Content warning: over 18s only

The following document contains material of a highly sensitive nature (including references to death, violence, and abuse) and may be upsetting for some individuals.

Reigate & Banstead
BOROUGH COUNCIL
Banstead | Horley | Redhill | Reigate

OVERVIEW REPORT

of the

Domestic Homicide Review and Serious Case Review

relating to the death of Doris in June 2016, the injuries to Lee in April 2016 and the emotional wellbeing of Sam.

on behalf of:

EAST SURREY COMMUNITY SAFETY PARTNERSHIP and **SURREY SAFEGUARDING CHILDREN BOARD**

Report Author:

Liz Borthwick
Independent Chair

Report submitted to Home Office July 2019

Report updated post HO feedback March 2020

CONTENTS

Section	Page No.
1.0 Preface	**4**
i.DHR	
ii.SCR	
iii.Timescale	
iv.Incident Summary	
v.Confidentiality	
vi.Dissemination	
1. Details of the Incident	**6**
2. The Review	**7**
3. Terms of Reference	**8**
4. Parallel Investigations and Related Processes	
i.Inquest, SCR, Criminal Trial	**8**
ii.Panel membership	**9**
iii.Independence	**10**
5. Subject of the Review	**10**
6. Methodology	
i. Contributors to the review	**11**
ii. Involvement of Family and Friends	**12**
7. Equalities	**13**
8. Overview of Family Life	**14**
9. Voices of the Victims	**15**
10. Background Information-The Facts	**16-29**
11. Engagement with the agencies and IMR feedback	
i. Surrey Police	**29**
ii. Surrey Children's Service	**31**
iii. Health (Surrey GPs)	**32**
iv. Surrey and Sussex NHS Care Trust(SASH)	**33**
v. Children and Family Health Surrey(CFHS)	**33**
vi. Surrey and Borders Partnership NHS Trust (SaBP)	**33**
vii. Private Counselling	**34**
viii. Lee's Primary School	**34**
ix. Sam's Nursery	**35**
x. Doris's Employer	**35**
12. Analysis	**37-44**
13. Lessons learnt	**44-47**
14. Conclusion	**48**

15. Post Review Learning	50
16. Recommendations	51
17. APPENDIX ONE – DHR/SCR Panel Membership	
APPENDIX TWO – Terms of Reference	
APPENDIX THRE – Police Recommendations	
APPENDIX FOUR – ESDAS	
APPENDIX FIVE – Surrey Children Services Academy	

1.0 PREFACE

1.1 This report of a combined Domestic Homicide Review and a Serious Case Review examines agency responses and support given to Doris and Lee and their family including Peter and Sam before Doris's death in June 2016. The family were residents in Surrey.
The review will identify any agency involvement and will also seek to understand the family dynamics in the build up to Doris's killing, whether support was accessed within the community, whether there are identified gaps in provision and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 DHR: Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Adult Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.
The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3 SCR: Serious Case Reviews are commissioned by the Independent Chair of the Local Safeguarding Children Board where:

(a) abuse or neglect of a child is known or suspected; and
(b) either -

i. the child has died; or
ii. the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
iii. It should be noted that Sam was not initially identified as a victim by Surrey Safeguarding Children Board. The DHR/SCR Panel has included him due to the obvious emotional abuse and trauma he experienced in the build-up, during and after his mother's death.

1.4 Time scales: The review will consider agencies' contact / involvement with the family. The review began July 2016 and concluded with submission to the Home Office in July 2019. The Home Office requested some alterations in March 2020.and that the report should be published in a fully anonymised format. Doris's family had hoped to use her original name in the report but respected the Home Office decision. The family chose the pseudonym 'Doris' as used in the report.
This report reflects the Home Office amendments.

The Home Office agreed to the extension of the standard six-month deadline due to the additional parallel investigations: two criminal court hearings, two Family Court Fact Finding hearings and the Children's Welfare hearing.

1.5 Incident summary: The purpose of this review is to examine the circumstances surrounding the tragic death of Doris, and the physical abuse to Lee, including the serious injury she sustained during the incident in which her mother died. Doris was stabbed to death in her home in June 2016 by Peter who pleaded self-defence and was later acquitted of her murder in May 2017. Prior to her death, she was issued with an Adult Caution for smacking Lee and common assault on Peter.

1.6 Confidentiality: The detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers. A confidentiality agreement has been signed at each meeting of the DHR Panel.

1.7 Dissemination: The Executive Summary, Overview Report and Recommendations have been redacted to ensure confidentiality, with pseudonyms used for the victim, children and father. The reports have been disseminated to the following groups:

- East Surrey Community Safety Partnership
- Surrey Adult and Surrey Children Safeguarding Boards
- Surrey Community Safety Board
- Surrey DHR Oversight Group
- Surrey Domestic Abuse Management Board
- The Leader of the local Council and relevant Portfolio Holders in the Borough where the death took place
- East Surrey DA Working Group
- The Office of Surrey Police & Crime Commissioner (OPCC)
- The agencies involved on the DHR Panel (See Appendix 1)
- The family of Doris (DHR and elements of SCR) and Peter (SCR).

The DHR/SCR panel members wish to thank the family, friends and colleagues who participated in the review. We understand what a difficult time this must be and offer our sincerest sympathies on their tragic loss.

2.0 DETAILS OF THE INCIDENTS

Incident One (Domestic Homicide)

2.1 On 2 June 2016, a 999 call was made by Peter from the family home. He described a knife attack upon himself and his daughter Lee and identified the assailant as Doris. Peter explained that Doris was in the dining room and that he was safe in the bedroom with their two children Lee and Sam. Peter stated that Lee had a cut on her arm and that he had a cut on his hand and his head was bleeding. He did not mention that Doris had significant injuries.

2.2 When the Police arrived at the house, they found Doris lying face down in a large pool of blood on the dining room floor. A Police officer turned Doris over and there was a large cut across her throat.

2.3 Peter, Lee and Sam were located upstairs in a bedroom. Peter was holding a sock to Lee's injury and was crying. Both children kept asking "Why would mummy hurt us?" Peter stated that he had been hit on the head twice with a knife.

2.4 An ambulance and Police units arrived at the house and Doris was confirmed to be deceased at the scene. Peter, Lee and Sam were taken to hospital accompanied by the Police.

2.5 Later that evening on 2 June 2016, Peter was arrested on suspicion of Doris's murder.

2.6 Lee and Sam were taken into Police protection at the hospital until a foster placement could be arranged. The Local Authority issued an application for a Care Order (Children Act 1989) and they were subsequently made the subjects of an interim Care Order.

2.7 On 3 and 4 June 2016 Peter was interviewed under caution. Peter stated that on 2 June 2016 he had been out at work and had returned home at 17.30. Lee and Sam had been out with their maternal grandmother and arrived shortly after him and Doris was already at the house waiting in her car outside. Doris's family stated that she did not enter the house as she was frightened of being alone with Peter. Doris and Peter were living separately at the time but shared the care of the children.
Later in the evening, Peter and Doris had an argument in the kitchen over Doris's poor relationship with Lee. Peter states that Lee came between them, at which point Doris picked up a knife and swung it at Lee, cutting her arm. He states he pushed Lee out of the room and that Doris then swung the knife at him resulting in two cuts to his head. Peter took the knife from Doris but stated she kept coming towards him and they grappled. During this he inflicted the fatal knife wound to Doris's neck. Peter went upstairs to be with Lee and Sam and contacted the Police. He claimed he had acted in self-defence.

2.8 Post Mortem: On 4 June 2016, a post mortem examination was carried out. The Consultant Forensic Pathologist found that Doris had sustained incised open wounds to both hands, a 13.5cm long deep incised injury to her throat that had severed her carotid artery and jugular vein and completely severed her windpipe and oesophagus, resulting in massive blood loss. Cause of death was given as 'incised wound to the neck. The Pathologist opined that Doris would have collapsed and died a short time afterwards due to massive loss of blood circulation. Toxicology

revealed traces of Mirtazapine (anti-depressants) and Ibuprofen in Doris's body. No alcohol or illegal substances were detected.

2.9 On 5 June 2016 Peter was charged with Doris's murder.

Incident Two (Serious incident against a child)

2.10 On 8 April 2016 the Police received a distressed call from Lee who stated she had been assaulted by her mother, Doris. A Police unit was immediately deployed to the family home and Lee answered the door, clearly upset and crying. Lee stated that Doris had thrown her off her bed onto the floor and started punching her and kicking her.

2.11 Doris was interviewed by the Police and admitted that she had hit Lee on the bottom for misbehaving as she would not get out of bed to go to her grandmother's house. The Police contacted Peter who was at work; he disclosed that Doris had assaulted him on a number of occasions since January 2016.

2.12 On 8 April 2016 Doris was arrested on suspicion of assault on Lee. She was Cautioned for smacking Lee's bottom and for Common Assault on Peter.

3.0 THE REVIEW

3.1 Surrey Police notified the East Surrey Community Safety Partnership (ES CSP) of Doris's death in June 2016. The ES CSP met in July 2016 and decided that the criteria for a DHR had been met. Liz Borthwick was appointed as independent chair, supported by Debbie Stitt as coordinator (see Section 6.1 below).

3.2 The DHR was commissioned by ES CSP in accordance with the revised Statutory Guidance for the conduct of Domestic Homicide Review[1] published by the Home Office in March 2016.

3.3 The Strategic Case Review Group (SCRG) of Surrey Safeguarding Children Board (SSCB) received a referral for a Serious Case Review (SCR) and considered Lee's case in September 2016**.** It agreed that the case met the criteria for a proportionate SCR, in accordance with the Working Together 2015 Statutory Guidance[2]. The DHR / SCR Panel subsequently included Sam within the SCR as a victim of emotional abuse.

3.4 It was agreed by the SSCB and ES CSP that both reviews would be combined (i.e. a joint DHR & SCR) to streamline information gathering and to reduce the emotional impact on family and friends being interviewed twice for the reviews. Ofsted[3] and the SCR National Panel were notified in October 2016.

3.5 The Chair of ES CSP notified the Home Office on 18 July 2016 that a combined DHR / SCR would be commencing. The Home Office agreed to extend the initial 6 month deadline (and to

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

[3] The Office for Standards in Education, Children's Services and Skills

further extensions on several subsequent occasions) due to the numerous parallel processes taking place including two criminal court hearings, two Family Court Fact Finding hearings and the Children Care Proceedings hearing.

