Merton Safeguarding Children Partnership

Serious Case Review

Child D

January 2020

Contents

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Merton Safeguarding Children Partnership

Merton Civic Centre

https://www.mertonscp.org.uk/

August 2019

1. Executive Summary

1.1 D died in November 2017. During the trial, in April 2018, her father changed his plea to guilty to her murder. He was sentenced to life imprisonment.

1.2 From January 2017 D's family was known to statutory, charitable, independent and private services, some universal and some specialist, first as a result of D's mother's emotional reaction to the breakdown of the parental relationship, and later because of D's father's suicide attempts.

1.3 After the trial, in 2018, the Independent Chair of the Merton Safeguarding Children Board agreed that a review should be undertaken into agencies' work with D and her family to see if any improvements to local safeguarding systems and arrangements were required.

1.4 This review used information from post-incident management analyses of the agency and multi-agency work done, information from original case records, and information from the criminal investigation. The Independent Reviewer met with D's mother. Practitioners' views were sought through a Learning Focus Group.

1.5 D's mother and father jointly consulted their GP in January 2017 as she was reacting badly to the discovery of his long-standing affair. They were advised to seek relationship counselling. They later separated, temporarily. D's father sought private therapy in the spring. Due to concern about D's progress at school the parents arranged for her to transfer to boarding school in September.

1.6 As a result of D's father making a suicide attempt in the summer the family came to the attention of mental health services and children's social care services. He made a further suicide attempt a few weeks later. Mental health services and children's social care completed assessments. It was noted that D's father had stress-related depressive episodes. He was not diagnosed to have a mental illness and at no time was he seen to require compulsory admission under the Mental Health Act. The assessments did not find any ongoing risk to others or to D's father himself. By late September it was agreed that there was no ongoing need for statutory mental health services or children's services; it was understood that D's father was accessing local independent counselling.

1.7 The review has found six main areas of learning and two lesser issues for further exploration.

1.8 In relation to the **mental health assessments**, following the attempted suicides, it was found that they met national and local standards and that as there was no prior evidence of violence there was no reason to predict harm. He was assessed as low risk and consequently proportionately lower priority. It is questioned, however, whether sufficient attention was given to a possible pattern of stress-induced suicide attempts (he said he had attempted suicide on a prior occasion when faced with stress); and consideration of family members, including D, being responsible for the stress.

1.9 **Multi-agency working** was not as good as it could have been, although there was some exchange of information. Mental health services and children's social care worked more in parallel than jointly. Other agencies, except the GP, were not informed of the nature of the concerns. Given the assessment of low-risk agencies have suggested that joint work would have been

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disproportionate. There was a lack of curiosity about D's mother's view, and her own needs, and no questioning about the state of the marriage – there was an assumption that they were a couple again, which was not so. Given D's mother's racial, cultural and language background there was over reliance on D's father to speak on her behalf which allowed him to exercise control. She became disempowered, did not understand what was happening or what services may be available to her and the children. She did not fully understand what she was asked or advised in English, or why agencies may be concerned about the children. She was not asked independently about the (failed) state of the marriage, about the dynamics at home or about financial worries.

1.10 **Thresholds and 'step-down'** When it was agreed that the children did not need ongoing social work support the case was not formally 'stepped-down'. The schools were not aware of what the issues were. Although there was a good handover from mental health services to primary care to support D's fathers mental health there was also an erroneous assumption that he was in receipt of help from the independent sector.

1.11 **Interpreters and cultural sensitivity** More attention should have been given to D's mother's need to have an independent interpreter to help with language and understanding cross-cultural and systems issues. The Panel has queried whether this is a systemic issue going wider than this case.

1.12 **Coercive control and disguised compliance** D's father controlled access to D's mother and her access to services; she was dependent on him. He also gave misleading information to practitioners, which was taken at face-value, as he was plausible. The case shows the need to consider these two dynamics in contemporaneous work, but this is a challenging area for face to face work and only became fully clear in retrospect. Fuller conversations with D's mother may have signposted this at the time.

1.13 **Information sharing** Information was shared but there were boundaries and anxieties about what could and could not be shared. Key information held by one services was not always passed on to another. A greater sharing of information and a team approach may have highlighted the discrepancies in the father's accounts – these directed the work.

1.14 In addition to these findings the Review also noted possible systems dynamics in relation to assessing and working with families where there are **different socio-economic, cultural and language factors** and where a family uses **private and independent sector resources which are not part of the mainstream of child welfare services**.

1.15 At the time of D's murder there was no information available to suggest that D or her family were at risk. Her death could not have been predicted. Information from the criminal investigations after her death shows that D's father had been considering her murder throughout October; he also spoke, after the event, of also planning to kill his wife and son, and himself.

1.16 The Review has made eight recommendations from these lessons in relation to: assessments after repeated suicide attempts, joint agency working in parental mental health, use of local thresholds and 'step-down' processes, interpreting, practice awareness of coercive control and disguised compliance, information sharing guidance and reviewing local approaches to detecting sexual abuse.

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2. Reason for the Review and Methodology

2.1 The Independent Chair of the Merton Safeguarding Children Board (MSCB)[1] decided shortly after D's death that, with the information available at that time, the circumstances of D's death met the requirements for a **Serious Case Review** under **Working Together to Safeguard Children**, 2015, chapter 4[2].

2.2 The Review was to learn lessons about agency and multi-agency practice, using systems theory methodology, avoiding hindsight bias in making judgements, and seeking to involve D's parents. The practitioners who had worked with D and her family in the period before her murder were involved in a Learning Focus Group.

2.3 D's mother met with the Independent Reviewer with a personal supporter and an interpreter. D's father declined the invitation to meet or contribute.

2.4 D and her family were known to three schools, a local GP Practice, private and independent counselling services and, as a result of D's father's depressive episodes and attempted suicides, to statutory mental health services, to children's social care, and to the police. Each service was asked to provide a report of its contacts with the family and an analysis of how the work was undertaken and of any lessons learned. The review examined, in detail, the agencies' work in the period from January 2017 to D's death in November 2017.

2.5 The Independent Chair of the MSCB agreed the Terms of Reference and appointed a Serious Case Review Panel of senior managers who had not been directly involved in the case management. An experienced Independent Reviewer was commissioned to work with the Panel and compile the report for the Safeguarding Children Board (now Partnership).

3. Child D, D's Family and Background prior to January 2017

3.1 D lived with her mother, father and her older brother. At the time of her death D was 7 and her brother was 9. This was her father's third marriage. He told at least one agency that he had older children from a previous marriage, but D's mother has told this Review that D's father had no other children by the previous marriages. He co-owned a business.

3.2 D's father had had a prior episode of mental health problems and had made a previous attempt to take his life. This was understood to be twenty years prior and associated with the ending of a relationship and money worries.

3.3 D's mother was from Thailand. She was not fully fluent in English. The couple married shortly before D's birth.

[1] The MSCB was replaced by the Merton Safeguarding Children Partnership (MSCP) in April 2019

[2] **Working Together to Safeguard Children**, 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

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3.4 From September 2013 to July 2014, D attended the nursery class of a local primary school. She was a quiet, happy, sociable child who achieved the expected level of development for her age across all areas of the curriculum. There was no concern about her welfare and there was good engagement between the nursery and D's parents.

3.5 In September 2014, D transferred to a local independent day school. The school had no concerns about her welfare. Between November 2015 and January 2016, it was noted that D's academic progress was slower than average. Additional lessons were arranged for her. By the end of Year One (July 2016) D's standardised test results were within the average range.

3.6 D's brother attended a different independent day school from September 2012. He was seen as a bright pupil, working at his potential. There were no concerns for his welfare.

3.7 In 2016 D's mother discovered that D's father was in a relationship, of two and a half years, with another woman. This led to tensions in the marital relationship. It is understood that, as a result of this discovery and the reconciliation that followed, D's father bought a new family home. This later contributed to perceived financial difficulties which became a key factor in the possible causes of D's father's mental health difficulties in 2017.

4 Summary Timeline of Agency Involvement from January 2017

4.1 The Review Panel collated all known contacts with the family members by local agencies. Not all agencies had completed a day by day record of their contacts with the family or other agencies about D and her family members. Some agencies had summarised their work in periods. In a summary report of this type it would not be appropriate or proportionate to show the complete timeline which the Panel analysed.

