a risk to Sue or Hayley, but rather that their risks were of self-harm, isolation and disassociation from their support networks.

141. Both Sarah and Daniel were offered or received CAMHS services. In Daniel's case

he did not wish to engage and did not attend any appointments, while Sarah's involvement was limited through 2015 and then again after her suicide attempt in 2016. Neither had a diagnosed mental illness, although they clearly presented challenging behaviours and experienced considerable anxiety, emotional distress and were psychological vulnerable and volatile. CAMHS assert that Sarah was given the support that she was assessed to need at the time.

142. Daniel made it clear when interviewed that he had not wanted support – he found the involvement of so many people in his life difficult and he wanted more space. In hindsight he observed that it might have made things easier for his aunt if she had had a break from him and his brothers "At the time I probably wouldn't have wanted to move to a different area, but it might have been good for me. I needed more space."

143. I am not convinced that CAMHS fully investigated the persistent and deep-seated nature of Sarah's issues, the extent to which they were intimately combined with the domestic violence and abuse in her early life. The service response was focused on matching Sarah to what was felt to be the appropriate level of service for her currently presenting behaviours (with the reallocation to Tier 2 support in May 2015) rather than to her underlying needs. It is clear from the GP referrals (including the references to the court report), input from Sarah and her mother, her suicide attempt in February 2015 and the significant history of concerns, that Sarah needed an on-going package of support in which mental health expertise played a part, but that this was difficult to match to a diagnosis or specific services. It is also clear that the relationship with her mother was a key feature in improving her well-being. Indeed, the CAMHS practitioner who saw her at Tier 3 requested the CAMHS consultant's opinion in April 2015 about the possible admission of Sarah to an acute inpatient unit for a period of assessment and observation to help establish the best way forward. This might have been a positive opportunity to assess Sarah's needs more comprehensively. The consultant did not respond to this suggestion in his reply to the GP about Sarah's care.

144. Since these events the CAMHS services has been re-commissioned to offer a more inclusive service for young people in need to emotional support but who might previously have not fitted the criteria for Tier 2 or Tier 3 services. This is a welcome change and it is possible that this more flexible service might have been better placed to respond to Sarah and Daniel's needs had it been available at the time.

145. Hayley was not in receipt of any specific interventions. Her voice is heard through limited school reports (see below) and in the care taken by the CAFCASS FCA to record and present her views to court. It was perhaps assumed that her compliant behaviour did not indicate any particular needs, but the court report suggests that she also was not securely attached to her family and that further support to her individually and in the context of the whole family might have been beneficial.

The importance of wider networks of support

146. This KLOE asked agencies to consider the friendship, employment, social and

support networks available to Sue to support her role as parent, and to support her own emotional wellbeing. Beyond the school and church connections there was little evidence of other community or social contact that might have prompted any potentially protective 'bystander' intervention in the lives of either family, and nothing that might have triggered this. Neither family appeared to have a wide or especially close social network other than the examples noted in the Report.

147. The agency report compiled by the Diocese on behalf of the church attended by the family sets out very clearly the importance of the church, school and related activities to the life of Sue. It is also clear that the friendship with Ms F[23], who had been the foster carer for the two girls in 2008, was a significant support.

148. Ms F had introduced Sue to the School, where Sue secured a job as a Midday Supervisor, and she was Sue's manager in that job. She had helped introduce the girls to the School, and her husband had assisted the family when they moved home. She continued to see the family and provide support to the girls. The importance of these relationships does not appear to have been recognized by professionals working with the family and might have been linked into a more comprehensive package of support. Ms F felt that Sue was trying her best with no support.

149. Sue became involved with the church in 2013 through helping with the School drama club, where the Priest in charge was a facilitator. The family started to attend church from 2013 and were baptized and confirmed together in May 2014. Sue was involved in the setting up of the church choir and other activities involving children at the church. She was popular with the children, seen to be good at keeping discipline and was well liked by other members of the church community.