3.6 The joint DHR/SCR involved one Panel, with membership including representatives from the Surrey Safeguarding Partnership. The Independent Chair updated as appropriate the ESCSP and SSCP (SCR Strategic Project Group). This ensured that the joint review followed the requirement of the Home Office DHR statutory guidance and Ofsted Working Together to Safeguard Children guidance.

4 TERMS OF REFERENCE

4.1 Terms of Reference were agreed by the DHR / SCR Panel in July 2016 and were regularly reviewed and amended as further details of the incident emerged (see Appendix 2 for the final version.).

5. PARALLEL INVESTIGATIONS AND RELATED PROCESSES

5.1 *Inquest*
An inquest was opened into Doris's on 10 June 2016. Once Peter's verdict of 'Not Guilty of Murder' was received the inquest was not resumed and a final death certificate was issued.

5.2 *Serious Case Review*
The Surrey Safeguarding Children Board (SSCB) was represented on the DHR panel from the outset, which was renamed the DHR / SCR Panel to reflect its joint responsibilities. Lee was nine years old at the time of the incidents. Every attempt has been made to include the voice of Lee and also Sam within the process and discover any relevant learning. The Panel agreed that the Terms of Reference would include Doris, Lee and Sam.

5.3 *Criminal Trial*

Peter was put on trial for the murder of Doris in December 2016. After four days the trial was stopped as Peter made further revelations about the attack. The second trial commenced in May 2017. Following a trial lasting five weeks and deliberation by the Jury over five days Peter was acquitted of Doris's murder.

5.4 *Family Court Fact Finding Hearing*

5.4.1 An initial Fact-Finding Hearing took place in the summer of 2017 as part of the proceedings within the Family Court. Following a two week hearing the Judge stated in the report that Peter had killed Doris and that he had not acted in self-defence. Peter appealed the Judge's findings as this was not the outcome of the criminal trial. The appeal was upheld leading to a further hearing with a different judge in April 2018

5.4.2 All witnesses were required to be re-interviewed as part of the process. The Judge made the following conclusions:

- On 2 June 2016, Peter had killed Doris by cutting her throat.

- That following the breakdown in the relationship of Peter and Doris between December 2015 and June 2016, both parents failed to protect their children from their numerous verbal and physical disputes.
- That Lee and Sam had suffered long lasting trauma resulting from their exposure to the acrimonious and violent relationship between Peter and Doris and the death of Doris.
- That Peter inappropriately involved the children, especially Lee, in the adult matters of the parents' relationship.

  By way of example:
  - *Asking Lee to decide whether he should go out with his new partner.*
  - *Asking Lee to unlock Doris's phone so that he could check it for messages;*
  - *Encouraging Lee to check her mother's phone, leading to disclosure at school that her new boyfriend was under the name that mum and dad were going to call their baby, should they have another daughter;*
  - *Telling Lee to throw her mother's phone on the floor so that it smashed;*
  - *Telling Lee not to say too much to people at school because he did not want to get social services involved;*
  - *Engaging in a collusive relationship with Lee, including instructing her not to tell Doris that he had been talking to her school teacher and to keep it a secret;*
  - *Causing Lee to side with him against her mother in the parental disputes.*

5.5 *Care Proceedings*

The Care Proceedings in respect of the children concluded in the autumn 2018. A Special Guardianship Order was made in respect of both children with their paternal uncle and aunt, along with a Supervision Order to Surrey County Council for 12 months.

5.6 *Police Disciplinary Investigation*

5.6.1 The Police referred their involvement in this incident to the Independent Office for Police Conduct (IOPC). The IOPC stated there was no case to answer and referred it back for a local an internal investigation.

5.6.2 Surrey Police reviewed its involvement in the case through its Public Protection Standards Team (PPST) and PSD (Professional Standards Unit) The conclusion stated there was no individual misconduct; the issues identified should be addressed in the form of learning, especially in the issuing of simple Police Cautions for child abuse.
This was followed by a Death or Serious Injuries report in which several individual and learning recommendations were made. Many of these were for internal training and guidance for individual Police roles. Those with wider implications are included **Appendix 3.**

6.0 PANEL MEMBERSHIP AND REPRESENTATIVES

The Panel consisted of senior representatives from the following agencies (see **Appendix 1** for full list of officer attendees):

Surrey Police
Surrey Safeguarding Children Board
Surrey County Council Children's Services

Surrey and Sussex Healthcare Trust
Surrey-wide Designated GP for Safeguarding Children
Surrey and Borders NHS Foundation Trust
East Surrey Domestic Abuse Services (ESDAS)
Lee's School
East Surrey Community Safety Partnership
The local Borough Council
Independent DHR / SCR Chair
Independent DHR/SCR Coordinator

The panel met 10 times during the period July 2016-May 2019.

6.1 Independence of Chair

The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council. Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with a number of SCRs. Liz has no connection with the local Borough or any of the agencies in this case.

Liz was supported in this review by Debbie Stitt as DHR / SCR Coordinator. Debbie has worked in Community Safety for many years and has a thorough understanding and knowledge of domestic abuse and the processes involved in DHRs. Debbie has attended Home Office training in the running and delivery of DHRs.

7.0 SUBJECTS OF THE REVIEW

The main subjects of this review are:

DHR/SCR subject	Date of birth	Date of death
Doris - deceased victim (female adult) and cautioned for physical abuse to Lee and DA to Peter	[redacted] 1977	**2nd June 2016**
Peter - perpetrator (male adult); cleared of murder by Criminal Court; alleged DA victim	[redacted] 1973	
Lee - victim of physical and emotional abuse	[redacted] 2007	
Sam - victim of emotional abuse	[redacted] 2011	

Significant others:

Subject	Relationship
Doris's mother	Maternal grandmother
Doris's sister	Maternal aunt
John	Doris's new partner

8.0 METHODOLOGY

8.1 Contributors to the Review

8.1.1 Statutory and Voluntary Agencies:

Each involved Surrey agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. Authors were independent of the incident and the reports were Quality Assured by the organisation. As the review progressed, additional agencies were identified who had contact with the family members and further information was requested. IMRs were received from:

- Surrey Police
- Surrey County Council Children Services
- Surrey and Borders Partnership Foundation NHS Trust (SaBPT)
- Surrey and Sussex Healthcare NHS Trust (SASH)
- Children and Family Health Surrey (CFHS)
- Health (Surrey GPs)
- Lee's Primary School
- Sam's Nursery
- Doris's Employer

The panel has given detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

The following agencies and voluntary groups were contacted and confirmed that they had no relevant engagement with the family:

- The local Borough Council
- ESDAS (East Surrey Domestic Abuse Services)
- Surrey Youth Service
- Surrey County Council Adult Care

8.1.2 The Independent Chair supplemented the IMR information with face to face group meetings with some of the front-line Police officers and social workers involved in the two incidents. Issues explored included the culture of the organisation at the time of the various incidents, pressures on services and why decisions were made. The information, honesty and insight into why decisions were made were very difficult to capture in an IMR and therefore the interviews were invaluable in this review.

8.1.3 The Independent Chair and Coordinator of the DHR / SCR attended the start and the conclusion of Peter's trial.

8.1.4 The Family Court Fact Finding Reports were also shared with the Independent Chair and the Panel to inform this review. The Independent Chair made a request to obtain further background reports relating to parenting and psychology assessment of Peter but Peter refused to allow disclosure.

8.1.5 Further information was also provided about by the private counselling agency which was commissioned by Doris's employer.

8.1.6 Information was also provided about the initial Foster placement investigation into alleged physical abuse of the children and this provided post review learning.

8.2 Involvement of Family, Friends, Work Colleagues, Neighbours and the wider Community

Information has been supplemented through interviews / conversations with family, friends, work colleagues and Doris's employer in an attempt to understand the personal backgrounds of Doris, Peter, Lee and Sam.

8.3 Research by the Independent Chair relating to Doris, Peter, Lee and Sam took place through face-to-face meetings and telephone conversations as detailed below, Individuals were provided with the relevant Home Office leaflet (for family, friends, employers and colleagues) in advance. All those contributing were able to do so using the medium they preferred.

8.4 Contact with Doris's family: The families of Doris and Peter have been updated regularly throughout the Review, regardless of whether they chose to be involved in the process. Lee and Sam have been kept updated via contact with the children's Social Worker. Doris's mother and sister attended a DHR / SCR Panel meeting on 13th December 2017, accompanied by their AAFDA[4] Support worker. This meeting had a profound effect on the Panel, highlighting the impact of the domestic homicide on the family. They also attended a further Panel meeting in May 2019 having read the draft report and raised a number of questions in advance. The Children's Services representative arranged a separate meeting to discuss concerns.

Peter, as the remaining parent involved, refused permission for Doris's mother and sister to see the entire SCR report, stating that 'the whole family really need to move on'. Doris's mother and sister were given the opportunity to discuss the sections they had contributed to and to highlight any factual amendments.

8.5 Contact with Peter and his family: Peter and his family initially declined to contribute to the review. Much later in the process, Peter agreed to meet with the Independent Chairperson, Support Manager from Surrey Safeguarding Children Board and the DHR / SCR Coordinator. Peter was also kept updated about the review by letter. All other members of Peter's family who were contacted declined to take part.

8.6 Research and contacts by the Chair

The Chair made the following contacts to gather further insight into 'the voice' of the victim:

[4] AAFDA - Advocacy After Fatal Abuse https://aafda.org.uk/

8.6.1 Meetings:

- Doris's mother
- Doris's sister
- Doris's friends and work colleagues
- Doris's new partner (referred to as John)
- Doris's employer
- Social workers for Lee and Sam
- Head teacher of Lee's school and the Safeguarding Lead

8.5.2 By Telephone:

- Surrey County Council Children Services Manager
- Surrey-wide Designated GP for Safeguarding Children
- Sam's nursery
- Doris's sister's partner
- Doris's brother
- Neighbours of Doris and Peter
- Senior Management at Doris's employment.