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4.2 **January** Problems within D's family first came to light to public agencies when D's mother and father attended their GP. D's mother had discovered that D's father had been in a long-standing affair and as a result she was experiencing acute anxiety. The relationship was discussed, and the couple were advised to consider attending relationship counselling, to which they would have had to self-refer. They planned to remain together. There were no concerns about D's father's mental health at this time and there were no concerns about the children or the children's care.

4.3 **March** At D's private school, D's father queried whether D may have special needs and whether she might be dyslexic. He talked of arranging a screening for dyslexia – the school completed a questionnaire about her for an external organisation for a special education assessment. She was described as below average in key subjects but said to be happy and to have friends. D's school was unaware of the difficulties at home.

4.4 **April - June** **D's father in private counselling** In late April D's father self-referred and started private counselling in his own right to discuss his emotions and the stresses he was experiencing as a result of the discovery of the affair and the tensions in the martial relationship. These took

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place in the premises of a local charity but were not provided by them. This arrangement later led to confusion as D's father told several agencies that he was receiving or had received a service from the charity when in fact the service was from a private and independent practitioner who was not part of the charity.

4.5 D's father had seven meetings with the counsellor between late April and early June when he ended the sessions. Initially he had appeared anxious and distant. He was planning to move out of the family home but was unsure if that was the best thing to do. He talked about a historic suicide attempt when he was experiencing financial difficulty during his second marriage. This had been a turning point for him, and he had not considered suicide since. In later sessions D's father shared problems with eating and sleeping as a result of his worries but said that he did not feel suicidal. He saw his children as something to live for. He revealed a history of extra-marital affairs. He was anxious and regretful about what he had done. He was encouraged to visit his GP if his low mood and anxiety continued.

4.6 In a later session he expressed fear of being alone when he moved out of the home and agreed to see his GP. In the next session he said that he had seen the GP who had prescribed anti-depressants. D's father felt that his mood had improved and that his anxiety had lessened. He also said that he had moved out of the family home earlier than planned as a result of the rapid deterioration in the marital relationship. In the sixth session, at the end of May, D's father stated that he wished to end the individual counselling as he felt better, but that he would like to consider group psychotherapy. The counsellor was concerned that it may be too early to withdraw from counselling, given his circumstances. The counsellor advised him how to self-refer for group therapy. In the final session, at the beginning of June, D's father seemed calmer and showed signs of improved mood.

4.7 **May** There were concerns about D's brother's possible bullying behaviour at school and counselling was arranged for him, for a short period. The school was unaware of the difficulties at home.

4.8 D's father made an application for D to attend a state boarding school from September. Her independent day school provided a reference for her. They noted that there were no safeguarding concerns for D. The school thought that D had grown in confidence. They were concerned about her academic progress.

4.9 D's father did attend the GP Practice in mid-May and requested anti-depressants. He told the GP he was leaving D's mother. When seen two weeks later it was understood that he had moved out of the home and was seeing the children at the weekend.

4.10 **June** In early June D visited the proposed boarding school and, after interview, was offered a place. Both parents signed the forms and indicated that there were no safeguarding concerns.

4.11 D's father saw the GP again, three days after the final session with the private counsellor and stated that he was living back at home with his wife. Three weeks later he reported that he was attending relationship counselling with her. *D's mother has told this Review that they did not attend relationship counselling.*

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4.12 D's father referred himself to the local charity which provides group psychotherapy, amongst other services. He was seen initially in the third week of June for an assessment. He stated that he was not living at home (*which is different to what he told the GP*). No safeguarding issues were identified.

4.13 **July** In the middle of July D's father cancelled a second appointment to consider group psychotherapy, a further appointment was offered for the beginning of August.

4.14 D went to Thailand with her mother and brother. *D's mother has said that D's father had moved back into the family home when they returned.*

4.15 **August** At the beginning of August D's father was seen again by the group psychotherapist as part of the assessment of his suitability for group psychotherapy. He spoke of worries about finances, marital problems, isolation and loneliness. The children were only discussed briefly when D's father mentioned that they fought occasionally. The assessment concluded that in the present circumstances group psychotherapy could not be offered to him as his personal needs would not fit with the current group dynamics and it was known that he was being treated by his GP.

First Critical Incident

4.16 In the middle of August D's father attempted to take his life. He had taken sleeping pills and tried to hang himself in a London hotel. When he was unsuccessful, he called an ambulance and was taken to the emergency department of an acute hospital in west London. D's father told staff in the psychiatric hospital that he had changed his mind and untied the ligature rather than his attempt had failed. He stayed in the acute hospital overnight under mental health supervision. In assessment he stated that he had financial difficulties 'because of maintenance payments to an ex-wife' and not being able to find a job. D's father said that he was 'not ready to talk about' the difficulties with regard to access to children from his first marriage. He did not see a way out of his situation and felt hopeless.

4.17 He was transferred to the local psychiatric hospital for his family home in Merton early the following morning. The acute hospital informed Merton children's social care of the admission – however, it has transpired that there was an error in the home address used.

4.18 In the psychiatric assessment unit D's father was re-assessed. He reported a previous attempt to hang himself 20 years before, in the context of a divorce. The current attempt was because of financial stresses. He described himself as a self-employed man who had suffered a financial crisis, but also reported that he had just made a lucrative sale. There were also family stresses and low mood. He described thinking about ending his life for some time. D's father reported that he was currently in 'private psychology' sessions *(this was not so)*. He said that his family was a protective factor. He was discharged to the family home that same day after the psycho-social and risk assessment. It was noted that D's mother was involved in his care. His psychiatric care was transferred to the Home Treatment Team (HTT) and Children's Social Care (CSC) was advised. The GP was also informed by letter and was told that D's father was most worried about how he would pay D's boarding school fees.

4.19 D's father was seen the next day at home by the Home Treatment Team. He was seen to be evasive when questioned but was assessed as no longer being a risk to himself or to others. He

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declined daily contact but agreed to be seen after two days but then later cancelled this saying he was going away with his family. *(This was not the case).*

4.20 The Children's Social Care (CSC) received the referral from the west London acute hospital. It was noted that D and members of her family were not previously known to CSC.

4.21 There was liaison between the Home Treatment Team and the Merton Multi-Agency Safeguarding Hub (MASH) early the following week and the social worker from CSC asked for D's mother's telephone number.

4.22 It was noted by CSC that D's father did not wish to have home visits from children's services. The following week, it was agreed that a **child and family assessment**[3] should be undertaken. From the initial information gained by CSC there was nothing to indicate that a child protection assessment was required.

4.23 D's father was seen by a Home Treatment Team (HTT) practitioner and he described being more positive and planning to return to work the next day. He also reported that he was attending the local charity for counselling – which was not the case. The worker asked him for D's mother's phone number to give to CSC – but he said that he did not have it with him. D's father did not keep the next appointment, three days later, as he 'had a stomach upset'. The HTT kept in touch with him by phone. Two days later, on the Bank Holiday Sunday, he was reviewed by phone and provided D's mother's phone number.

4.24 **September** D's father was seen by the HTT at the team base at the beginning of September. Risks to himself and to others were assessed as low. He was given sleeping tablets for two nights. He spoke of a session of counselling at the charity and gave the worker the impression that he was receiving therapy from them – which was not the case.

4.25 D's father was seen by the HTT three days later, as agreed. His sleep had improved. He was given two more days sleeping tablets and agreed to see the GP for a prescription. Risk to himself and to others was assessed as low. The plan was to assess him three days later with a view to discharging him from the service.

4.26 D started at her new boarding school, the same day. The school was not aware of any of the current family issues.

4.27 D's father saw the GP two days later and was prescribed more sleeping tablets. He stated that he was living back at home with D's mother.

Second Critical Incident

4.28 That evening D's mother reported D's father as missing to the police. He was found the next day in a local park by the police, D's mother and D's brother (age 9). He had taken an overdose of 12 of the sleeping tablets and some other similar tablets the night before. He was taken to the

[3] Child and family assessment – can be undertaken under sections 17 or 47 of the Children Act 1989. This assessment was under section 17; its purpose was to see if the children were **in need** (or parents) and may benefit from any support.

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local acute hospital was assessed and then admitted as a voluntary patient to a psychiatric ward. He was discharged home six days later.