150. She did share some information about her previous circumstances and the domestic abuse she had experienced with the churchwardens and the lay minister. The parish did not have at that time a robust understanding of safeguarding, nor did it enact the necessary policies and record keeping. An incident in autumn 2015 when her husband turned up at the church car park when Hayley and her mother were about to leave on a trip was recalled by church members in interview, but was not recorded at the time and the visible distress felt at this incident by Sue and Hayley did not trigger any further action. Hayley was very distressed and had to be taken inside a calmed down by church members, and Sue shared her concern that the father had turned up to visit Sarah when she and Hayley would be known not to be at home. There was not an appreciation that this could be related to significant risks of harm – neither Sue nor the girls were viewed as possible victim of domestic abuse or harassment. This strengthens the importance of ensuring that public awareness of and attitudes towards these risks must be developed and promoted, and that community and faith organisations have a considerable role to play in identifying and responding to such concerns.

[23] This is an anonymised name.

The relationship between Sarah and Hayley

151. All accounts of the family note the differences in character between the two sisters, the contrast in their relationship with their mother, and the fact that they had a difficult relationship. I attach particular importance to the incident when Sue hit Sarah in 2008 and which resulted in the period of foster care. I believe this indicated a growing separation between the sisters and a divergence in their relationships with their mother. Sarah recalls that they got on really well when younger, but that as they grew older her sister became "closer to mum than me". Sarah felt that she did not have the same quality time with her mother and that her mother spent most of the time with Hayley.

152. It appears that Sarah felt that the arrival of her younger sister had displaced her from her mother's affections – not an uncommon reaction from an older child, but the frequent moves and uncertainty of family life after Sue sought refuge away domestic violence may have made this difficult to overcome. The single episode in 2008 when Sue hit Sarah reinforced her alienation and the distance she felt from her sister, who she began to see as her mother's favourite.

153. The engagement with the family from various services largely focuses on Sue and Sarah – Hayley's voice and views are not frequently recorded. The CAFCASS FCA who worked with the family took time to listen to each child and clearly reflected their different responses to their father in her recommendations to court, and in her advice and support directly to the family.

154. At several points Sarah referred to her feelings that Hayley was, as she saw it, more loved by her mother, and that she received more of her mother's time and attention. Their relationship went up and down – sometimes sharing and sometimes not. Hayley is reported as finding her sister's behaviour difficult and wanting her to have someone to talk to.

155. School records provide something of a portrait of Hayley. From her primary years there are the following comments:

- In Year 1, Hayley is described as a happy and confident girl who settled well amongst her peers. She was keen to help others and showed understanding of rules and routines.
- She is subsequently described as well behaved, making progress and working hard, and forming good relationships with both adults and children. In Year 4 Hayley is described as "a cheerful girl who was always willing to undertake jobs round the classroom, in addition to having impeccable manners". In Year 5 Hayley is "someone who volunteers her time to complete many responsibilities which she completes to a high standard. She is trusted with many additional lunchtime tasks and applied a lot of effort to her learning activities".

156. An indication of how Hayley viewed her sister is provided in her recorded feelings following the episode when Sarah and Daniel went missing in October 2015. Hayley

is reported to have been very relieved that Sarah was back home as both she and her mother had been extremely worried. Hayley felt that Sarah did not want to join in with things at home – just wanting to play on her iPod and not speaking to anyone. Hayley stated at this time that she felt that Sarah got stroppy if her mother asked her to do anything and thought that Sarah would benefit from someone to talk to as she does not want to talk to her mum or Hayley. Hayley went on to say that it would be helpful if mum could have someone to help her when Sarah was not doing what she is asked to. Hayley said that she liked it when she and Sarah had played games together the previous night as Sarah did not have her iPod at that time. She would have liked more of these times.

The nature of the relationship between Sarah and Daniel

157. The relationship started around April 2015, perhaps a little earlier. This was a time of uncertainty, low mood and pressure on both young people. They each saw themselves as isolated within their family situation and felt forced to rely of their own resources rather than trust others for help. Sarah had been coping with her mixed emotions about her father's reappearance and his attempts to establish access and then to contact her in contravention of her mother's wishes (and the court order). Her GP had referred her and Hayley for CAMHS and family therapy, although this did not proceed. Sarah had indicated suicidal ideation at school. Daniel had gone missing in March and April, was displaying a range of violent and aggressive behaviours, and when referred to CAMHS had declined to become engaged. He was vulnerable and uncertain.