8.6 The Independent Chair and the Panel discussed whether contact should be made with the children to add their voice to the DHR / SCR. It was decided this would not be appropriate as Lee has been diagnosed with Post Traumatic Stress Syndrome and Sam was being assessed by Social Services for learning issues. The Independent Chair viewed the video evidence given by Lee in the criminal trial. It was felt that Lee and Sam's social worker could act as their voice to ensure they had the ability to contribute if they so wished.

9. EQUALITIES

9.1 Doris was a 39 year old heterosexual white British woman. Doris's relationship began with Peter in 1993 and they were married in 2003.

9.2 Lee was 9 years old at the time of her injury and is a white British Child. Sam (who was not seen originally as a victim in the SCR) is now included as a subject of the DHR / SCR as his emotional welfare suffered during the breakdown of the marriage. Sam was 4 at the time of his mother's death and is also a white British Child.

9.3 Peter is a heterosexual white British man who was a 43 year old at the time of the incident.

9.4 The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Only two of these characteristics are considered by the review to have had an impact – marriage and sex. These two characteristics are considered later within this report.

10.0 KEY PRACTICE EPISODES:

Social Care Institute for Excellence (SCIE)-Learning Together [5]

10.1 A wealth of information has been made available for this review through the Court proceedings, the Family Courts and significant detail within the IMRs. The Independent Chair and the DHR / SCR Panel agreed to utilise the SCIE model "Learning together" to identify the key episodes in the lives of Doris, Peter, Lee and Sam which led up to Doris's death.

10.2 The Key Practice Episodes (KPE) are identified below and will be referred to throughout the report.

- **KPE One:** Early family relationships and health, including birth of their children
- **KPE Two:** Bullying and coercion of Doris by Peter and grooming of the children and professionals
- **KPE Three:** Separation / breakdown of the family unit late 2015
- **KPE Four:** Wellbeing of parents and children January 2016
- **KPE Five:** Changes in Lee and Sam's behaviour March 2016
- **KPE Six:** Assault of Lee and Peter by Doris April 2016
- **KPE Seven:** Child arrangements/coercion and control of the children April 2016
- **KPE Eight:** Death of parent / impact on children and agencies June 2016

11. OVERVIEW OF FAMILY LIFE

This section describes family life up until December 2015 when there was a significant change within the family.

KPE ONE: EARLY FAMILY RELATIONSHIPS AND HEALTH INCLUDING BIRTH OF THEIR CHILDREN

11.1 Peter was 43, and Doris was 39 at the time of her death. They met around 1993 and married in May 2003. They moved to the family home in 2006 where they were still living when Doris was killed on 2 June 2016. According to information provided, Peter had a very strict upbringing and his father was a bully and disciplinarian often using physical punishment.

11.2 Doris and Peter lived in south London until 2010 but then moved to be closer to the maternal/paternal parent's homes to facilitate easier childcare. Doris's father died in 2014. Her sister and brother lived away from the area.

11.3 Lee was born in 2007. Peter and Doris had been trying to have a child and they were overjoyed. Lee started school in September 2011. She had good attendance and was supported by her parents at parents' evenings and other school events. *(Source: School IMR)*

11.4 Following a family holiday to Australia when Lee was three, Peter became unsettled and spoke with Doris about the family moving there. Doris refused as she wanted to stay near her family.

---

[5] https://www.scie.org.uk/children/learningtogether/

11.5 Peter then began to carry out extensive building work in their home. A comment was made that the family home resembled a building site for a number of years.

11.6 Doris and Peter were desperately trying for a second child and Doris had a miscarriage before Sam was born in 2011. Several family and work colleagues spoke of how sad Doris was at the loss of this child but also spoke of her joy at the arrival of the Sam; Lee and Sam were much wanted by both parents. A family member said that Doris was thrilled at being a mother. Sam started at nursery when he was three years old. Doris dropped him off and nursery staff said she was very caring. *(Source: Nursery IMR)*

11.7 During the period of the review, Doris, Peter, Lee and Sam were registered with one GP practice in Surrey. Family contact with the GP had been unremarkable until the last six months before Doris's death. The children attended routine appointments and there were no safeguarding concerns. Peter had no recorded history of previous mental health problems, alcohol or substance misuse, and no recording in relation to domestic abuse. Doris had no history of mental health problems until the consultations of March-May 2016. From then onwards until her death, Doris was seen by a GP six times. *(Source: GP IMR)*

11.8 Both parents worked; Peter was a carpenter and since 2003, Doris had worked in IT with a local housing provider. In 2013, Doris was signed off work for around 3 months due to stress, relating to a grievance she had taken out against her manager. Her grievance was upheld and she returned to work. Following a restructure in Doris's department she achieved promotion.

11.9 Doris and Peter were assisted with childcare by Doris's mother and the paternal grandparents. Sam started nursery in January 2015 and Doris took on the nursery / school runs before work. Prior to early 2016 there were no concerns noted about the children at either Lee's school, or Sam's nursery. The school and nursery reported to the Family Court Fact Finding that the children's progress had been very positive. Both parents disciplined the children with the occasional smack as did Doris's mother. The family have stated that Peter had a long ruler with which he used to chastise the children.

11.10 Surrey Police reviewed their local and national databases for prior involvement with the family. Peter had a PNC[6] record showing he had seven convictions for theft / fraud / kindred offences in 1994.
Doris had a PNC record for the simple Adult Caution relating to the assaults against Lee and Peter in April 2016 as detailed earlier in this report. *(Source: Surrey Police IMR*

12 VOICES OF THE VICTIMS (based on information provided by family, friends and reports)

12.1 Doris

12.1 1 Doris was viewed as lively and fun. She was a good mother and loved her children. She was very well respected by her employer and her colleagues and was good at her job. She was also always the first to organise social events and in the words of one of her colleagues "got things done". Doris enjoyed girly nights out as well as the fellowship with

[6] Police National Computer

mothers at the children's play group. She loved Star Wars and Disney. Doris could have great high moods but also low periods and she sometimes became very angry.

12.1.2 The last six months of Doris's life were chaotic. With the breakdown of her relationship with Peter, she experienced great stress, mental health issues, coercion and control by Peter of the situation, domestic abuse, and loss of daily access to her children. This eventually led to the incident where she lost her life. In the words of her family, "Doris was never seen as a victim by the professionals involved during this time".

12.2 Lee

12.2.1 Lee is a very bright and articulate girl, funny and outgoing with an 'old head' on her. She loves singing, dancing and drama. She was a Daddy's girl. As her relationship with her mother deteriorated, she began to refuse to call her 'Mummy' and referred to her as Doris. Her behaviour towards her mother became verbally and physically aggressive including pushing Doris downstairs and spitting in her face, which would appear to have been encouraged, or certainly allowed to go unchallenged by Peter.

12.2.2 Lee went through significant trauma in the last six months of Doris's life. This included being assaulted by her mother in the incident described in paragraph 2.10-2.12 .and partially witnessing her death, which has resulted in her experiencing Post Traumatic Stress Disorder (PTSD).

12.3 Sam

Sam is a very tactile, endearing child. He can struggle to communicate with other children and although he may have some learning difficulties, the situation was not able to be fully addressed before he moved school and therefore it is not known if this has been formally diagnosed. Sam also suffered significant trauma leading up to the death of Doris and began to regularly soil himself and become 'clingy' with staff.

12.4 Peter

Peter appears to have had a strict upbringing which involved physical punishment from his parents. He did not have many friends, only colleagues who he worked with and did not socialise like Doris. Peter loved the family, especially Lee, and was seen as charming by others. However, family members felt he was very controlling and became manipulative.

13.0 THE FACTS

The below information has been drawn from a range of sources; the IMRs submitted by agencies (referenced where appropriate), the findings of the Fact-Finding Report of the Family Court judge, and interviews from friends and colleagues.

KPE TWO: BULLYING AND COERCION OF DORIS BY PETER and GROOMING OF THE CHILDREN AND PROFESSIONALS

13.1 In late 2014 and into 2015, Doris disclosed to her family and work colleagues that she was experiencing controlling and undermining behaviour from Peter. Doris had been seen with a black eye by her family and she had indicated that she had been raped by Peter. A close friend and colleague disclosed that Doris stated that Peter would stand right in front of her face and poke her with his fingers, sometimes so hard he would knock her backwards. Family and work colleagues highlighted that they heard Peter making comments to Doris about her weight, ridiculing the way she looked, and how she had let herself go. He made sexually suggestive comments to Doris's sister.
Doris stated she was scared to leave Peter as he harmed himself whenever she mentioned it. He was particularly fixated with trying to find out who her new partner was and head butted the wall when unable to. (*Source: Police IMR*). There were multiple occasions when he accessed her phone, was verbally abusive, and stated he had tried to commit suicide by taking an overdose of co-codamol. (Source: *SaBPT IMR*). Although there is no record in the medical notes, her GP recalls her saying she had put up with her husband's emotional abuse for years and had had enough. (*Source: GP IMR*).

KPE THREE: SEPARATION / BREAKDOWN OF THE FAMILY UNTIL LATE 2015

13.2 In 2015 Doris and Peter's relationship began to deteriorate rapidly. After her work's Christmas party, Doris shared a taxi home with a male colleague John, who was also having some marital issues. From this encounter a relationship started.

13.3 Peter found a Christmas card to Doris from John when he was searching her handbag. Doris and Peter argued, with Doris admitting she had begun a relationship with another man. Whilst she was asleep, Peter accessed her unlocked phone, and read the text exchanges between Doris and John. Peter texted John several times and left answerphone messages on Christmas Eve which John eventually replied to saying Peter should talk to Doris rather than him.

13.4 This was a difficult time for Doris and Peter although evidence suggests that Peter thought they would be able to work through their difficulties. Early in **January 2016** Doris said she wanted them to separate. Peter struggled to accept this. Peter and Doris needed to share a home for financial reasons as Doris provided the regular, larger salary and was "the breadwinner". Doris stated they should have separate bedrooms, and Peter moved into the room in the loft. The house had been under renovation for over five years. Over the following weeks Doris and Peter secured a further loan to complete the house renovation with the plan to then sell the property, split the proceeds equally and each find their own accommodation.