4.29 While in hospital D's father was re-assessed. He said that he had 'just wanted to sleep. He had been 'thinking about taking his life for some time'. Financial worries had led him to take the overdose. He felt guilt and anguish about what he had done. He was lonely and had difficulty forming relationships. Although D's mother and D's father's brother visited him in hospital, they were not interviewed about him or his circumstances, on the ward. During this in-patient stay, as an informal, voluntary patient he had periods when he was allowed to go home; psychiatric staff spoke with D's mother about those arrangements. The assessment was that D's father had depressive symptoms as a result of psycho-social stressors and that he had taken an impulsive overdose. He was discharged back to the care of the Home Treatment Team.

4.30 CSC was informed by the acute hospital of this second suicide attempt by overdose and of the in-patient stay. The MASH / CSC social worker was, however, unaware of this second suicide attempt when they visited the family at home on the day of D's father's discharge from hospital. *This may suggest a systems issue in relation to information received on open cases. This was the first social work visit.* The delay in visiting has been noted to be because of the error in the address on the first referral, delays in gaining D's mother's phone number, and because the case was given lower priority, based on the initial information received. The parents were unprepared for the visit and were described as wary. They did agree to agency checks being undertaken about them but not with the schools. D's brother was at home; the social worker spoke with him briefly.

4.31 D's father contacted the group therapist at the local charity by email saying that he had 'had a short holiday to France' – this is unlikely to have been true (D's mother has no knowledge of it); the email appears to have been sent on the day of his discharge from hospital.

4.32 A mental health HTT practitioner visited D's father at home the following day and assessed the risk to self and others as low. D's father planned to sell the family home to deal with the financial stresses. D's mother's view was not noted. He also told HTT staff of an appointment with the counselling service at the local charity the following week. It was agreed that HTT would see him every two days.

4.33 After the first follow up HTT contact the frequency was changed to every three days. The next contact three days later was by phone rather than face to face as there was a clinical emergency on another case. D's father advised the HTT practitioner that he had seen a worker at the counselling charity and that they had suggested Cognitive Behavioural Therapy, which they were arranging. This was not so, as he had not yet seen the group therapist. He had also contacted the Improving Access to Psychological Therapies Team (IAPT) and left a message on an answerphone seeking to refer himself. As he was feeling better HTT considered discharging him from the service soon.

4.34 D's father emailed D's boarding school to say he was in hospital and would not be able to attend a parents' event, scheduled for the Saturday. D's mother attended with a friend who translated for her – but she did not speak individually to any of the school staff.

4.35 On the Sunday, during a home visit by a HTT worker, D's father was remorseful, he said that he had decided to sell the house and that his 'family is protective'. That same day D's father visited

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D at the boarding school and spoke directly with a child and their parent there since that child had allegedly bullied D. The school asked him not to speak directly to other children but to speak with them if he had concerns. He was polite and agreed to do so.

4.36 The local charity group therapist met with D's father to assess if his circumstances had changed from the previous assessment that he was not suitable for group psychotherapy. He disclosed that he had attempted suicide and was under the care of the Community Mental Health Team / HTT. It is not clear if he disclosed both suicide attempts. The clinical assessment was that it was still not appropriate for him to be seen in group psychotherapy. It was also noted that he was still in treatment with the HTT.

4.37 D's father was seen at home by HTT the next Saturday. He was concerned about the side-effects of his medication; he was advised to discuss it with his GP. He wished to be discharged from the HTT as he understood this would prevent him using the IAPT service. (*Information from the IAPT suggests that he had not at that point self-referred; but that is not clear as he reported leaving a message on an answer phone.)* He was more positive about his business picking up. However, he was worried about a visit from CSC which that was planned for the next day. His concern was that the children would be taken away. The worker planned to discuss the possibility of discharging D's father from the HTT with the Multi-Disciplinary (HTT) Team so that D's father could start with IAPT.

4.38 The CSC social worker visited the home the next day, the last Sunday of September as D was at home from boarding school. The social worker undertook direct work with D and tried to engage her brother, but he was reluctant to talk. Their father came into the room to encourage D's brother to speak but he did not, except to answer, 'I don't know'. There was nothing observed in the children's behaviour or conversation that indicated any anxiety or concern. It was noted that D's brother was aware of his father's suicide attempt, but that D was not. D's mother reported that she was fearful of D's father killing himself or running away if the house was not sold. The parents gave permission to contact the children's schools.

4.39 The next day (Monday) the CSC social worker contacted both schools to seek information, advising the schools that something traumatic had happened but not giving detail. D's brother's school had no worries about him. They have reported that they asked the social worker for more information about what had happened but that the social worker declined to provide more information, on grounds of confidentiality. D's school responded two days later with reports saying that there were no concerns about D but that she was behind academically. They also mentioned that D's father had been asked not to speak directly to other children if he had concerns but to raise the matter with staff.

4.40 On the Tuesday the HTT social worker contacted D's father and mother by telephone and spoke with both of them. During the conversation she asked D's father and mother questions based on the Merton Wellbeing Parenting Capacity proforma. There was no concern about D's mother's ability with the use of English. The HTT social worker advised them both about local resources which may be able to assist financially and also the possibility of D's mother using the local Carers Association – but D's mother agreed with D's father who said that she did not need support. Information from this call was shared with the CSC social worker.

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4.41 Later the same day another HTT practitioner visited D's father at home. D's father described poor sleep. His medication was reviewed. He was to be discharged back to the care of the GP with a plan for him to engage in therapy with the IAPT.

4.42 The next day, the IAPT noted receipt of a self-referral by D's father who had made a self-referral asking for help with depression. The referral was screened and there was no risk indicated.

4.43 The HTT Consultant Psychiatrist discussed the plan for discharge with the GP, in a phone call, and sent a letter noting low risk and recommending that the medication should be prescribed fortnightly. There is no information to suggest that there was direct contact by D's father with the GP after this, to review his medication.

4.44 At the end of September, the Child and Family Assessment was completed. It concluded that the case was not one of **child in need** and that the schools could monitor the situation. The schools, GP and HTT do not appear to have been made aware that the social worker was withdrawing.

4.45 In the second week of October D's father was assessed over the phone by IAPT. He revealed the recent suicide attempt (not the first one in August) and said that he had been in hospital and seen by the HTT. He disclosed the suicide attempt 20 years previously. He reported being no longer suicidal. He described his wife and children as protective factors. He did not share that the marriage had broken down. D's father said that a CSC social worker and HTT had visited but were no longer involved and said that he was seeing his GP every two weeks, which was not the case. He was keeping himself well by walking and with YOGA; and he had returned to work. There were still financial worries but he planned to sell the family house to resolve these. He said that he had no current symptoms of anxiety. D's father finally told the IAPT assessor, in this phone call, that he had been seeing a therapist at the charity for the past two months and that he would continue with this; and so he did not wish to follow up with IAPT – this was not, in fact, the case.

4.46 From the information gathered no professional seems to have seen D's father, face to face in October.

Assault on D and her death

4.47 At the end of October D came home for half-term from boarding school. At the beginning of November while D's mother was taking D's brother to school D's father strangled D with a dressing gown cord while she was still in bed. He then rang the police and reported what he had done. She was resuscitated at the scene but died in hospital, the following day.

4.48 There was post-mortem evidence of the presence of semen in D's vagina (probably within the last seven days). The forensic evidence was rigorously tested and there was detailed consideration by the Crown Prosecution Service but it was not possible to establish how the semen came to be present. D's father denied sexual assault but admitted the strangulation.

Information which became available in hindsight through the subsequent criminal investigation and trial

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4.49 It is important when considering information gathered in hindsight to be careful not to judge the quality of the work with this bias. A question is, however, could this information have been reasonably gathered in the work at the time and, if so, what systems dynamics may have prevented that?

4.50 The Judge described D's father as 'deceitful and manipulative' and 'calculating and disingenuous', concealing his plan to kill D.

4.51 D's father told police that he had intended to kill his wife and family (and himself) as he feared bankruptcy and wished to spare them pain; but in the end he could not and could not explain why. He described D's school fees as the 'whole scenario of his debt'. He said that he had become 'too tormented with his life' and 'could not bear going on'.