158. Both Sarah and Daniel expressed at several occasions their sense of being isolated from the rest of their family. Daniel had lost his mother through cancer; Sarah did not know her father. Daniel felt the odd one out between his two brothers – and was extremely equivocal in his feelings about his father – he rejected his drinking and violent behaviour, but also wanted at times to be with him, but found it difficult to sustain contact. Sarah felt that her younger sister had usurped her mother's love and that she had lost her father, and that her mother was against any future contact with him. Sarah recalls that they both felt "isolated, lonely and let down by the world" and that it was "nice to have another person who felt the same way". Sarah felt that she did not have anyone to turn to apart from Daniel.

159. Daniel said that he was attracted to Sarah because "She listened to me. It was a first. My auntie would listen to me, but not the same – a different generation". He and Sarah shared interests and liked reading. Daniel was finding school difficult, moving out of mainstream teaching– and Sarah felt protective towards him and that she could help him re-integrate.

160. When their relationship started it was first seen as bringing some stability and that Sarah was a positive influence on Daniel and had helped calm some of his behaviours. Very rapidly over the summer the relationship became more exclusive, culminating in the episode when they were missing for 4 days in October. It appears that their shared

feelings of low esteem were mutually reinforcing – and that they came up with the idea of running away on the spur of the moment as a means of escaping all that they found difficult.

161. Work with them continued both jointly and singly, concentrating on relationships and safety. It does not appear that the underlying indications of alienation and isolation were addressed. It is positive that joint work was done through the Targeted Youth Worker working with them both, and also that the two School nurses agreed to hold the cases separately although there was limited contact with them as there were no new health needs identified into 2016.

162. In late 2015 after the missing episode both received appropriate sexual advice and were judged to be Gillick competent – although under 16 they had the maturity to understand and make decisions about their sexual health without the expressed consent of a parent. However, the advice needed to go beyond sexual and health matters and needed to focus on promoting a healthy relationship. It is clear that for both children there were already elements of manipulation, control and coercion in their relationship, in both directions.

163. Whilst safeguarding polices need to challenge the perception of partner violence as a normal aspect of teenage relationships. Interventions also need to assist young people to recognise the difference between caring concern and coercive control. Many of the young people in a recent study had come to view violence as a normal aspect of intimate relationships. Violence for some was present in nearly all areas of their lives, including families, peer groups and in their intimate partner relationships, as recipients, instigators or both. For several, violence had become so ingrained in their childhoods that to acknowledge the emotional or physical impact of violence, including intimate forms, was viewed as an indication of weakness. This severely restricted their ability to seek help. More girls in the study, compared with the school-based research, viewed partner violence as a 'normal', if unwanted, aspect of their relationships. This impeded participants' ability to recognise the psychological damage such violence can have on victims. Female participants also normalised their partners' high levels of control as an expression of protection and love.[24]

164. It appears that their relationship became more volatile towards the end of 2015 and into 2016. Sarah was concerned about Daniel's disruptive and angry behaviour in school, and that he might move to a separate education provision. Each was using the other as a means of establishing independence from what they each felt was the control of their mother and aunt.

165. When Sarah took an overdose in March 2016 Daniel had taken what was observed as a more mature and caring approach in ensuring Sarah's safety and letting her

[24] Sousa, C., Herrenkohl, T. I., Moylan, C. A., Tajima, E. A., Klika, J. B., Herrenkohl, R. C., & Russo, M. J. (2011) Longitudinal Study on the Effects of Child Abuse and Children's Exposure to Domestic Violence, Parent-Child Attachments, and Antisocial Behavior in Adolescence. *Journal of Interpersonal Violence*, 26(1), pp. 111–136.

mother and others know what was happening.

166. Clearly Sarah was at this point in a very low mood. She explained to the Barnardo's worker that she had a bad relationship with her mother and that she was anxious because she felt that all her family had mental health problems. She was not getting on with Daniel as he was continuing to get into trouble at school. There was not a coordinated response to her situation and her expressed worries. A CAMHS risk assessment was completed on 31 March and Sarah agreed to attend an anxiety management group, stating her preference to commence in the summer due to transport issues. Although Sue told staff that Sarah was 'oppositional at times' the CAMHS assessment did not see signs of Sarah having an unusually strained relationship with her mother. This view was not informed by the wider knowledge of her history and family dynamics and resulted in a minimal evaluation of risk and or the urgency in providing Sarah with support. This was a significant missed opportunity.