13.5 Evidence presented to the Family Court by Peter describes Doris's behaviour changing from late December 2015. Peter stated that Doris was becoming verbally and physically abusive towards him and the children, and that the difficulties they experienced were largely attributable to Doris's behaviour. Reports from family, friends and colleagues presented a different picture;

Peter was devastated by the breakdown of the relationship and behaved in a controlling and manipulative way towards his wife, either to try and keep Doris in their relationship and / or to lay the ground for the children remaining in his care**.**

KPE FOUR: WELLBEING OF PARENTS AND CHILDREN

JANUARY 2016 onwards

13.6 In the early part of 2016 the situation in the home became increasingly difficult. Peter did not want the marriage to end, there were arguments when he would threaten to take his own life and self-harm. On one occasion Peter head butted the wall in the family home. On another occasion Peter said he was going to drive his motorbike into a wall but then returned shortly afterwards unharmed. Evidence from the Family Court describes how Peter had told Lee he was going to kill himself and that he showed her his self- harm marks.

13.7 Doris spoke to her sister about her concerns for Peter, including her fear that she was going to return home to find Peter had seriously harmed himself. Her sister informed the Police, and Doris subsequently attended the Police station in **late January 2016**. Police records of the meeting show that Doris did not consider Peter to be a danger to her or the children, but mainly a danger to himself, detailing the threats Peter had made to kill himself. She said he was not physically abusive to her but could be verbally abusive and she outlined her concerns about the knives in the home.

The Police completed a DASH Risk assessment[7] with Doris. In her responses Doris stated that she was very frightened when Peter "goes off on one". She described how Peter was very jealous - he liked to check up on her and read her personal texts. He admitted that he had stalked her when they started dating 21 years ago (when Doris was around 15-16 years old). Doris also stated that Peter owned knives as he was a carpenter and he had some ceremonial swords. Her 10 positive responses were assessed as 'Standard Risk' (meaning *current evidence does not indicate likelihood of causing serious harm*). Doris was signposted to ESDAS[8] outreach support and given relevant literature at that time but she declined a referral to the service. The advice was for Doris to call 999 if Peter became violent or aggressive towards her or the children.
Safeguarding Referrals (39/24s) were also completed for the children and for Peter and submitted to the MASH[9] for dissemination to appropriate agencies. Both referrals were RAG[10] rated as Amber.

The referrals for Peter highlighted concern for his mental health and self-harming and also around the children witnessing the verbal altercations between Doris and Peter. *(Source: Surrey Police IMR)*.

The family was first referred to Adult Social Services in **late January 2016** following Doris's visit to the Police about Peter's emotional wellbeing. The Duty Service Manager evaluated the Police

---

[7] DASH: Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment Checklist
[8] East Surrey Domestic Abuse Services https://www.esdas.org.uk/
[9] Multi-Agency Safeguarding Hub
[10] RAG: Red Amber Green - level of risk harm

Safeguarding referral form and Doris was contacted to offer details about family support services available, including ESDAS. Doris said she was aware of such services and also said Peter had seen his GP. The Duty manager made the decision that no further action was needed. (*Source: Surrey Children's Services IMR*)

13.8 The Surrey and Borders Partnership Trust (SABPT) Community Mental Health Recovery Service (CMHRS) received the safeguarding referral for Peter following Doris's visit to the Police. It was reviewed by a Rapid Access Worker (RAW) and there were not felt to be any safeguarding concerns and no secondary mental health issues. The RAW wrote to the GP on **28 January 2016** enclosing the referral form and asked for Peter to be assessed and signposted as appropriate. (*Source: SABT IMR)*

The GP contacted Peter to arrange an appointment and he attended on **3 February 2016**. Peter said that Doris had announced she was divorcing him and that she was his best friend. He was finding it hard to cope and self-harmed by head butting the wall and had suicidal thoughts, but "the kids were his protective factor". The GP noted that Peter was very anxious, his nails were bitten and he had a fine tremor.

The GP prescribed antidepressants gave him contact details for CRISIS Mental Health Support (now Crisis Overnight Support Service)[11] and details of the First Steps Mental Health Support Programme (currently under review due to budget constraints). On the second visit the GP noted that Peter was calmer and his main concern was that the children could be taken away. Peter was phoned the following week by the GP to check on his progress. Peter stated that he was getting on much better, had gone back to work and was not keen to access talking therapies at this stage. *(Source GP IMR)*

13.9 Doris was continuing to disclose to her work colleagues and family the difficulties in her relationship with Peter. Doris told them that Peter was coercive and controlling. Peter alleged that Doris was angry, argumentative and, on occasions, physically abusive towards him and Lee. On one occasion John (Doris's new partner) described overhearing a lot of shouting between Doris and Peter during a phone call.

13.10 In **January 2016** Peter contacted John's wife, initially making contact under a false name, as his first attempt through his own Facebook account had been blocked. Peter and John's wife met in a car park; it was unclear whether he revealed his real identity to her or used the false name. She described her concerns about Peter's threats to harm himself and John and about his behaviour generally. She said that Peter told her that he had been looking at Doris's phone and began to cry. He asked if she was still having sex with her husband and if not whether he (Peter) could get her pregnant. (*Source: Trial and Family Court statements*).
Soon after this meeting John's wife became ill and had to be admitted to hospital.

13.11 Doris continued to confide with close friends at work about Peter's behaviour, describing how he would goad and provoke her, knowing, as she described 'which buttons to press'.

13.12 Doris had very little personal space in the family home. There are descriptions of Peter coming into her bedroom in the early morning with a torch, looking for things, of Peter always

[11] Crisis Overnight Support Service: https://varb.org.uk/blog/2018/03/22/changes-to-respite-crisis-mental-health-services-in-east-surrey/

being around her. Doris's mother stated that the situation became intolerable for Doris. Peter would goad her and one night it became too much for Doris. She called her mother in such a state that she drove to her house and collected her. Doris also told her a friend that she 'flipped' on 1 March 2016 during a row with Peter and she pummelled him with her fists.

13.13 In **March 2016**, Doris visited her GP and was very depressed and tearful. She was diagnosed with Mild Mixed Anxiety and Depressive Disorder. She stated she wanted a divorce but Peter did not and she felt angry and frustrated. Doris said she had left home to stay with her mother and that Lee and Sam were with Peter. She had no concerns about the children's welfare at that time. A small supply of sleeping tablets and antidepressants were given to Doris. From then onwards until her death, Doris was seen by a GP six times. *(Source: GP IMR and SaBPT IMR).*

13.14 Doris reported to a work colleague that she and Peter had argued in front of the children and that Peter prodded and pushed her and shouted in her face. He said to Lee that 'Mummy doesn't love me anymore and that she has a new boyfriend'. In the Family Court Peter describes an incident in **March 2016** when Lee intervened in an argument between them, during which he said that Doris had grabbed Lee by the neck removing her from the room and slapped her face. Peter described taking a photo of Lee's face, to 'show Lee' as there wasn't a mirror in the sitting room. He informed the Police about the photo when they attended the home in **early April 2016** and gave a copy of the photo to the officers.

13.15 Around this time Doris, without prior notice to Peter, took the children, with some of their belongings including passports, to stay with her mother so she could have quality time with the children.

Peter was reducing the time Doris spent with the children by phoning and keeping her talking. Peter was very distressed on discovering the children had been taken without being told. They returned about a week later. Doris stated she wanted a shared care arrangement, with the children remaining in the family home, and with the parents alternating care. Peter would not agree to this because he had nowhere else to go; his father was ill in hospital and he did not want to place additional pressure on his mother. Doris wanted this arrangement to allow her to re-engage with the children stating "I need time alone with them." However, the arrangements resulted in Doris remaining at her mother's, getting up early and going to the family home for about 5.30am to enable Peter to go to work. She would then get the children up and take them to nursery and school before she went to work herself.

KPE FIVE: CHANGES IN THE CHILDREN'S BEHAVIOUR MARCH 2016

13.16 In **February 2016** Lee's school became concerned about incidents she mentioned happening at home and the adult way she was phrasing them. Peter told the Class Teacher in February, in front of Lee, that things were bad at home and there was physical and verbal aggression between him and Doris. The class teacher heard Peter say to Lee *'remember not to tell Doris you have seen me, keep it a secret'.* This, and the adult language Lee used, raised concerns that Peter was grooming the children to present his point of view to others.

13.17 The Class Teacher advised the Head Teacher of the Junior School about Peter's visit, who reinforced to Peter that parental meetings should only be by appointment and that Peter was not to seek to meet in this ad hoc way. The concern was raised that Peter was attempting to 'groom' the staff to see his point of view rather than Doris's.

13.18 The Class Teacher disclosed that Lee would mention issues at home in a very adult way e.g. *'Doris is never around and always with John. 'Doris is being vicious'. 'Daddy* is *always supporting us'.* Having known Lee for a year, the Class Teacher considered her language to be very adult-like in nature and not age appropriate. She felt it replicated Peter's conversation with her e.g. Lee referred to Doris as *'now getting physical'.* This reinforced concerns that Peter was manipulating the children to present his own views

13.19 Peter went to see the Class Teacher again in early **March 2016**, reporting that 'Doris had walked out the night before and taken Lee and Sam with her'. Peter asked her not to share this with any other agency, which she explained was not possible. The Class Teacher said Lee returned to school the next day.

13.20 During this time, the school decided to introduce a 'Worry Book' to support Lee, in which she could write anything that concerned her. This would be confidential to her and the information would only be shared if the school had worries about her safety. The Class Teacher was concerned when Lee revealed that Peter had said that she was *'not to tell the teachers everything in her book'.* On another occasion she stated that *'Daddy said I am allowed to tell you now'.* The Class Teacher noted there was some discrepancy between what Lee was writing in her book and what she actually described to the Class Teacher had taken place e.g. in the book she described '*punches and kicks by Doris*', but verbally she said '*it was a slap*'.

Worry Book entries:

- *Mum came home, hurt dad, nearly crashed (car) with me in it.*
- *Name calling, punching arms, slapping chest and kicking legs.*
- *Mum called me a little bitch, fucking bitch and punched me on my chest.*
- *Dad has been really nice to me and (my brother). Mum's got a new boyfriend.*
- *Mum has told me Dad's horrible and Mum is really nice, her boyfriend's name is John*
- *I am worried that Dad needs to move out.*
- *Mum is going to be mean to me. John has teared our family apart (sic)*
- *I am having nightmares about my Mum killing me.*
- *Wherever I go I don't feel safe" (Source: School IMR)*

13.21 The Head Teacher spoke to Peter about the correct procedures for speaking to staff through appointments, which he accepted. The Head Teacher stated that Doris had also spoken to her to say she had left the family home, the difficulties with Lee and that she had a new partner. The Head Teacher described Lee as being very vocal about Doris in 'adult-like' language and in her view that Lee was an emotional crutch for Peter. Lee said things like '*John has ruined our lives'* and, on another occasion, '*Doris had broken her marriage promise to her Daddy'*.