4.52 The Forensic Psychiatric Assessment provided to the trial indicated that at the time of the offence, D's father was suffering from a moderate depressive episode. However, this would not have been such as to impair his mental ability to understand his actions, judgement or self-control at the time. He did not meet the thresholds for legal defences of insanity or diminished responsibility. It became clear that his actions were pre-meditated.

4.53 In the psycho-social history given by D's father as part of the forensic assessment, he revealed a troubled childhood and adolescence, with social awkwardness and isolation; including being bullied, assaults on others and a period with an eating disorder. He considered self-harm and overdosing in his teens. He had a brief period as a young man as a soldier but was discharged for psychological reasons. Subsequently he established a successful business with a brother.

4.54 He married three times and on occasions had affairs with other women. Under stress, as a result of financial pressure from the purchase of a house with his second wife he was responsible for an altercation in which she was injured. As a result, he took an overdose and tried to hang himself but sought no medical assistance.

4.55 D's father, in his account, said that there were no children from the two prior marriages.

4.56 D's father said that he found being a father of young children, D and her brother, 'trying'. He found it hard to spend time with them. He sought escapism from his situation by entering into an affair. He found the stress of hiding the affair and the costs incurred difficult but enjoyed the affair.

4.57 To conciliate with D's mother when this affair was discovered he bought the family house in Merton but entered into financial difficulty as a result (repeating the response when he had bought a house to appease his second wife).

4.58 D's father said that from May 2017, he experienced a 'breakdown' as a result of the stresses over the affair, the marriage, finances, and difficulties for D at school and the parental view that she should change school. These stresses led to the two suicide attempts in the Summer of 2017.

4.59 On the day of the assault, while being psychiatrically assessed in custody, D's father reported that he had been experiencing low mood, poor concentration, poor sleep and low appetite over nine months. He had not had any psychosis or hallucinations. He reported that he had been thinking about killing both children and his wife to save them the shame of bankruptcy and loss of

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the home. He was assessed as suffering from a depressive episode, but he did not meet the criteria for assessment for a sectioning under the Mental Health Act.

4.60 D's father told the police that he had been planning to kill D for several weeks and had been ready to do so several times in the preceding week. He realised on the fatal day that this was his last opportunity, as she was due to return to boarding school.

4.61 D's father told the police that he had been going bankrupt, had no control over anything and had been finding it impossible to live. He felt trapped. He felt he had neglected his children. He had been unable to discuss any of this with D's mother, with the mental health services, or with his GP.

4.62 Evidence from the investigation showed that D's father had sufficient funds to settle all his current debts but that there was a substantial future payment required to redeem the mortgage for his former wife's home.

4.63 Internet use on D's father's computer and phone in the last month showed searches about child killing, child killers in jail, suicide, and children's homes.

4.64 In subsequent police and psychiatric interviews, before trial, D's father denied sexually abusing D. He feared bankruptcy. He also maintained that he had had voices telling him what to do and that D must die. He told no-one about these voices. The psychiatric view of these later statements and thoughts by D's father about his reasons for killing D and the voices is that they are less reliable than the contemporaneous accounts given on the day of D's death.

5. The Parents' Views

5.1 D's parents were informed of this Review and its purpose and were invited to take part by meeting with the Independent Reviewer or by making a submission in writing. D's father declined the invitation.

5.2 D's mother met the Independent Reviewer, with a supporter and an interpreter. The interpreter had worked with D's mother during the murder investigation and trial and so was familiar with the case. D's mother had great confidence in the interpreter. It was clear that D's mother had a limited understanding of English and appeared to understand more that she was able to say. It was important to use the interpreter for her to be able to fully understand and fully express her views and questions.

5.3 D's mother gave new information which had not been known to the agencies at the time. Namely that, in early 2017 D's father moved out of the family home and went to live in a flat in another borough. At the start of the school summer holidays D's mother took both children on holiday to Thailand. When they returned, D's father moved back into the family home but the parents lived separately within the house. He stayed in his own room, working most of the time. There were continued arguments between them. There was no physical violence and D's mother did not fear him. D's mother said that she and the children did not go to France and she does not know if D's father did.

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5.4 **D's father's worries about money** D's mother thought that the family had enough money but there were problems as D's father previous wife, who still had an interest in the family business, successfully sued him as he had used money from the business to purchase the new house. The court ordered that he should pay his former wife a large sum of money, which he did not have.

5.5 **Support from local services** D's father controlled which professional services D's mother had access to. In her view, he would often 'put her down' to those services. Regarding his mental health treatment in hospital and the community, he would tell her that it was not her business. She did not know he had undertaken private counselling – she only learned about this later. *(This would appear to have been in the period when he was not living in the house).*

5.6 **GP Service** Early in 2017 D's mother had been very stressed about the relationship breakdown. She did not feel that the GP Service helped her with the breakdown in the parental relationship. She would have liked counselling in her own right but was not referred. Although relationship counselling was recommended D's parents did not take this up. (D's mother did not know about an agency called Relate). D's father acted as the interpreter and spoke positively about how things were.

5.7 **Change of school for D** Originally D's parents had planned that D's older brother would go to boarding school as the two children 'fought too much'. However, it became necessary for D to change school. She was not doing well at her school and they did not think that it suited her needs. D's brother did not want to go to boarding school. It was agreed that D would go instead, and she was happy to go. D's parents chose the boarding school together. D did better at the boarding school. At first, she was very happy but after a while she was sad because she missed home. There was an (alleged) incident of D being racially bullied and her father intervened but was asked by the school not to speak direct to the child involved. D and her mother kept in touch by phone and text. D could have come home for more weekends but did not do so on the first two weekends as her father was unwell. D's mother was pleased with the brother's school and with D's boarding school.

5.8 **The awareness of their father's mental ill health** D's mother was sure that D did not know about her father's mental ill-health or suicide attempts. After the first attempt D was told that he was in hospital, but not why. They kept from her the second admission as she was at boarding school. D's brother was aware of the second attempt.

5.9 **Mental Health Services** D's mother did not really know what had happened to D's father. She was told about the first suicide attempt. She did not feel that she was given much assistance by the mental health staff. She was not offered an interpreter. He was discharged home. She did not feel that she was given advice and feels, in retrospect, that she should have been given more information and that he should not have been let out of hospital. When she asked him about his treatment he said it was 'none of her business'. She was not included when mental health staff visited D's father at home. She understood that she was not involved in his after care as they lived separate lives in the house. Regarding the second suicide attempt, D's mother reported him missing when they had not seen him for the day in September. She did not think that he was a risk to the children.

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5.10 **Children's Services** D's mother said that she was not involved with Children's Social Care (CSC). She did not know that they had been wanting to contact her and that D's father had not given them her number. D's father feared that CSC was going to take the children away. D's mother could not see why that would be so as she thought that her care of the children was good and that, even if there was worry about D's father, there was no reason to take the children from her. She did not think that the social worker involved her enough. There was no interpreter to assist communication. She thinks that when the social worker spoke to the children the social worker should have then met with her, as the mother, to tell her what the children had said.

5.11 **What help would have supported D's mother when D's father was unwell?** D's mother thought that the workers (from all services) should have spoken directly with her. She said that she should have been given advice about D's father's mental health and told what was happening with him. There should have been interpreters to help her. After the children were interviewed, she should have been told directly what the children had said and, as their mother, she should have been involved more fully. She did not know what help to ask for or why some agencies were involved.

5.12 **Police** D's mother said that the police were very helpful and kind. Since D's death there has been a very good relationship with the Family Liaison Officer; and the Police have used an interpreter.

6. The Practitioners' Views

6.1 Practitioners with direct contact with D or members of her family and the direct line-managers of those practitioners took part in a confidential focus group with the Lead Reviewer and the Designated Nurse. The purpose of the event was to give practitioners the opportunity to share their perspectives on what had happened and the work done to assess D's father and to support him and the children and D's mother from an agency and multi-disciplinary point of view. The group was also invited to comment on the emerging lessons suggested by the Review Panel which had been drawn from the analysis of the agency reports. Twenty practitioners attended; some were representing their whole service as not all staff who had been directly involved could attend.