167. Sarah and Daniel invested a great deal in their relationship initially – it was seen by them as a counter to their difficult and volatile relationships at home and at school. It quickly became the main focus for their time, became sexual, and offered to each other support that they were not able or prepared to accept from other sources. This is demonstrated by the missing episode in October, which was an extreme attempt to find refuge with each other from their worries and concerns. Towards the end of 2015 it is clear that the relationship was under some strain, as it was not bringing the security and stability each wanted. Daniel continued to be disruptive in school, and Sarah was increasingly feeling that she was neither getting the support she wanted from him, or that her influence was mitigating his behaviour. From February 2016, the behaviour and reported mood of each was becoming more volatile, resulting in further incidents of self-harm, missing and truancy, arguments and aggression with each other and others, including family, school peers and professionals. Sarah was not considered by Children's Services to reach the Child in Need threshold after her overdose in March, and yet the TAC process was not sufficient to enable a wider view to be taken of their situation both singly and together. This is reflected in the mixed reports different agencies presented at TAC meeting on 12th April (see paragraph 173 below).

168. This pattern reflects research evidence of how children react to trauma. Boys seem to express their distress much more outwardly, for example by becoming aggressive and disobedient. Sometimes, they start to use violence to try and solve problems and may copy the behaviour they see within the family. Older boys may play truant and start to use alcohol or drugs (both of which are a common way of trying to block out disturbing experiences and memories).

169. Girls are more likely to keep their distress inside. They may become withdrawn from other people and become anxious or depressed. They may think badly of themselves and complain of vague physical symptoms. They are more likely to have an eating disorder, or to harm themselves by taking overdoses or cutting themselves.

They are also more likely to choose an abusive partner themselves.[25][26]

Social Media and other influences

170. There is little evidence that social media were used much by either Sarah or Daniel or that it had any significant impact on their lives. However, it appears from Daniel's own account that they were introduced by a mutual friend through social media and regularly exchanged text messages. There was little evidence from the police investigation or other sources that they either used social media extensively except to exchange routine messages or were influenced by other media in their behaviour.

Conclusions

171. **No action or engagement with the individuals could have predicted that Daniel and Sarah could or would commit murder. Sarah and Daniel were responsible for the actions they planned and undertook, and for the deaths of Sue and Hayley. There were no actions or interventions by agencies that might have prevented the murders. Their needs during this period did not reach any threshold for intervention that would have removed either of them from the care of their families or led them to be under any form of supervision beyond the day to day care of their families and professional support that was provided to each.**

172. By reviewing the experiences of the subjects, the professionals and others involved, it is possible with benefit of hindsight to suggest some areas of practice that could be strengthened for the future. There were a number of occasions when opportunities to provide further support were not developed.

173. Sarah received positive and sustained support from a Targeted Youth Support worker through 2013 to 2014. In July 2014 the worker received a thank you card from the whole family acknowledging the impact her support had had. The worker had learnt a great deal about Sarah and her relationships and emotional health and wellbeing. However, despite several instances when Sarah repeated that she hated her mother, and that mother would be happier with Sarah out of the way, there does not appear to have been a discussion with Sue about this or consideration of whether a **multi-agency discussion** or strategy meeting should have taken place to determine whether there were persistent concerns. If the detailed psychological assessment report and the concerns it illustrated had been the basis for raising a safeguarding concern to Children's Services from CAFCASS, the extent of the worries about relationships in this family might have been better understood. Signs of Safety, which is now widely used in Lincolnshire, would have been an appropriate framework to work with both Sarah and her mother to identify more clearly their relationships and

[25] Dong, M; Anda, R.F.; Felitti, V.J.; Dube, S.R.; Williamson, D.F.; Thompson, T.J.; Loo, C.M.; Giles, W.H. (2004) The Interrelatedness of Multiple Forms of Childhood Abuse, Neglect, and Household Dysfunction" *Child Abuse & Neglect*. 28(7): pp. 771–84.

[26] Wood, M., Barter, C., & Berridge, D. (2011). *Standing on my own two feet: Disadvantaged Teenagers, Intimate Partner Violence and Coercive control.* NSPCC.

to explore their wishes and feelings and whether these presented risks or additional needs that required support. This might have identified more clearly whether there were substantive threats to the resilience and wellbeing of both Sue and Sarah. To undertake an assessment other than due to risks of immediate harm consent would have been required, but there is no suggestion that this would not have been forthcoming from Sue.