13.22 A second referral to SCS was received from Lee's School on **21 March 2016** regarding the comments in the Worry Book where she wrote that her Mother had called her names,

punched her on the cheek and arm and had kicked her feet. The Head Teacher stated her concerns to Doris who admitted she had smacked Lee and pushed her on the shoulder. Doris explained that she had moved out and accepted she got cross with Peter and understood why the referral had been made. The Head Teacher spoke separately to Peter who said that Doris had slapped Lee on the face. However, he was also content with the referral. Both Doris and Peter were given an individual opportunity to discuss issues with the school; the school wanted to support the family as a good relationship had been established throughout Lee's school life.

There were concerns that Peter was trying to keep Lee on his side by asking her to keep secrets. He was also felt to be trying to manipulate, intimidate and coerce professionals by repeatedly requesting to meet without appointments and was not following school policy. At the subsequent meeting with Peter, he stated that he was unaware of the school policy as Doris had mainly dealt with school matters *(Source: Meeting with Peter).*

A social worker attended the school on **18 March 2016** to interview Lee following the disclosures in her Worry Book. There was no contact from the social worker after this meeting and no details of what would happen next. *(Source: School IMR).* A social worker was allocated on **22 March 2016** to carry out a Child and Family Assessment (CFA)[12] as it was felt that the criteria for a Section 47[13] referral had not been met at this stage as the parents had now separated.

The oversight remit stated;

- The CFA should explore the incident and determine how the parents will ensure that Lee and Sam's needs and wellbeing are prioritised whilst going through the separation.
- Speak with Lee regarding the disclosure and explore her feelings
- Consider support available to the children (emotional)
- Speak to Doris and Peter regarding the concerns and how they will keep the children safe and explore if they are exposing their children to risk.

Before the children could be seen, a further referral was received from Surrey Police on **8th April 2016** relating to the 999 call from Lee about being assaulted by her mother. See KPE 6 below. *(Source: Surrey Children's Service IMR)*

13.23 The Nursery also noticed a regression in Sam's behaviour around soiling himself and needing to be comforted. Staff were not fully aware of the breakdown of the family relationship until a neighbour arrived to pick up Sam. *(Source Nursery IMR).*

13.24 In **late March 2016**, Doris and the children went on holiday to the Isle of Wight with Doris's family. Doris was clear that her relationship with Peter was over. Doris's family were concerned about her behaviour and the pressure she seemed to be under and her relationship with Lee was described as "being fragile".

13.25 Peter had joined a dating website in **January 2016** and met his new girlfriend. Peter told the Police he had asked Lee whether he should date her or not and started seeing her regularly

---

[12] CFA: http://surreyscb.procedures.org.uk/zkpqp/managing-individual-cases/assessment

[13] Section 47: Under section 47of the Children Act 1989, where a local authority has reasonable cause to suspect that a child is suffering / likely to suffer significant harm, it has a duty to investigate further and decide if any safeguarding actions are required.

from **March 2016.** The new relationship did not seem to result in any noticeable change in Peter's behaviour towards Doris.

KPE SIX: ASSAULT OF LEE and PETER BY DORIS APRIL 2016

13.26 On 8 April 2016 Doris attended the family home in order to get the children up and ready for school. Lee would not get out of bed, which resulted in Doris physically dragging her out of bed onto the floor and smacking her. Doris disclosed further details to a social worker later in April where she explained how she had tried to get Lee out of bed and then lifted her out when she refused. Lee started hitting her and Doris held her down saying such behaviour was inappropriate.

As a result, Lee rang Police alleging that Doris had assaulted her. The Police attended the family home. Doris accepted she had smacked Lee and was arrested and cautioned. In her Police interview Doris also accepted there had been lots of arguments in the home and she had been physically abusive towards Peter in the past, for which she was also Cautioned.

A DASH form was completed with Peter following the incident leading to thirteen positive responses and a Medium Risk evaluation. This was reassessed afterwards to Standard Risk as "current evidence does not indicate likelihood of causing serious harm"

Doris detailed her concerns that Peter may be influencing the children, in particular Lee. She stated that Lee was saying things like '*You are not my mother, Doris. You need to dump your new boyfriend and come home*'. She told the Police in relation to Peter '*I just asked him to leave me alone and he wouldn't. He kept coming up and coming up and I said leave me alone, just leave me alone and I had Lee there as well, standing there with her hands on her hips looking at me saying 'You just need to come back and love us and ditch your boyfriend'. 'Stop being horrible to Daddy. He then got his mother on the phone so I had him and his mother going off and yelling at me.'*

Safeguarding referrals, assessed as Amber, were submitted for the children regarding risk of physical harm and witnessing domestic abuse between their parents. A referral for Peter was submitted for the non–recent disclosures of domestic violence from Doris, and for Doris regarding concerns her mental health and anger issues. These were shared with SCS and Health via the MASH.

On receiving the report, Children and Family Health Service (CFHS) liaised with the school regarding a welfare update on 13 April 2016. The school also contacted the School Nurse and said there were concerns for the family and that this had been formally reported to SCS. *(Source: CFHS IMR).* The school nurse briefed that Lee was subject to a Child In Need (CIN) assessment and that Lee's school had commenced counselling for her, along with a Worry Book for Lee to add entries when she felt it would help.

It was also recorded that if the children had witnessed or heard any domestic incidents this should be covered in their ABE interviews[14]. *(Source Surrey Police IMR)*

---

[14] ABE: Achieving Best Evidence: Usually through a video-recorded interview https://www.cps.gov.uk/legal-guidance/achieving-best-evidence-criminal-proceedings-guidance-interviewing-victims-and

SCS convened a telephone Strategy Discussion with the Police and it was agreed that a Joint Section 47 enquiry should be undertaken. The actions agreed were;

- Police and SCS to undertake a home visit immediately to see those involved. Purpose: To gather the wishes and feelings of the children around the incident and their relationship with their parents including what they wanted to happen regarding contact with their mother.
- To see if Lee needs a Child Protection Medical[15] for any possible injuries received.
- SCS to speak to Peter about the care and contact of the children from himself and Doris. What are the risks?
- Explore with Peter his mood and emotional wellbeing.
- Explore with Peter the support for the children via extended family and friends

During the s47 visit, Peter disclosed that Lee had told him that her grandmother had smacked her while they were on holiday when she wouldn't eat her porridge. Sam also told him that Mummy hit him because he had 'poo'd his pants'. *(Source: Surrey Children's Service IMR)*

The nursery was unaware Doris had been arrested until they spoke to Peter when he arrived to collect Sam on **27 April 2016.** The Nursery Manager contacted SCS to request information relating to Sam and that the nursery should be included in the CIN assessment. *(Source: Nursery IMR)* The Outcome is unknown.

It was agreed that the Child and Family Assessment would still be completed and a meeting arranged with parents and other professionals to share worries. The plan would ensure that the children were supported and not exposed to negative adult behaviours which would impact on their emotional wellbeing. The children's School and Nursery were both spoken to and stated that whilst Peter may be the victim of domestic abuse, they believed he was grooming the children to be negative about their Mother. It was agreed this would be considered at the planned Professionals meeting.
(This meeting had not taken place by 2nd June 2016 when Doris died. (Source: SCS IMR).

The assessment was completed following Doris's death and it concluded that if Doris had lived a CIN plan would have been put into place to support the children. (*Source; SCS IMR*)

KPE SEVEN: CHILD ARRANGEMENTS / COERCION and CONTROL OF THE CHILDREN 8 APRIL ONWARDS 2016

13.27 Following the police involvement in Lee's assault, a social worker was allocated and undertook the s47 investigation as detailed above. The social worker met Peter on **8 April 2016** where he described the difficulties in the parents' relationship since December 2015 which he blamed on the changes in Doris, who he described having turned into *'an angry person'*.

On completion of the safeguarding enquiries, it was agreed that Doris and her mother would *not have unsupervised* contact with the children until further notice and that Peter would make alternative child care arrangements. Peter stated he requested support from the social worker to find an approved childminder but was advised 'this was not their remit'. He was not referred

[15] Child Protection Medical: https://www.surreycc.gov.uk/__data/assets/pdf_file/0012/14511/Child-protection-medical-guidance.pd f

to the Surrey Family Information Service[16] where he could have easily found this information and instead looked on the internet. (*Source: Meeting with Peter).*

The verbal agreement was eventually confirmed with a written agreement on **15 April 2016**. Until then, Doris had no independent understanding of the conditions under which she could see her children. Doris was requested to provide names and details of anyone she proposed to be present during her supervised contact.

The social worker did not consider that Doris's mother posed any risk to Lee and in discussion with her manager agreed that she could have *unsupervised* contact with the children. This was not communicated to Doris's mother **until late May 2016**, despite her chasing the local authority about the situation. As a result there were a number of weeks when the children did not see their mother or maternal grandmother who had previously played such a large part in their lives.

The social worker saw Doris again six weeks later on **31 May 2016**. There was no active social work involvement with the Doris and Doris's mother between **20 April 2016 and 31 May 2016**. By then, Peter had instigated an arrangement whereby Doris came to the family home on two evenings a week, Tuesday and Thursdays, to see the children and put them to bed. This meant that Doris had no access to the children without Peter being present.

13.28 The social worker attended Lee's school and met with her and the relevant staff on **19 April 2016**. Lee described what happened on 8 April 2016 and stated she didn't want contact with her mother and grandmother as they ganged up on her and bullied her. Notes from the social worker's records states that she felt some of what Lee described had been influenced by what she had overheard, or by Peter having inappropriate conversations with her about Doris.

13.29 On **20 April 2016** the social worker saw Doris and her mother. The social worker described Doris as remorseful and tearful; she explained how she had tried to get Lee out of bed, she then lifted her out when she refused. Doris described her fears about Peter's influence on the children, particularly Lee, and that she did not want to have contact with the children whilst Peter was present.