6.2 The practitioners' insights are valuable in helping to gain a picture of how D's father, the family and the professional systems were working at the time. However, caution is required when considering the practitioners' views since D's death had had an impact on them and they had re-evaluated their views of the family in the light of the tragedy and of the newer information that had become available after the event but which some of them had not known at the time. Some of those present were seeing a fuller picture for the first time in this meeting.

6.3 The MSCP would like to thank the practitioners for their openness and honesty in sharing their thoughts about what happened, about the decisions they made and about the work done. They had clearly been affected by the tragedy and saw the importance of seeking to learn from it. Their feedback was grouped and summarised into themes and possible lessons.

6.4 The event preceded D's mother's meeting with the Lead Reviewer, thus the different information which she gave (see section 5) was not known at the time of the practitioners' focus meeting.

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Could the assault on D have been predicted?

6.5 For several of the practitioners and managers a key question was: could D's father's behaviour and the assault on D have been predicted and prevented? Such a question is not a primary reason for this Review which is seeking to learn about wider systems dynamics and patterns in agency and multi-agency working. Risk and parenting assessments were done with regard to D's father's mental state. Even in the light of information that has come to light subsequently there was nothing that would have shown that he was a potential risk to D, or to anyone else. An important lesson from the clinicians is that when an individual does not have a significant mental health problem, risk is likely to be assessed as low. It is not possible to know if a sane and intelligent person has a criminal intent if it is not shared in conversation or through behaviour.

6.6 It was still the view of those who saw D's father that there was nothing in his behaviour, at the time, which showed him to be a risk. He gave the impression of being caring of D and her brother, although at times frustrated with their perceived behaviour. He expressed his anxiety about them being taken away. Until his two attempts at suicide in the summer of 2017 there were no concerns about him or his role as a parent by any agency.

Practitioners' Views on Mental Health Assessments and Parenting Assessments

6.7 The practitioners noted that at the time the priority was the possibility of D's father being a risk to himself. He was assessed not to have a diagnosable mental illness and in the clinical observations and conversations with him there was nothing in what he said or how he behaved to suggest that he may be a risk to anyone else.

6.8 Mental health practitioners noted that adult-focussed mental health workers need to think about how to talk with patients who are parents with regard to the possible impact of their illness on children and to include the second parent in assessments, if one is available.

6.9 At the time of the assessments, in the late summer of 2017, **The Joint Mental Health Protocol** applied only to adult mental health workers and children's social care staff. It has been re-issued since and now includes all services[4]. A lesson from this case for the practitioners was that there should have been more joint-working and even joint-visiting. The two services seemed to work in silos. The case did not show evidence of a **Think Family**[5] approach being in place in day to day practice at the time. Psychiatric assessments must use Think Family principles to reinforce good joint working and appropriate referrals to social care colleagues. *The Mental Health Trust has questioned, given the low priority of this case, whether the practitioners' suggestion about joint working or visiting would have been proportionate.*

[4] **Multi agency Protocol to meet the needs of children and unborn children whose Parents or Carers have Mental Health Problems**, Merton Safeguarding Children Board and Merton safeguarding Adults Board, February 2018
https://www2.merton.gov.uk/joint_protocol_for_safeguarding_children_and_families_with_mh_needs-_dec_2014.pdf

[5] Social Care Institute for Excellence: **Think child, think parent, think family: May 2012**
https://www.scie.org.uk/publications/ataglance/ataglance09.asp

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6.10 Similarly, there was recognition among the practitioners that there had not been use of wider systems thinking in looking at the needs of this family. For mental health practitioners the focus was on D's father. A view was shared that this may still be so in some cases.

6.11 It was also questioned by practitioners whether there is professional cultural resistance to joint visits and that this should be explored further. If this is so it would be a systems issue. The Mental Health Trust has subsequently queried whether this is also a practical matter.

6.12 CSC thought that after the second suicide attempt the mental health services should have made a further referral to children's social care, to ensure that they were aware. *It has been noted that the Mental Health Trust was aware, at the time, that the Hospital and the Police had informed CSC about the incident and so it is reasonable that the Trust would not also do this.*

6.13 A question was posed, in retrospect, about how assessors consider the risk of a possible filicide when a parent is being assessed for suicidal ideation and behaviour? Practitioners noted that the significance of the children to D's father was not known. They wondered, in retrospect, what they meant to him. (*The Lead Reviewer's comment here is that D's father may not have been able to say what the children meant to him or his answers may have been unreliable. What was known at the time, and has been confirmed by D's mother, is that he was frustrated by the children fighting but he was also very worried that the children were going to be taken away. The post-incident forensic assessment confirms that this was his view also.)*

6.14 **The family as a system and the context of the family's culture** Practitioners accepted that there was too much focus on D's father and that not enough attention was given to the importance of D's mother by services. D's father was able to prevent services accessing D's mother and this was accepted too readily. Some practitioners asked if this may have been a response to perceptions of the family status in terms of wealth and culture. Are practitioners less likely to question and challenge a family such as D's? There was recognition, again in retrospect, in the practitioners' group that D's mother had been disempowered and that interpreting services should have been arranged for her.

6.15 **Practitioners' Views on professional curiosity, control/manipulation and possible disguised compliance – the need for triangulation in assessments** In seeing a much fuller picture, after the event, practitioners recognised the need to consider that information should be questioned rather than taken at face value. Information from D's father that he was using and being helped by the services of a voluntary agency was not checked out. It is important to keep an open mind about patient statements about intentions and to seek corroborating information, if necessary. A challenge for practitioners is how do you hold in mind that a patient / service user may be exercising control over information or using disguised compliance. A busy work environment may hinder professional curiosity.

6.16 A question arose about evidence of the use of professional curiosity, about what the significance was for D's father in seeking assistance from different services – a private therapist, and independent counselling services. What was his reason for wanting group therapy rather than individual therapy – did he feel isolated? These questions were perhaps not considered at the time as the case was seen as low risk and low priority.

Practitioners' Views on Proportionality and Thresholds for Intervention

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6.17 The case did not meet the thresholds for child in need. *(This raises the question of how it was 'stepped-down' to the schools and to primary health care and other services, if they were unaware of what the issues were or that CSC was closing the case. It also raises a question about how the overall **impact** on the children and D's mother of D's father's mental health was assessed – not just the risk.*

6.18 D's brother's school were unaware of the issues at home – they had learned that there had been a 'traumatic incident' at home in September but when they later sought to ask D's father about it he had composed himself and presented as a man in control and getting help. This led the school to be reassured that there was no risk to D's brother, especially as CSC had closed the case.

6.19 There are challenges in ensuring a dynamic engagement between the MH Home Treatment Team and the Primary Care Team. Copying correspondence to the GP is probably not sufficient as a means of joint working.

6.20 Be clear about risks to others when someone harms himself – or impact on others.

Practitioners' Views on Information Sharing, confidentiality and consent

6.21 Mental health practitioners noted the need to develop skills to have authoritative conversations with patients who are parents about consent to share information with other services in a way to support and inform child in need assessments.

6.22 Information sharing needs to improve as key services, including schools, were not advised of what had happened – especially in relation to the second suicide attempt.

6.23 When information is requested from a service (e.g. by the CSC for an assessment) it is important that the service knows why the information is being requested so that they can respond proportionally and in line with the need for information in a way which meets the Data Protection Act.

6.24 Is there a challenge in mental health services sharing information with CSC? That was how CSC experienced it.

6.25 How explicit should consent be when children are involved?

6.26 Information sharing across the wider system has been better since the Multi-Agency Safeguarding Hub came into place.

Practitioners' Views on recording of rationale for decision-making by mental health practitioners

6.27 Mental health services and practitioners need to consider how they document the reasons behind the decisions that are made.

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Practitioners' Views on Other issues

6.28 The importance of accuracy in referrals with regard to the family address. The mistake in the address in this case caused delays for CSC.

6.29 How can schools get a fuller picture of families to support children, without compromising the admissions procedure or intruding into family privacy?

6.30 The good work by the CSC social worker in seeking to engage directly with the children and to help their father to think about the impact of his ill-health on them.

6.31 The GP Practice was unaware of D's father's background in terms of culture and previous marriages.

6.32 Is enough known about how to access interpreter services in primary care?

6.33 Agencies were unaware that there was a period in the late Spring of 2017 when D's father was not living in the family home.

6.34 There was not enough systems thinking about the family and what was happening at the time? Was there a cultural issue of 'Well to do people do not harm their children?' There was a lack of consideration for D's mother.