174. In May and June 2014 concerns about Daniel and his brothers were mounting. In May Daniel moved to the separate provision in school to avoid permanent exclusion. In June following two referrals, the case was allocated for a Child In Need social care assessment. This identified some of the problems with father's care and supervision, the setting of boundaries and the lack of shared expectations between him and aunt, the need for her to have some respite and the tensions and fighting between the brothers. The assessment identified that Daniel felt the odd one out with his brothers and as a result often got frustrated and angry. In August, despite the concerns about their father's care, it was agreed that the boys should holiday with him. This undermined the attempts to strengthen aunt's capacity to manage, although it did provide short term respite for her. Daniel ran away from this boat trip and was found by police and returned to his aunt's care. A Family Group Conference was organised in October, but the wider family support and development of a plan does not appear to have been followed up. This was a combination of concerns that might have prompted a **more thorough assessment of the underlying dynamics**. Instead there was a shifting focus on Aunt's need to support; Dad's behaviour and lack of effective supervision; the fighting between the brothers; the wider network through a Family Group Conference not followed up. This changing attention of each issue persisted through to 2015 and did not enable a consistent plan to develop for Daniel, against which he and others could measure progress, and which could underpin improvements in his behaviour and wellbeing.

175. The family received positive support from the CAFCASS Family Court Advisor during 2014 and 2015. This worker established a good relationship with Sue, Sarah and Hayley and had a clear appreciation of their needs and the tensions in their relationships. She was also clear about the negative impact of her husband. The expert report highlighted some worrying psychological issues and complex attachment and family dynamics. It was unfortunate that a **formal referral to Children's Social Care to assess the risks** within this family was not made in early 2015 informed by these insights. There were constraints on what could be shared from the court process, and one of the parties had refused consent for the report to be shared – but the issues raised were significant. The CAFCASS worker apparently intended to make a referral but this was not done.

176. It was also a regrettable that the GP's **recommendation for family therapy** was not followed through when this was made in January 2015. Instead of a response which engaged with the whole family, Sue and Sarah went on to have separate interventions from mental health services (CBT for Sue and CAMHS Tier 3 and 2 appointments for Sarah). Although both these interventions recognised the centrality of the mother/daughter relationship they did not directly engage with it, nor did they

include Hayley. Some of Sarah's CAMHS appointments were conducted with her mother – in others she was seen alone. At least one of her appointments was arranged to suit Sue's availability. This may not have been helpful in placing Sarah herself at the centre of the treatment and may have increased the feeling of "being trapped" that she repeatedly reported at this time. Sarah now recalls that she did not feel listened to and was not able to articulate her concerns.

177. **Sarah's engagement with the CAMHS** service following her referral with suicidal ideation in February 2015 was not sustained. Her mother accompanied her on most appointments and CAMHS do not appear to have been aware of the wider family situation. While the step down to Tier 2 was appropriate as Sarah did not have a diagnosed mental illness, the inability to arrange a convenient appointment meant a four-month gap between April and August 2015 when she was not seen, during which her life was undergoing a lot of new pressures and changes. The CAMHS practitioner taking on her case at Tier 2 did not regard the gap as clinically concerning because of the information she had received in handover – but Sarah did not see her until 19th August, and then presented in a more positive manner, so that the record of that meeting is about whether she requires on-going CAMHS support rather than picking up on the disturbing behaviours and anxieties of the previous months. It was unfortunate that she did not receive continuing CAMHS support until the autumn and she was then discharged in November and transferred to the Team around the Child process. The CAMHS worker linked positively to the TAC support, but there was little direct therapeutic support for Sarah through this period.

178. The CAMHS assessment of Sarah did not fully recognise the strained relationship between Sarah and her mother. The School continued to be concerned about Sarah's expressed depression and alienation from her mother and sister and had requested that Sue make an emergency CAMHS appointment in April 2015. This she did supported by her GP's referral. The FCA worker observed the impact of father's attempts to make contact and that this was giving rise to further anxiety. Following Sarah's overdose in March 2016 CAMHS felt there was reduced risk of self-harm and that Sarah did not presented any risk to others. A safety plan was agreed, and further work with the CAMHS anxiety group was proposed to start in a few weeks' time. Sarah was discharged from the self-harm pathway on 11th April.