13.30 Information provided by family, friends and John seemed to show that Doris and Peter were communicating better.

13.31 Following the incident on 8 April 2016, a neighbour assisted Peter with child care and then a childminder was employed from **17 April 2016** to look after the children in the morning and take them to and from school or nursery. A neighbour supervised a contact visit between Doris and the children on **13 April 2016** although Lee refused to see her mother.

13.32 Doris was seen by her GP on **18 April 2016** and he noted her mood had dipped. Her antidepressant dose was increased and she was advised to self-refer to Mind Matters which she did on **30 April 2016.** The GP recalled that Doris had stated that that "she had put up with her husband's emotional abuse for years and had had enough". Doris said he was manipulating the children and telling them what to do.

[16] Surrey Family Information Service https://www.surreycc.gov.uk/people-and-community/family-information-service

At a follow up visit to the GP on **25 April 2016** her main concern was that Lee was still refusing to see her. Doris's mood was stable, but she had developed bruising on her hand which could be a side effect of the antidepressant and therefore the tablets were changed.
(Source: GP IMR).

13.33 On **6 May 2016** Lee had an appointment with the GP. She reported increasing nightmares, worried that Doris would try to harm her after she called the Police. Information was given to Peter about a private counsellor for Lee as there was a long wait for CAHMS.

13.34 Early **May 2016**, Doris's mother started seeing the children again and was permitted to supervise Doris's contact. Peter told the social work team manager on **6 May 2016** that he did not agree with this as he stated '*there is a history of Doris and her mother ganging up on the children but that if this was our advice, then he knew who to sue if he sent the children for contact and something went wrong'.*

13.35 On **9 May 2016** Doris attended a therapy session; the notes record her concern that her anger and frustration will return. Through Mind Matters, Doris was offered telephone based Cognitive Behavioural Therapy (CBT) guided support to help her with her low mood and anxiety. The Therapist completed the first of two telephone sessions with Doris on the **20 May 2016** and felt she engaged well. Doris mentioned having occasional thoughts of wanting to end her life but these had stopped by the second session. Doris mentioned that she had hit her daughter and that she was frustrated with Peter still trying to maintain their relationship. She found Peter controlling and that she would have violent outbursts and slap and punch him through frustration. Doris explained she had moved on and had started a new relationship and that she wanted to work on her depression and anxiety around the children *(Source: SABPT IMR).*

13.36 Doris's last visit to her GP was on **11 May 2016**. Doris stated that things were difficult at home, Lee was still refusing to see her and that she herself was due to start counselling sessions the following week. In his statement to the Police the GP describes Doris reporting her concerns about Peter being manipulative and controlling over the children. *(Source: GP IMR).*

13.37 Doris met with her Line Manager and Head of HR on **18 May 2016** and explained about her Police Caution **(8 April 2016)** and that she had been referred by the Police for anger management counselling on a Friday. Doris's employer supported her by allowing her to work from home on a Friday so she could attend her counselling, reduced her workload and offered her the Employee Assistance Programme (EAP) provided by a private company. Up to 8 sessions of telephone counselling could be provided to employees and their families free of charge. Doris confirmed with the Head of HR that she had contacted the service on **20 May** and was finding it useful. *(Source: Employer IMR, EAP feedback).*

Doris explained her current issues to her EAP counsellor and that she wanted to control her anger, work through her depression and to see the children and that she had started CBT. Strategies and goals were discussed with the counsellor. She said she wanted to focus on her anger management. It was agreed to arrange a further session. Doris died soon after this contact. *(Source: EAP IMR)*

13.38 On **17 May 2016** a neighbour witnessed an argument between the parents outside the home. He described Doris as shouting, being forceful and not wanting to speak to Peter, wanting him to go back inside.

13.39 On **24 May 2016** the Nursery expressed concerns for Sam, reporting to SCS that he was soiling himself daily and was always seeking love and nurturing from an adult. The nursery reiterated their view that his father was encouraging Sam to be negative about his mother. *(Source: SCS IMR).*

13.40 Doris attended her second therapy session on **27 May 2016**; she reported that Lee challenged her about not being present at Peter's father's funeral, when Peter had been there for her when her father died. Doris had offered to go to the funeral to look after the children but it appears she was told by Peter "she was not needed". Doris accepted she needed to control triggers that made her upset, which included her not being able to see her children.

13.41 Doris spent the Bank Holiday weekend with John. Peter contacted Doris by text over that weekend asking her to accompany him and the children to the park. Doris responded that she was unable to come at such short notice.

13.42 Doris had what transpired to be her last meeting with her social worker on **31 May 2016**. The Social Worker noted that:

- Doris reported that she and Peter were communicating better
- Doris reported that Lee was having outbursts with everybody including Peter whereas previously these were aimed just at her
- Peter had informed Doris that he had taken Lee to the GP as she was having repeated nightmares about her mother killing her and wanted to arrange counselling for her. Peter said he was told there was no child psychologist available at that time. *(Source: SCS IMR.)*
- That evening Doris was very distressed; she said to John that she thought that Peter was stalking her, as he had found out she was staying with him at his address, which she had only disclosed to her mother and sister. On Doris's return to John's flat she packed her belongings and left but was eventually persuaded to return.

13.43 Around this time in **May / June 2016** Peter had texted and phoned a work colleague asking 'how much would it cost to give someone a slap' .(*Source* : Police IMR)

13.44 On **1 June** Doris had lunch with her mother and Sam. Doris's mother described her as being *'tired and angry and she hurt because she told me that Peter has punched her the night before and that the bruises were just coming out'.* In his Police interview after Doris's death, Peter accepted that previously he had shoved Doris, but he stated it was only after she had hit him on his arm or shoulder. Doris had told friends that Peter had been abusive and hit her causing bruising to her breasts. Bruising was later found on Doris's body during the post mortem.

13.45 John describes the evening of **1 June** as being normal; Doris and he stayed in and Doris rang the children to say goodnight, although it was difficult to get Lee to speak to her.

KPE EIGHT: DEATH OF PARENT / IMPACT ON CHILDREN and AGENCIES 2 JUNE 2016

13.46 On **2 June 2016**, the children went out with Doris's mother for the day. Doris attended the family home that evening, in accordance with the child contact agreement, to help put Sam to bed. Her mother described Doris already waiting in the car outside until she arrived with the children as she had agreed with her she would not go into the home alone.

13.47 Doris's mother described Peter as being agitated, like a 'cat on a hot tin roof'. Doris complained of a bad back and was having difficulty in moving. The children were excitedly showing Doris and Peter what they had bought during their trip that day. When Doris's mother left at about 6.30 pm, she thought Doris was following her out of the house.

13.48 Peter took Sam upstairs to bed at about 6.45 pm. Doris went to get him ready for bed and read him a story. Doris was ready to leave but Peter wanted to discuss why she had not agreed to meet him and the children the previous weekend. They went into the kitchen and the fatal incident took place resulting in Doris's tragic death
(see section 2.0 Incident One).

13.49. Lee was taken to the hospital by ambulance accompanied by the Police and Helicopter Emergency Service (HEMS), Lee, Sam and Peter. Lee presented with a two inch laceration to her forearm. Lee was treated and moved to the Children's ward, as a safe place and the children were placed under Police protection. The hospital made contact with SCS, who took emergency action to protect the children. An Interim Care Order was made on **3 June 2016** and the children were then moved to a foster placement.

13.50 On **3 June 2016**, whilst still at the hospital, Sam showed the Play Specialist his teddy and said "Mummy hit daddy and Lee last night" and then began to play. He then began to scribble across the paper he was drawing on and said this was blood, and dotted the paper hard and fast saying "punch punch punch punch" and "this is mummy punch daddy face". Sam then drew lines and said "this is mummy lying down".

13.51 Peter's injuries were assessed on admission; he had a large knife wound to his right shoulder blade and lacerations to the back of his head and left hand. These were cleaned and sutured and he was deemed fit for discharge.
(*Source: Surrey and Sussex Health Care Trust (SASH) IMR*)

Peter was arrested later that night and held in custody. Following interview, he was charged with murder on **5 June 2016** and released on bail on **7 June 2016**, with conditions that he resided at his mother's home.

13.52 On **4 June 2016** when Doris did not turn up for work and did not answer her phone, her employer's lone working policy was implemented. A senior officer called Doris's next of kin and Doris's sister informed the employer of her death. (*Source: Employer IMR*).

13.53 Lee's ABE[17] video interview took place on **6 June 2016.**

[17] Achieving Best Evidence

Care of the Children

13.54 Children's Services carried out the Child and Family Assessment within the agreed timescales, although the assessment was actually completed and signed off after Doris's death, dated **9 June 2016**, as acknowledged by the Manager in the Assessment. The assessment concludes '*the children have been, and continue to be, exposed to their parents' acrimonious relationship. The children have been exposed to domestic violence and Peter has discussed his feelings about the separation with Lee which is inappropriate. I am of the view that Peter has not come to terms with the [end of the relationship] and believes the marriage can be reconciled although Doris is clear the marriage is over'.*
The report recommended a Child in Need (CIN) Plan to ensure the children's safety and that the parents continue to engage with the agencies so the risk of harm is reduced.

13.55 The children remained with their first foster carers until **October 2016**. They were then moved to their final carers, due to allegations made by the children about how they had been treated during their first placement. Sam said he was hurt when his teeth were brushed too hard amongst other allegations. Some of those allegations have since been substantiated and are being investigated.

13.56 Peter had his first supervised contact with the children in early **June 2016** and thereafter his contact continued twice a week, on Wednesdays and Saturdays. Doris's mother and her family had weekly contact, more recently becoming fortnightly with one-off contacts with the maternal uncle and his family.

Peter's arrest and trial

13.57 Peter's urine was tested on arrest on **3 June 2016** and tested positive for cocaine. Some cocaine was also found in the home which Peter accepted was his. The levels were felt to have been insufficient to have influenced his behaviour. On **3 June 2016** a face to face mental health assessment of Peter was carried out in a Police custody suite. He was described as being polite, dishevelled and in shock. Peter demonstrated he understood the reason for his arrest but his main concern was the welfare of the children. Peter did disclose that he had had problems / suicidal thoughts / impulsive behaviour when he found out about Doris's affair. Peter was not assessed for drug or alcohol use support whilst in custody. *(Source: SABPT IMR).*

13.58 Peter's first criminal trial commenced in **December 2016**. This had to be abandoned following a revised account of events given by Peter.