7. Analysis and Lessons

The Panel members, in analysing information from the Agency Reviews and other source material, together with D's mother's comments and those by Practitioners, concluded that there are six priority areas of lessons.

7.1 Mental Health Risk Assessments

7.1.1 The Mental Health Trust's internal and independent Sudden Untoward Incident (SUI) Review and this Review have concluded that the mental health assessments undertaken in the Summer of 2017 with regard to D's father's two suicide attempts and subsequent mental health met the local and national guidelines.

7.1.2 An important lesson from the clinicians was that, when an individual does not have a significant mental health problem, has no history of violence, and does not express anything which would raise concerns, risk is likely to be assessed as low. It is not possible to know if a sane and intelligent person has a criminal intent if it is not shared in conversation or through behaviour. There was no suggestion or evidence at the time that her father intended to harm D or any other family member. It was not predictable and there was no evidence of mental illness.

7.1.3 D's father was plausible and there was no reason to doubt his statements, given the openness with which he seemed to share what he was thinking and what had led to the suicide attempts.

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7.1.4 In retrospect, an issue arises about how in repeat incidents, such as the two suicide attempts within a few weeks, consideration is given to the possible building up of risk. Coupled with this is the issue, of when children are seen as a 'protective factor', how do practitioners consider whether if the risk of self-harm becomes greater that there may then be an increasing risk to the children? Overview research into filicide and mental health, 2013[6] gives some pointers to possible links but there must be caution using them as clear predictors in current assessments (as they are by their nature retrospective studies when more information has come to light through investigation). The 2013 overview suggests that mental illness, per se, is not a major feature of filicide. However, it is suggested that parents who have severe mental health problems require careful monitoring. D's father did not have severe mental ill-health. The research literature review by McManus, Almond, Rhodes and Brian, 2015[7] suggests possible links between filicide and stress, such as financial stress, breakdown in relationships, and deaths in parallel with or as a result of sexual assaults. Parental mental health is a known risk factor in intra-familial deaths. However, no one of these singly or in combination can be seen as a clear predictive indicator. The literature review notes that 'acting strangely' in the days immediately prior to the incident may be an important factor. There are also links between suicidal thinking and filicide which may be significant. Other factors which may be significant are abusive and unstable parenting, including the breakdown of the parental relationship. However, there needs to be caution in using this information since the number of such deaths is small, and the variables and child characteristics are multiple.

7.1.5 A question for local services is how are these risks thought about in mental health assessments of parents indicating self-harm, suicide or violence? In this case D's father had made two recent attempts to kill himself and shared with professionals that he was under stress – relationship breakdown, severe financial failure / bankruptcy (in his view), and that D was a partial cause for that (school fees). He feared that the children would be taken into care. It is easier to see possible links after the tragic event but how can we raise awareness of such possibilities for current assessments in mainstream practice rather than just forensic practice? D's father did not seem to be a violent man and did not appear to have the other more worrying factors associated with abuse and harm. A key question for assessments: Is the partner or child in any way a focus or possible cause of the stress which may be leading to self-harm or suicidal behaviour and, if so, if there is not improvement will that lead to risk? If so, what protective factors should be put in place? There should be scepticism about children or dependents being seen as protective factors in preventing self-harm.

7.2 **Multi-Agency Assessments**

7.2.1 At the time of these assessments in 2017, the **Merton Safeguarding Children Board Joint Protocol for Safeguarding Children and Families with Mental Health and /or Drug and**

[6] **Filicide: mental Illness in Those Who Kill Their Children**: Flynn, Shaw and Abel; April 2013, PLOS One ,Volume 8, Issue 4 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0058981

[7] **The Co-occurrence of Risk Factors for Intra-Familial Child Homicides and Suspicious Child Deaths in England and Wales**; McManus, Almond, Rhodes and Brian; 2015, University of Central Lancashire, in **Journal of Investigating Child Death**, Volume 1, Issue 1, 2015
http://clok.uclan.ac.uk/11679/1/11679%20Journal%20of%20Investigating%20Child%20deaths%20V1%20Issue1.pdf

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Alcohol Needs was in place. This was first published in 2007, reviewed in 2010, and again in 2013. This was, at that time, a bilateral protocol for Adult Mental Health Services and Children's Services. Subsequently it has been extended to include other Partner Agencies[8]. The purpose of the protocol was to encourage greater understanding and co-working between adult mental health services and children's services of the needs of children, not just of possible risk but also of more general welfare.

7.2.2 The review of this case suggests that although there was information exchange between the two services (i.e. adult mental health and children's social care) their work was more in parallel rather than being joint. There were no joint-agency visits and complementary work. It is not clear if this was a cultural issue or a workload issue. It is possible that the children were seen to be cared for sufficiently because the mental health risk was assessed as low and there was not an ongoing need for community mental health services. The Mental Health Trust has said that they do not think it is a wider cultural issue but that it may be a workload issue or a priority or proportional issue. Practitioners stated that they thought it may be a more systemic cultural issue. In this case we found no evidence that joint-work was considered. A question for the MSCP and the Safeguarding Adults Board and the relevant agencies will be if this is common.

7.2.3 It is of note that the two services had different accounts of what information had been gathered from D's father in the assessments, for example about whether there were children from a previous marriage, or not. If he was truthful in the forensic interviews after D's death the answer is that D and her brother were his only children. The two Health Trusts believed that he had said that he had children from a previous relationship – but this was not shared with CSC to explore further.

7.2.4 Joint-visits and use of an interpreter many have prevented some of these confusions and the Trust staff may have been able to help D's father and mother understand that the role of CSC is not just to take children away if they had presented a more unified and supportive front.

7.2.5 The Panel has formed a view that insufficient account was taken of D's mother's needs and her understanding of D's father's mental state, or what to look for in any changes in his health or behaviour after the withdrawal of services.

7.2.6 There seems to have been an acceptance that they were 'a couple' again with no in depth exploration of how they had come back together, given what had happened, and that this was what D's mother wanted, nor how, or if, she had come to terms with her husband's infidelity. It is not clear that her views on his proposed sale of the house *where she and the children lived was explored. There should have been more professional curiosity about the reunification, about D's mother's willingness to 'look after' D's father, and about the impact on the children of the separation and reunification as well as the impact of the father's illness.*

7.2.7 The assessment social worker made good attempts to work with D's father and with both children on the need to help the children understand what was happening with him. D's

[8] Joint Services Protocol to meet the needs of children and unborn children whose Parents or Carers have Mental Health Problems; Merton Safeguarding Children Board (now Partnership) & Merton Safeguarding Adults Board, December 2018 https://www.mertonscp.org.uk/wp-content/uploads/2019/02/Merton-Multi-agency-Mental-Health-Protocol-Final-December-2018.pdf

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brother, in particular, was aware of the impact of the affair on his mother and the parental relationship (including, it has been found, that D's father sought to encourage D's mother to go to live permanently in her country of origin with the children, which D's brother did not want). D's brother had become involved in the parental dispute about his father's affair and he was also involved directly in the worry about D's father being missing and the second suicide attempt. It was recognised that D's brother would have been impacted by this but, as there were no apparent safeguarding concerns, it was not possible to do more than to negotiate with D's parents to help them understand the possible impact on the children of what had been happening. The social worker prepared material to help D but was reliant on D's father in using it with her. There was no evidence to suggest that he did do so. However, in a child and family assessment where it likely, or it is decided that the threshold for social work allocation as a child in need is not met, there is no opportunity for a social worker to seek to make a deeper relationship with children over time and to help them share their wishes and feelings and, in a case like this, perhaps their worries. This is a systems issue.

7.2.8 It is to be noted that for several months D's mother was the children's principal carer but on returning to the household D's father had re-assumed control in relationships with the welfare agencies; even though they were effectively no longer living as a couple – but this was not ascertained at the time. D's mother's account is that, although practitioners spoke to her, she did not feel consulted, informed, advised or involved by either mental health services or children's services. At times, discussion with her was through D's father because of her limited ability in English; *more will be said about this below.*

7.3 **Thresholds and 'Step-up' and 'Step-down '**

7.3.1 The children's schools were consulted and asked for information to assist the child and family assessment. Both schools have reported that they were not informed of the reasons why CSC was undertaking an assessment, even though they asked. The outcome of the assessment was that schools could keep a watchful eye but they did not know what they were watching for.