179. **Psychological support for** young people who display troubling behaviours and are emotionally volatile, but do not have a diagnosed mental illness is widely recognised as a significant gap in the pattern of CAMHS services nationally. The re-commissioning of services in Lincolnshire to provide greater flexibility is a positive development and might have provided a greater chance for sustained and effective engagement with Daniel and Sarah if it had been in place at the time. The workers involved were appropriately qualified and trained, although the Panel was not advised that they had had specific DVA training. There is now a significant programme to underpin and strengthen the awareness of the impact of DVA on families.

180. Daniel was referred to the single point of referral for CAMHS by his GP in April 2015. **He declined to engage and was discharged unseen**. There is a contrasting

picture of his situation recorded by different services. Social care records suggest an improving picture with Daniel engaging with education and having a better relationship with his peers, and with his aunt. The School nurse records that his behaviour changed at this time and became more focused in opposition to his aunt rather than towards his brothers. The significance and extent of these changes and the different presentations were not evaluated. At precisely the same time Sarah and Daniel started their relationship, found refuge in this from the other difficulties and challenges they felt, which only increased their reliance of each other. The fact that neither Sue nor Aunt was happy with the relationship reinforced this.

181. Sarah continued to be supported through the TAC process through 2015 and 2016, when the range of her needs, in my opinion, might have suggested that a **social care assessment was appropriate**. The complexity, longevity and repeating nature of her needs should have suggested that a multi-agency discussion, pooling information and awareness, might have helped identify how Sarah could be better supported and that that this could have included social work input. Trigger episodes (going missing, overdose) did not appear to change the level of need or risk that was recognised. After her overdose in March 2016 Children's Services said that she did not reach the CIN threshold and continued to offer support through the TAC process. While Sarah did not appear to be at risk of significant harm, she was, in my view, clearly a child in need whose health and development were at risk. Sarah felt increasingly isolated from the support that was available, which drew her back to reliance on her relationship with Daniel and increased her distrust that anyone could help her. Many adolescent young women experience difficult relationships with their parents as they grow up and seek independence, but Sarah's problems were persistent and worrying. She did not have a mental illness, but was in need of some tailored support and sustained professional expertise, rather than the fragmented and episodic interventions that she received. It is my view that this reinforced her dependence on the relationship with Daniel as a means of self-validation.

182. Although Sarah was seen by a CAMHS worker in hospital and at home it was unclear to her and her mother what support could be offered to her.

183. The CAMHS assessment on 31st March 2016 was not in a position to take into consideration any of the background history of Sarah's relationship with her mother, or of the nature of her other relationships and resulted in a **limited appreciation of the risks to herself**. It concentrated on the immediate presenting behaviours and safety risks and did not explore the deeper trauma behind Sarah's worries, or address the need for new strategies in building a more positive relationship between Sarah and her mother. The proposed interventions working with an anxiety group were to start, by agreement, in the summer because of difficulties in arranging transport. Given her previous history it is surprising that the urgency of intervention was not more explicitly questioned. LE reported at this meeting that "everything Sarah does now involves Daniel" and "this is not healthy". It is clear that their relationship involved a considerable degree of manipulation and control between them both. The CAMHS worker concluded that the risk of self-harm had reduced, and that Sarah's mood had improved with reduced anxiety – despite the continuing strong difference

of views between mother and daughter. Sarah was discharged from the self-harm pathway on 11th April and a referral made for her to join the anxiety group. Sue felt concerned that CAMHS could not give her any details of what was to be offered due to a restructure in the service.

184. There is a **confused picture of the TAC meeting held on 12 April**. This followed the incident on the previous weekend when Daniel and Sarah barricaded themselves in Daniel's bedroom and Sarah's overdose the previous month. It is now apparent that Sarah and Daniel had started making plans to commit the murders in the previous few days. Although it was acknowledged that the relationship between Sarah and her mother had deteriorated recently, the TAC meeting is described as very positive by Children's Services in their agency report, and it was noted that their relationship had continued to improve bit by bit from the previous year and that they were able to be more honest with each other about how they were feeling. In hindsight this appears to have been an optimistic interpretation. The School, in contrast, recorded that the mother/daughter relationship had deteriorated. The School records Sarah's falling attendance at school and that Sarah rated things at this stage between 2/3 out of ten. Sarah told the meeting that while she was willing to give the group sessions a try; she thought no-one could help her with how she was feeling. It is unclear to what extent the difficulties and changes in Sue and Sarah's relationship were seen as within normal bounds or were indicative of more serious concerns.