13.59 Peter's second criminal trial commenced in **May 2017**. He pleaded not guilty, saying Doris's killing was in self-defence. He was acquitted by the jury of murder after 5 days deliberation in late **May 2017**.

14 ENGAGEMENT WITH OTHER AGENCIES AND IMR FEEDBACK

This section has been compiled from the Individual Management Reviews (IMRs) submitted by the agencies involved in this case. The IMRs aimed to provide an accurate account of an agency's involvement with Doris, Peter, Lee and Sam up until the date of Doris's death, evaluate

their actions and identify improvements for the future. All IMRs have been challenged robustly by the panel and, where appropriate, have been subject to review and revision.

Some IMR comments have been included under the relevant KPE in the main body of the report, to provide a clearer, chronological overview. Where this is the case, the IMR source is clearly referenced.

14.1 SURREY POLICE IMR

14.1.1 LESSONS IDENTIFIED - Surrey Police

The investigation into KPE Four (Lee's assault and historic domestic abuse on Peter by Doris) and KPE Six (Doris's death) has been the subject of intense internal scrutiny by the Police, as below

- **Public Protection Standard Team Review (PPST) 20 June 2016** and **Death or Serious Injury Investigation Report (DSI) - October 2016**

i. The PPST review reported that the initial Police responses to KPE Four were good. The Police acted positively arresting Doris on suspicion of assaulting Lee. The investigation supervisor had set a clear investigation strategy and an action plan that covered the main requirements of the case including working with SCS. The action plan included that Lee would be ABE interviewed and that her Worry Book should be seized and examined.

ii. The PPST reviewer felt thereafter things became confused. The referral made by Lee's school noted within the Worry Book that Doris had carried out another assault. Peter had presented his photograph of an injury sustained by Lee in another assault by Doris. *There were no recordings or investigations of these previous assaults or any consideration that Lee and Peter were repeat victims.*

iii. The PPST review found that the decision to caution Doris did not take into consideration the previous assaults nor was there any investigation into the previous incidents. The PPST reviewer felt the rationale for Cautioning was focused on the assault on Peter (Caution was for a domestic assault) and *made no reference to the rationale for cautioning for a child assault.*

iv. On reviewing the Police interaction with SCS, the PPST noted that a joint action plan had been agreed at the Strategy Meeting on **8 April 2016**. However apart from the joint s47 visit taking place, no action was taken in respect of Lee undergoing a Child Protection medical nor were the children spoken to about their feelings and wishes regarding future contact with Doris. *Lee was not ABE interviewed after the initial assault in April 2016*, as it was decided against and she was therefore not given the opportunity to talk about the incident nor the disclosures recorded within her Worry Book.

v. The PPST reviewer stated that if the case had been fully investigated, it was likely to have met the evidential threshold for a charging decision against Doris. *The review highlighted that the CPS guidance on domestic abuse states that it would be rarely appropriate to issue a simple caution in a domestic incident unless a victim did not want to support a prosecution and the available evidence would only support a minor charge.* (There were no records to show whether there had been a conversation with Peter or Lee to discuss the option).

vi. The DSI report agreed with the findings of the PPST. It felt that an early decision to issue Doris with a caution for Common Assault had prevented the investigation from proceeding to a stage of completeness, whereby all the evidence could have been included and assessed. It also noted that a full investigation would have included an ABE interview with Lee, a statement from Lee's teacher and a review of the Worry Book.

vii. The DSI report stated that if a full investigation had taken place, there would have been sufficient evidence to charge Doris with a number of assaults and that the Crown Prosecution Service (CPS) was the appropriate authority to make the decision re best public interest. It also commented that this decision was made without a full risk assessment and that all safeguarding options had not been fully explored. In the opinion of the DSI author, the decision to caution Doris prevented pre or post charge bail conditions which would have helped manage the situation from potentially escalating.

viii. The IMR author highlighted that as Peter provided thirteen positive responses to the DASH questions, the risk to him was a Medium Risk. On examining the DASH itself, it was actually graded Standard Risk. It was unclear who made the changes; there was no formal record of this decision and there was no record as to whether Peter was offered referral to Outreach Services.

ix. The IMR also highlighted that KPE Four and Six were seen as two separate incidents and that initial risk grading was changed without having assessed all information. Learning has also been identified in relation to Police officers being more aware of coercive control and how perpetrators of CCB[18] may groom professionals.

14.1.2 POLICE RECOMMENDATIONS AND IMPLEMENTATION:

Surrey Police have identified a number of recommendations for changes to internal procedures and broadening of training, many of which have already been implemented. These are detailed in the Action Plan.

14.2 SURREY CHILDREN'S SERVICES IMR

14.2.1 LESSONS IDENTIFIED - Surrey Children's Services (SCS)

i. A DA check list was not completed nor a DASH assessment shared. In a subsequent discussion with the social workers involved, it appears that there was only a verbal discussion between the Police and SCS.

ii. The IMR highlights the challenge of eliciting the views of children.

iii. Supervision for the allocated social worker was not evidenced, although Management Oversight was recorded.

iv. It is important to keep staff supported and aware of the outcomes of DHR learning locally and nationally so they can be alert to extreme violence.

v. It is important that the voices of young pre-school children are heard and that there is an opportunity for the child to tell the story in a way appropriate to their age an understanding.

---

[18] - CCB - Coercive Controlling Behaviour See Michael Johnson 'A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence 2010)
- Coercive control: The entrapment of women in personal life
E Stark - 2009

14.2.2 *SCS RECOMMENDATIONS AND IMPLEMENTATION*

14.2.1i There is a need to strengthen practice around domestic abuse. Practitioners need to understand domestic abuse in its different forms, including coercive control, and to be professionally curious and questioning in their work so they can effectively assess risk.

14.2.1ii Surrey Children's Services were inspected by OFSTED in October 2014 and again in February 2018 who judged that services for children in need of help and protection are inadequate. Since then the Authority has embarked on a programme to fundamentally transform services, and the critical task within these improvements is to raise the standard of social work practice.

14.2.1iii A key development within this is the implementation of the Family Safeguarding Model, under the title of *Family Resilience*. This is a whole systems approach aiming to improve the quality of work undertaken with families, and thereby outcomes for children and parents. The model brings together a partnership including police, health (including mental health), probation and substance misuse services. This model will be implemented in April 2019 and the teams will be made up of:

- ***Social workers and family workers*** who work with parents and children and are the allocated worker
- ***Domestic abuse practitioners*** who work with victims of domestic abuse, and help them to recognise all forms of abuse and advise them of their options and choices. This will include raising awareness of the impact of DA on their children and help to safeguard them
- ***Domestic abuse perpetrator practitioner*** who works with perpetrators of domestic abuse and helps them recognise the impact of their actions and find ways to change their behaviour, stabilise their relationships and keep their children safe
- ***Recovery workers*** who work with adults around their alcohol and / or drug use, to support them to make positive changes and to help them care for their children
- ***Mental health practitioners*** who work with parents who are experiencing mental health difficulties
- ***Clinical psychologists*** who work with parents using cognitive behavioural techniques (CBT) and dialectical behaviour therapy (DBT) as well as looking at their parenting

14.2.1iv ***Support for practitioners:*** In developing this model there are significant changes in structure and it is part of a much broader transformation programme. This will ensure that practitioners including agency staff have manageable caseloads and receive regular high-quality supervision. The implementation of this model will significantly strengthen practice in the areas identified within this review.
It will be supported by a new Quality Assurance framework, and workforce development programme. This will ensure that the learning from this review, and others locally and nationally, will be shared with practitioners and managers and this will be the mechanism to implement service improvements.

14.3 HEALTH -Surrey Primary Care IMR

14.3.1 LESSONS IDENTIFIED (Primary Care / GPs)

i. The IMR author identified that domestic abuse and coercive control was not considered in this case. The parental assessment relating to KPE Four focused on mental health issues and despite the disclosure by Doris of emotional abuse and manipulation by Peter this was viewed in the context of a marital breakdown.

ii. DA training had been delivered to GPs as part of Level Three Safeguarding Children updates since 2014 and the IRIS project[19] had been funded since 2015 with initial training in July 2015 in ESCCG[20] Practices. It appears in this case the emphasis remained on the physical aspects of DA and not on the risks posed by coercive control. The IMR also highlighted that practitioners need to be mindful of the high risk of fatal domestic abuse during relationship breakdown.

iii. It should be noted that GPs do not generally receive information regarding Child in Need conferences, so often do not know when children are subject to a CIN plan. GPs also do not receive police notifications following a police call out to a domestic abuse incident. The need to share information effectively remains, as ever, a multi-agency responsibility.

14.3.2 ACTIONS TO BE IMPLEMENTED:

i. Future Level 3 Safeguarding Training and IRIS training will incorporate learning from this DHR / SCR. The purpose will be to better support staff working in primary care to identify and support potential victims of domestic abuse.

ii. Continuation of IRIS in East Surrey post 31st March 2019 and further exploration of roll out across the rest of Surrey.

14.4 SURREY AND SUSSEX NHS HEALTH CARE TRUST (SASH)

14.4.1 LESSONS IDENTIFIED

i. The IMR highlighted that SASH had tried and tested systems in place for Safeguarding Children with policies and procedures. These worked well.

ii. One of the main themes apparent from the IMR is how staff felt following the admission of Lee and Sam.

14.4.2 ACTIONS TO BE IMPLEMENTED

i. **Highlighting Domestic Abuse:** Although SASH has a policy to ask all pregnant women about DA, it is not documented whether Doris was asked during her pregnancy. SASH must ensure that all patients over 16 years old, regardless of pregnancy are given the opportunity to discuss any concerns relating to DA during visits to SASH and this should be documented.

ii. **Training:** That the mandatory and statutory Safeguarding Training (which includes DA) for all staff, is supplemented to ensure all staff are confident to *discuss* DA and to escalate concerns when a disclosure is made.

iii. **Support for Staff**

That following a traumatic event, staff have access to debriefing and clinical supervision.