7.3.2 The Panel's view is that, while it was correct that the threshold for **child in need** was not met, the children remained vulnerable and should have been considered for 'step-down' more formally under **Merton's Child and Young Person Wellbeing Model**[9]. This would have helped the schools to be aware of the issues that the two children were facing and to offer emotional support and understanding, and to keep a watchful eye. It raises a question for the MSCP and its Partner agencies, especially schools (including independent schools and non-Merton schools), about the interface between child in need and early help. It seems the referral pathway up the threshold hierarchy is clearer than the process by which families can be offered help when they are assessed not to meet the child protection or child in need thresholds. *The MSCP may wish to audit this area of 'step-down' to see if this is a one-off issue or more systemic.*

7.3.3 If more work had been done directly with D's mother about this, she may have understood the need for the children to have help. She could have been advised and asked to give consent

[9] **Merton Child and Young Person Well Being Model, (**2013) updated 2017
https://www.merton.gov.uk/social-care/children-young-people-and-families/safeguarding-children/merton-child-and-young-person-wellbeing-model-2013

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in her own right for the schools to know more if she had understanding of how what was happening at home may be impacting on the children. At the time, the predominant dynamic was D's father's fear that the children would be taken into care. It is not clear that D's mother understood what her status as a parent was and what actions she could take in her own right.

7.3.4 A parallel 'step-down' lesson is possibly the transfer of D's father's support from the mental health services to primary care. There was a good handover of D's father's care, in that the psychiatrist spoke with the GP surgery and followed this up in writing with a recommendation that medication should be prescribed fortnightly, given the two recent overdose attempts. However, there was no active monitoring or review. There was also an erroneous belief by professionals (from D's father himself) that he was in receipt of other community-based counselling services, which was not the case. This raises a question about what active review processes may be put in place by primary care when a patient has recently made one or more suicide (or serious self-harm) attempts. A family approach and support for D's mother was not part of this, yet it was known, earlier in the year, that she was acutely distressed by the discovery of her husband's longstanding affair. She does not appear to have been offered support nor was there consideration of how she was being helped to manage the aftermath of his two suicide attempts and the apparent re-unification of the relationship, which also impacted on the children.

7.4 **The Use of Interpreters and cultural sensitivity in assessments where English is not the first language**

7.4.1 A key dynamic in the response to D's mother was her limited ability in English. It is not clear what active thought was given to her need for an interpreter. D's father often spoke of her poor English and he acted as her spokesperson, yet it is not clear that he was a Thai speaker. Several practitioners spoke to her on the phone or face to face in his presence. It is not clear that she was ever offered an interview, advice or support in her own right, or asked if she would like or was even encouraged to have an interpreter. Her comments about this are noted above in section 5. After D's death the police were clear that she needed the support of an interpreter and the Independent Reviewer who met with her for this Review is also clear that her use of English was not good enough for her to understand the processes, to be able to express her wishes, and to receive information about services. As is common, she showed some limited ability to understand simple English spoken to her but she was not able to ask questions, or express her own thoughts or views in English without the interpreter.

7.4.2 It was not only a language ability issue but a cultural matter for her to understand how systems worked and what her rights as a woman and mother were. She was not clear what was happening, and the services relied on D's father to explain and mitigate it for her. For example, she would have liked relationship counselling, as suggested by the GP, but did not know how to arrange this and was dependent on her husband who did not follow this up. She did not understand why CSC was involved as, in her view, she was a good mother and this was not questioned. She was signposted by mental health services to the local Carers Association, but there appears to have been no assessment that she understood what this was or how to access it.

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7.4.3 A related issue may have been her cultural beliefs about the status of women in personal relationships, and as a Thai person dealing with professionals or those in authority. These were not explored with her.

7.4.4 Panel members have noted the systems issues in arranging interpreters, the financial costs, and that there is not a clear commissioning arrangement for activity. This may be leading to reluctance by workers to consider using interpreters or telephone-interpreting services when a service user has limited English. Absence of an interpreter will not permit the depth of interviews needed, including emotional and possible domestic abuse issues for complex mental health or child and family assessments.

7.5 Considering and Assessing Coercive Control and Disguised Compliance

7.5.1 Practitioners doubted D's father when he said that he did not have D's mother's phone number. This was a possible sign that he was being controlling. When she was asked questions, he appears to have answered for her or suggested how she should answer. He was able to be the filter by which D's mother was asked for information or to give her view or was given information. D's mother was financially dependent on him and relied on him to help her navigate her way through services. He did not follow up the relationship counselling. Coercive control is a known dynamic in abusive relationships.

Disguised Compliance?

7.5.2 Hindsight has shown that D's father told different practitioners different things and some of the things he told practitioners were not true. It is not clear how much this was deliberate deceit and whether some may have been a genuine misunderstanding on his part. The information given about older children from a previous marriage suggests deceit. An example of possible misunderstanding is that the services of the private therapist were being delivered in the same premises as the local charity services. With regard to his claim about group psychotherapy, he did meet several times with the therapist but was not in fact approved for treatment in the group.

Over optimism?

7.5.3 It was suggested during the Review that there was over optimism. A question arises as to what leads agencies or practitioners and their supervisors to be over optimistic and what might have counteracted this. Mental health professionals believed that D's father was accessing counselling resources as part of the treatment plan. The social worker believed that the children were probably impacted by their father's suicide attempts, particularly D's brother. The social worker prepared materials to help him support the children emotionally.

7.5.4 Practitioners have to assess what they are told with an open mind and consider whether it is true or not. D's father was known to have been deceitful to his wife, which was an indicator that some degree of scepticism and checking may be required in assessing what he said. Yet in many ways he seemed to be truthful, open and remorseful about what had happened. Indeed, there was a degree of congruence in what he said, and his statements seemed to be borne out from other information and not denied by D's mother.

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7.5.5 This is a challenging area for practitioners as it is hard to recognise and then challenge at the time. As the case was not in the child protection arena and was low priority there were not grounds to triangulate all the information with other agencies to check if D's father was actually attending therapy, etc. There is not more that could have been done at the time except to accept at face value what he said. Hindsight suggests, however, that he was manipulative. A reminder from this case is the need for practitioners and their clinical supervisors to keep an open mind and to exercise respectful scepticism about some of the behaviours and information from service users where they may be anxious about the possible outcomes of intervention by welfare and protection services.

7.6 **Information Sharing**

7.6.1 Linked to the point on disguised compliance and deceit above (7.5.2 & 7.5.4) is the issue of Information Sharing in assessments and ongoing work. A clearer picture may have emerged about discrepancies if there had been more comprehensive information sharing – including through joint work, or a Team Around the Family Approach. However, this was unlikely to change the final decision about whether D and her brother were children in need. Even if it had been known that D's father was not accessing counselling or even if the schools had had a more comprehensive account of what the children had been through this would not have increased the threshold or predicted the final outcome.

7.6.2 The case does, however, raise systems issues of how practitioners and agencies share information to enable assessments. CSC practitioners believed that mental health practitioners were reluctant to share information. Mental health practitioners had taken a psycho-social history, but this was not shared with CSC, which remained unaware of some of the stated background issues. The schools were asked for information but not, in their view, given information in return about why it was needed.

7.6.3 Clearly consent and proportionality are an issue here. The Panel understand that D's mother and father did give permission for information to be shared, but they were initially reluctant for this to be shared with schools, only agreeing to this later.

7.6.4 The schools reminded this Review that their duty in considering requests to share information with partner agencies involves a duty to assess whether the information that they share is proportionate and consistent with the need for such information. They cannot assess that duty if they are not told why the information is needed.

7.6.5 This is and was a known systems issue at the time of this case. Nationally, there was increased agency anxiety about information sharing and interventions by the Information Commissioner on breaches leading to a tightening of information sharing arrangements. The European General Data Protection Regulation arrangements were being introduced raising awareness about privacy and systems.