Learning Points

185. There are several general learning points identified by this review.

- The long-term effects of domestic violence and abuse on victims and those who are exposed to its effects needs to be better recognised and understood by all those working with troubled adolescents and their carers.
- It is an overall conclusion from this review that greater professional curiosity is needed to look at underlying needs, particularly when considering disruptive behaviour by adolescents. This should be supported by appropriate training.
- There were several occasions, as identified in this report, when there were opportunities to assess the risks to, and presented by, Sarah and Daniel, but there is no indication that anything would have prevented the murders they committed.
- Family Group Conference did not facilitate wider family support and a plan to assist aunt.
- The course of events over an extended period for both Sarah and Daniel questions whether the Team around the Child process was robust enough to identify the full picture of their needs and address underlying causes of adolescent trauma, rather than just presenting behaviours.

186. The Diocese has recognized that there were significant weaknesses in the application of safeguarding policies at the Church. There was no culture of informed vigilance, those with a legal responsibility for safeguarding did not understand their duties, and it is clear that safeguarding had not been a distinctive part of any Parish

discussions, despite the successful work to engage children and families, and to start a choir. There was an opportunity for Sue's own vulnerability to be made known to the Diocesan Safeguarding Team when this was seen by her parish friends. The concerns and worries shared by Sue about the relationship between Daniel and Sarah, if made known, would have warranted a referral to Children's Services. This would have brought another range of information to the attention of professionals and would have added to the understanding of their relationship as potentially coercive and controlling.

187. The work of the School nurse with Daniel was sustained over 7 years and she was a constant and stable part of his life, who was able to develop a good understanding of his needs. Her work with him, and in prompting other agencies, resulted in positive changes.

188. There were similar examples of consistent and resilient work from other practitioners with the family – the Targeted Youth Worker in 2013-14; the CAFCASS FCA in 2014-15 – which are examples of good practice.

189. Their aunt received little practical support in taking on the challenging responsibility for three troubled boys, although she did not always find it easy to seek assistance. At times she struggled and felt powerless, and at times she found it difficult to accept help. There is no evidence that the impact of her own health worries was ever fully considered when she had cancer treatment in 2014. There is no evidence of the engagement of the GP with the School nurse or through multi-agency meetings so the impact of extra stresses on a vulnerable family could be better appreciated. As this raised potential serious concerns there should have been no bar in raising these concerns between practitioners, even though she was reluctant to seek support.

190. There was an assumption both by the GP practice and at hospital appointments that his aunt was Daniel's mum. As the relationship within this family unit were critical; at most points of presentation, it would have been good practice to establish that she had parental responsibility as the boys' aunt, and that their mother had died in 2006. This impact of this loss was not consistently appreciated in its effect on Daniel's attachment.

191. Procedure has been changed since these events to ensure that faxed referrals – as made by the GP to the LPFT single point of access in January 2015 cannot go astray. A protocol on how to access services not ordinarily commissioned by the trust – such as the family therapy requested by the GP and recommended in the court report – has now been introduced.

192. During 2015 several services became aware of the developing relationship between Sarah and Daniel, and also of the intense and exclusive nature of this relationship and the concerns about it from both families and some professionals. There was some joint work on healthy relationships, but the degree to which their

relationship had elements of mutually controlling behaviour was not addressed although this is a known indicator of trauma. During interviews with CAMHS staff, there appears to have been no consideration or concern regarding the appropriateness of Sarah's relationship given her age and life history. There is no evidence that the intense and exclusive nature of the relationship was recognised as being relevant for further exploration. With two young people displaying volatile and often disengaged behaviours the possibility of exploitation or coercion should have been considered, if only to be ruled out.

193. It is also not clear that the possibilities and dynamics of child to parent/carer abuse were ever considered at any point, despite the volatile behaviours that were known and the violence that Daniel and his brothers sometimes displayed. This is an under-researched and ill-defined problem but where the volatility of behaviour seen in Daniel and Sarah might have suggested greater professional curiosity. This case should provide a fresh opportunity to explore the variety of forms that coercion, control, manipulation, abuse and violence can occur within families, and how presenting behaviours can be better understood, together with the signs and indicators that indicate risks. This case should encourage review of this aspect although there is no firm evidence that it was a significant or direct factor.