7.6.6 No single agency had an overview about what was happening for D and her brother.

7.6.7 In July 2018 the Department for Education recognised some of these dilemmas for practitioners in sharing information and updated both the Information Sharing section in

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Working **Together to Safeguard Children**[10] and the separate revised **Information Sharing Guidance**[11]**.**

7.6.8 Page 17 of **Working Together**, paragraphs 23 and 24 are clear that good information sharing is **not just a safeguarding matter**:

> *23. Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe. Serious case reviews have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children.*
>
> *24. Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care (e.g. they are being supported as a child in need or have a child protection plan). Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child's safety or welfare.*

7.6.9 Consent, proportionality and security remain key issues and require skills in authoritative work with service users to help them see the need for information sharing for children's welfare. *(See: The seven golden rules of information sharing – quoted in the Appendix to this review.)* In this case, the social worker was later able to help the parents see the importance of sharing information for the children's welfare. However, the case would have benefitted from better information sharing between agencies. The practitioners' views have suggested that there is a lack of confidence in this area, more generally.

Other issues

7.7 **Sexual Abuse**

7.7.1 A question which has arisen from the hindsight of the post-mortem is: **Was there any evidence that D was being sexually abused? If so, was there a missed opportunity to recognise this and protect her?**

7.7.2 At the time of the assessments in 2017 there was no such suggestion and no evidence to suggest that D was being harmed sexually or in any other way.

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[10] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HM Government, July 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

[11] **Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers**; HM Government, July 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

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7.7.3 The criminal investigation and enquiries for this Review, after D's death, have established that there was no physical evidence of prior sexual abuse and that there was no evidence in D's behaviour prior to her death that was suggestive of sexual abuse.

7.7.4 The Merton Safeguarding Children Partnership has recognised that the presence of semen in D's vagina may be an indication of sexual abuse. Even though the forensic evidence was rigorously tested and there was detailed consideration by the Crown Prosecution Service it was not possible to establish how the semen came to be present. A wider learning point is that D's experience serves as a reminder that sexual abuse is often hidden, and that children and young people do not always speak out about it at the time. National data show an under-reporting of sexual abuse[12]. There is a need, therefore, for systems and practitioners to hold in mind the possibility of sexual abuse and when it would be appropriate to raise with children the possibility that they may have been sexually harmed.

What worked well?

7.8 The Review has noted the following areas of good practice:

- There was good use by the assessing social worker of the Mental Health Adviser based in CSC.

- There was good work by the assessing social worker to engage the children – in one visit - and to get the father to see the need to help the children understand what was happening, including the preparation of some materials to help them, particularly D. A challenge is what is possible in a short-term assessment to develop a trusting relationship with a child.

- The local charity thoroughly assessed D's father (on two occasions) and noted the inappropriateness of him joining group psychotherapy – following their own guidance and the then Joint Protocol for Mental Health.

- Both schools were responsive to children's general needs – but they were unaware of the marital, financial and mental health issues at home.

7.9 **Additional Analysis**

7.9.1 Given the information available at the time the decision that the case did not meet the criteria for child protection or child in need was correct.

Systems issues

7.9.2 The Review has noted the following systems issues.

7.9.3 **The family's socio-economic status, different cultures and language** may have been dynamics in affecting how they were approached and assessed. The financial issues which

[12]**Improving understanding of the scale and nature of child sexual abuse**; Measuring the scale and changing nature of child sexual abuse. Analysis of 2017/18 official and agency data; Sherrelle Parke and Kairika Karsn; Centre of expertise on child sexual abuse. July 2019
https://www.csacentre.org.uk/documents/scale-and-nature-update-2019/

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were stressors in the family are not familiar ones in social work assessments. There was a need to have a fuller understanding of the family cultures as a mixed culture family – D's father was white-British and D's mother was from SE Asia. This was not explored as fully as it might have been with regard to what it meant for daily life and relationships and significance.

7.9.4 **The family's use of private sector resources.** The family used a number of private resources. Both children went to private school until D transferred to another school with boarding fees, outside Merton. D's father used private counselling services; and sought access to, or was signposted to, charitable and voluntary services. This poses systems questions about information sharing and joint working for statutory agencies where there may not be clear expectations and protocols. Where such services are part of commissioned services through contracting this may be easier. This is an area that the MSCP and the Commissioners may wish to explore further how to ensure that such local services are aware of the local multi-agency child welfare systems. How are such services brought into the local safeguarding arrangements – protocols / guideline? Are there issues about how such services are commissioned, financially supported and quality assured, and what are their relationships to the expectations of the Safeguarding Adults Board and the MSCP?

8 Recommendations

At the time of D's murder there was no information available to suggest that D or her family were at risk. Her death could not have been predicted. Information from the criminal investigations after her death shows that D's father had been considering her murder throughout October; he also spoke, after the event, of planning to kill his wife and son, and himself. The recommendations which follow have been developed from the lessons from this Review. This does not mean that the Panel saw any failings in the case which would have brought about a different outcome. It is unlikely that if D's father had been asked more questions about his mental state and any possible risk that he would have answered truthfully.

8.1 The MSCP should seek assurance from the Mental Health Trust that in mental health assessments following attempted suicide, and particularly repeat attempted suicide, where the adult has responsibility for children or dependants, that risks to them and to partners or carers are fully considered, including the risk where the dependent may be seen as part of the patient's perceived 'problem' or as a 'protective element'.

8.2 The MSCP should review how the Multi-Agency Mental Health Protocol is working to ensure that information is being shared appropriately and that joint work is considered as much as possible, including with the non-statutory sector. It is recommended that an audit of recent cases is considered, including involvement of schools and the non-statutory sector.

8.3 The MSCP and SAB should update the Multi-Agency Protocol to ensure that it is compliant with the most recent national **Information Sharing** guidance (2018).

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8.4 The MSCP should ask Children's Social Care to review how cases which do not meet the criteria for child in need are formally considered for Early Help under the Merton Family Well-Being Model. It may be appropriate for this to be the subject of a future audit.

8.5 The MSCP should ask all Partners to confirm that the data from and efficacy of practice arrangements for interpreting is monitored by senior management. This should include protocols on the inadvisability and possible risk to vulnerable people when family members act as interpreters. In addition, agencies should be asked to confirm how practitioners are supported in understanding cultural dynamics in assessments and ongoing support to families.

8.6 The MSCP should ask Partner Agencies to confirm arrangements for regularly raising awareness with front line practitioners and their clinical supervisors / advisors and designated safeguarding leads of the dynamics of coercive control, disguised compliance, and possible over-optimism. The MSCP may wish to offer a seminar on this for cascading to Agencies, through its Training Programme.

8.7 The MSCP should seek assurance from all Agencies that as part of their Section 11 Children Act 2004 and Section 175 Education Act duties they have updated their local guidance on **Information Sharing** in line with the revised national guidance of July 2018; and that practitioners and clinical supervisors or managers are aware of this and supported in work in this area so that direct work with service users to seek consent is authoritative and not defensive. (See also recommendation 8.2)

8.8 The MSCP should review the multi-agency approaches to assessing for the possibility of sexual abuse of children, through its policies, training and practice and by examining its own data about incidence of sexual abuse. Such a review will enable the Partnership to decide if any actions should be taken in relation to the multi-agency detection of and response to sexual abuse locally.

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August 2019

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Appendices

Review Panel Membership

Chair: Asst Director of Children's Social Care;
From March 2019 replaced by Designated Nurse, CCG
Independent Reviewer: Malcolm Ward

Panel Representatives
Merton CSC: Head of Service - Quality Assurance Unit (replaced by subsequent Head of Service from April 2019) & Interim Asst Director of Children's Social Care (from April 2019)
Clinical Commissioning Group: Designated Nurse (took over as Chair from March 2019)
South West London & St George's Mental Health Trust: Named Nurse
Central London Community Health Services: Safeguarding Lead
Metropolitan Police: Sergeant of the Child Abuse Investigation Team
Merton Education Service: Education Inclusion Manager; and Head of Service, Early Years
Local Charity: CEO and Senior Manager
MSCB: MSCB/MSCP Policy and Development Manager

MSCB/MSCP Administrator supported the Panel.

The seven golden rules to sharing information [13]

1. Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice from other practitioners, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4. Where possible, share information with consent, and where possible, respect the wishes of those who do not consent to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared.

[13] **Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers**; HM Government, July 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

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5. Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6. Necessary, proportionate, relevant, adequate, accurate, timely, and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

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Malcolm Ward

Independent Reviewer

August 2019

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