194. The work of CAFCASS in private law proceedings may well bring to light significant safeguarding concerns and provide an insight into concerning family dynamics. It is a point of learning that these concerns – which were fully and appropriately dealt with as part of CAFCASS's own work – could have been shared with children's services in a safeguarding referral or at least for a Child in Need assessment. The very clear concerns contained in the psychological assessment, the understanding of the Family Court Advisor about the risks posed by father, and the fragility of the family relationships would have warranted further investigation. An assessment informed by this information would perhaps have realised the fragility of the attachment between Sarah and her mother and might have usefully informed the subsequent work by the Targeted Youth Worker with Sarah and Daniel. Referrals should not only be seen as an entry route to social care services, but as the use of social work assessment skills to inform better multi-agency support for a child and family. I do not disagree with the view that neither Sarah or Daniel were at risk of significant harm, but I do believe that a comprehensive social work assessment as children in need should have brought greater focus on the underlying causes of their behaviours and enabled a more holistic engagement with them.

195. Family Group Conferences were offered for both families. The purpose of these processes, and the opportunity to include the contributions of those outside the immediate family were not fully developed. The linkage between the professional network brought together through a TAC process and the family and friend involvement through FGC seems to have been little explored.

196. Because Sarah's behaviour presented as challenging and was of concern to her mother, there was little consideration or voice for Hayley in the various interventions

with her family. Her views about contact with her father were clear and consistent, but there appears to have been little attempt to understand her view of her relationship with Sarah or her mother – reinforcing her generally compliant and conforming behaviour. This may have disguised or minimized her own views, needs and wishes. A whole family approach was not taken as the focus of Sue and professionals was on Sarah's behaviour.

197. The Agency report from the School identified weaknesses in supervision and reporting arrangements within the School, and with other agencies. These have been addressed since a new Trust took over responsibility for the School and the steps taken to address these issues were appropriately identified in the agency report.

198. Lincolnshire Youth Offending Service commissioned a review of Child to Parent/Carer Abuse[27]. This highlights from a review of cases and interviews the key dilemmas when working with families who experience this form of abuse. The study illustrates the difficulties of categorizing and recognizing this complex dynamic. It highlights that the format of DASH assessments is not designed to cover these behaviours, although it could have been used to identify risks in both families if they had been more explicit acknowledgement of the framework of domestic violence and abuse that prevailed. The conclusions and recommendations of the study should be reviewed and in particular the need to align this learning with other work around managing adolescent risky behaviours. The need for multi-agency training to raise awareness of these issues is strongly supported. The development of the Health Minds[28] service is a welcome addition to the range of support available and might have been appropriate for both Sarah and Daniel.

Recommendations

199. Lincolnshire Safeguarding Partnership to evaluate the capacity and performance of services to address the needs of adolescents with difficult or risky behaviours, but without diagnosed mental health illness.

200. Safer Communities Lincolnshire to review how parent/child abuse is identified and assessed and to seek assurance that domestic violence and abuse is understood to often be a key factor in adolescent trauma and behavior.

201. Lincolnshire Safeguarding Partnership to improve awareness of trauma informed practice and adverse childhood experiences, particularly concerning the long-term impacts of domestic violence and abuse on children and parenting capacity in order

[27] Ceryl Teleri Davies, (2017) *A veil of silence surrounds child to parent violence*, Report to Lincolnshire YOS

[28] This is a county wide emotional wellbeing support for young people up to 19 years old (25 years for SEND and Care Leavers) where they do not meet eligibility for other services (e.g. CAMHS). It offers a focus on early intervention, promoting resilience and the prevention of emotional wellbeing concerns escalating to mental health issues. The service will also be available to parents/carers whose children met the criteria.

to develop strategies for better professional assessment of these.

202. Lincolnshire Safeguarding Partnership to work with faith groups to ensure positive awareness of safeguarding procedures and to encourage participation in joint training.

203. Lincolnshire Children's Services to review how social work expertise is accessed by TAC processes to encourage professional curiosity and to support complex needs where there is not an incident or trigger for direct social work intervention or assessment.

204. Lincolnshire Safeguarding Partnership to seek assurance that cumulative and whole family perspectives are strengthened in assessment and support work, particularly for families who do not meet social care thresholds.

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