---

[19] IRIS Project: Identification and Referral to Improve Safety http://www.irisdomesticviolence.org.uk/iris/

[20] East Surrey Clinical Commissioning Group

14.5 CHILDREN AND FAMILY HEALTH SURREY (CFHS) IMR

14.5.1 LESSONS IDENTIFIED

No lessons have been identified although comments have been made about the school not informing the school nurse about their concerns for Lee prior to KPE Six happening.

14.5.2 ACTIONS TO BE IMPLEMENTED **-** None identified

14.6 MENTAL HEALTH

SURREY and BORDERS PARTNERSHIP FOUNDATION NHS TRUST

14.6.1 LESSONS IDENTIFIED

A Serious Incident Investigation report (SI) highlighted the following;

i. **Mind Matters.** Doris was on the case load for over a month before being discharged once the Police had notified SaBP of Doris's death. According to practice guidance she should have been discharged at the end of June instead of end of July, freeing up a space.
ii. It would have been beneficial for SaBP to have a named contact in the Police or SCS to liaise with to gain more information about a patient.
iii. The outcome was recorded (but not the reason) for the CMHRS decision not to offer Peter an assessment. The outcome was only recorded on the safeguarding referral form and not on the progress notes.
iv. From the information provided in the referral, it may have been prudent for CMHRS to offer Peter an assessment.

14.6.2 ACTIONS TO BE IMPLEMENTED

i. Patients are reviewed and discharged accordingly. Implementation of a better practice would be beneficial; to keep patients on a case load and ensuring that the GP is aware of the progress of a patient.
ii. That as a learning exercise, the CMHRS Multi-disciplinary Team reviews the referral and discusses the basis on which decisions are taken and whether or not to offer an assessment.
iii. **Update.** An MDT discussion and review has taken place and the RAW[21] will discuss all Police safeguarding referrals with a senior manager and document the discussion and reason for outcomes on their electronic records.

14.7 PRIVATE COUNSELLING PROVIDED BY DORIS'S EMPLOYER.

No lessons or actions identified.

[21] Rapid Access Worker

14.8 LEE'S PRIMARY SCHOOL (THE SCHOOL)

14.8.1 LESSONS IDENTIFIED

i. DA was prevalent in this family environment which was not recognised. It was identified that further information could have been shared with the family as to what support was available.
ii. The senior leadership team required further DA training as part of the safeguarding remit of the school.
iii. Doris's killing deeply affected staff, pupils and the community at the school. There was an opportunity for staff to discuss their concerns with line managers and access to free counselling was arranged.

14.8.2 ACTIONS TO BE IMPLEMENTED

i. ESDAS provided up to date training for the school Senior Leadership Team and designated safeguarding officers in July 2017.
ii. Mandatory safeguarding training has been given to all staff to enable them to identify all forms of abuse towards children and correct procedures to follow when referring children.
iii. The school has employed a full-time safeguarding officer to coordinate all safeguarding and vulnerable families' concerns to ensure better outcomes for children and families.

14.9 SAM'S NURSERY

14.9.1 LESSONS IDENTIFIED

Sam did not return to the nursery following Doris's death. The staff and other families found the situation very difficult and there was no 'closure' after the tragedy.

14.10 DORIS'S EMPLOYER

14.10.1 COMMENTS FROM EMPLOYER

i. Support to existing staff was seen as essential. Doris's immediate team and close colleagues were offered the opportunity to go home and bespoke sessions were arranged by the EAP (Employee Assistance) Company for trauma counselling for those most affected.
ii. The IMR author highlighted that the employer was not aware of all the issues that were happening in Doris's life. They were unaware of the new relationship with a fellow member of her team and the break-up of the relationship with her husband. If it had known more, further sign posting to various charities and DA outreach could have been made. The employer is an active promoter of ESDAS and contact details are displayed widely in the building.
iii. Her employer feels that if the Police had been able to advise them of the full nature of KPE Six, then they would have strongly suggested that Doris take time out from work to support her own wellbeing.

14.10.1 LESSONS IDENTIFIED

i. Recognition of the importance of the DA Workplace, Lone Working, Safeguarding and Welfare Policies which are updated every three years, and which worked well in this incident.
ii. The importance of line managers spotting stress and supporting employees in difficult times.

iii. Recognition that there are two sides to domestic incidents; all facts need to be considered and there may be the need to consult an outside agency for a considered view.

14.10.2 ACTIONS TO BE IMPLEMENTED

i. Roll out of new Line-management Training Course which includes identifying stress and how to sign post to appropriate support.
ii. To work with other agencies if there are issues affecting their staff such as a Caution, (better sharing of information if appropriate).

14.11 VOLUNTARY ORGANISATIONS AND SUPPORT GROUPS

The IMR process was supplemented by the Independent chair interviewing various voluntary organisations who may have been able to support the family through the relationship break-up including Relate and ESDAS. The family did not engage with any of these services and therefore IMRs were not requested.

14.11.1 Mediation Services- East Surrey

The local Relate charity (the largest provider of mediation services) offers a range of services to residents in Epsom and Ewell, Mole Valley, Reigate and Banstead and Tandridge with offices in Reigate and Epsom.

The services offered include: Counselling for couples, individuals, families, young people in schools and within relationships, sex therapy, and mediation. Like many voluntary organisations funding is an issue and the main source of funding is from client donations. Trained counsellors are paid but trainees are volunteers.

Relate counsellors are trained to understand and identify possible DA including controlling coercive behaviour. Couples counselling commences with both adults together followed by an individual meeting to allow a counsellor to explore issues including DA. If there is a disclosure then the person is signposted to a relevant DA support service, e.g. ESDAS.

Relate promote their services via a web site[22] and information in GP practices, schools and churches. Statistics provided by Relate-East Surrey show an increase in the number of clients being seen who are suffering some form of DA. In 2016/17, 65 clients seen reported suffering some form of DA and in the first six months of 2018/19, the number increased to 101 clients. This has added pressure to the services offered.

There are risks for domestic abuse victims using mediation services and concerns have been raised in court litigation and literature about power balance, the rights of women suffering from domestic abuse and safety[23]. With partners together with a mediator then domestic abuse issues may not be disclosed and mediators need the skills and training to understand how to identify domestic abuse in a relationship.

---

[22] Relate: https://www.relate.org.uk/
[23] Domestic Violence and Mediation Concerns and recommendations Anita Vestal 2007 www.mediate.com

14.11.2 East Surrey Domestic Abuse Services (ESDAS)

ESDAS completed an IMR which confirmed that there was no contact with any family members. ESDAS has been an active participant in this review providing expert advice throughout the process.
Established in 1993, it began delivering services across East Surrey in 1998. Its purpose has always been the relief of hardship, need and distress of those who are experiencing or have experienced domestic abuse including any associated children. The Outreach Service provides advice, advocacy, information and support on a range of issues including criminal and civil law, benefits, debt, housing, safeguarding, risk and safety planning as well as empowering survivors to take control of their own futures. The service aims to provide holistic services to avoid survivors and their children being re-traumatised by repeating their experiences to multiple professionals. This includes programme of group work, an informal Drop-In Support Group, the Freedom Programme and Recovery Toolkit as well as Self-Esteem and Parenting Workshops, along with associated services such as Independent Domestic Violence Advisors (IDVA) at MARAC[24] and Surrey's Specialist Domestic Violence Court (SDVC).
See Appendix 4 for further details around client numbers and the wider services and support provided by ESDAS.

15. ANALYSIS

15.1 This analysis is based on information provided in the IMRs. Where relevant this includes an assessment of appropriateness of actions taken (or not taken), and offers recommendations to ensure lessons are learnt by relevant agencies. The Chair and Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.

15.2 Doris, Peter, Lee and Sam seemed a reasonably happy ‘normal’ family to most observers up until late 2015, although Doris suggested she was experiencing verbal /physical abuse (black eye) including an allegation of rape and controlling behaviours from Peter during this time; undermining her in front of her friends about her weight and appearance, stalking, threats to self-harm and resisting separation. Both parents worked, and they had the pressure of caring for two young children, getting them to school / nursery and a house that “resembled a building site” for a number of years.
In 2015 Doris met her new partner John and the subsequent breakdown in the relationship with Peter and Lee was rapid and resulted in Doris’s death six month later on 2 June 2016.

15.3 Key themes identified: Through analysis of the significant volume of information gathered, the following issues were recognised:

i. *Domestic Abuse* – including coercive and controlling behaviour and lack of understanding of a victim’s behaviour, including the use of retaliatory violence.

[24] MARAC - Multi-Agency Risk Assessment Conferences

ii. *Mental Health Issues* relating to Doris, Peter, Lee and Sam which could have indicated domestic abuse.

iii. *Lack of professional curiosity* around DA including coercive controlling and stalking behaviour.

iv. *Lack of understanding around the DASH risk assessment* and how a small number of factors such as coercive control, stalking, separation, self-harm, mental ill health can indicate a situation is high risk regardless of the number of ticks.

v. *Lack of understanding of the family dynamics* during the breakdown of a family relationship.

vi. *Lack of understanding by professionals of grooming behaviour*, especially relating to the children and key professionals involved.

vii. *The lack of communication between agencies* and between agencies and the family especially relating to KPE Six.

viii. *Lack of risk management* around the assessment of KPE Four and KPE Six.

ix. *Professionals lacked the skill to know how to listen and fully understand the voice of the child with complex family relationships.*

15.4 ***Were there any barriers experienced by Doris, Peter / friends / colleagues in seeking support from professional service providers?***

Doris, Peter and the children were involved with many service providers, namely the Police, SCS, health agencies, education and the workplace. Prior to the break-up of their relationship, contact with the various agencies e.g. school and health were seen as routine.

In January 2016 as part of ***KPE Four (Wellbeing of Parents and Children)***, several agencies became involved with the family; the Police, social services and health. The IMRs indicate that professionals saw this as a key episode in the life of the family, linked to the breakdown of the relationship between Doris and Peter and the children. Peter was seen as the victim and Doris was seen as the person responsible for breaking up the relationship.

Although a number of organisations were involved with the family, neither Doris nor Peter accessed specialist DA services or voluntary / charity services that support breakdown of relationships. It is known that information about DA services was provided to Doris and Peter by colleagues and agencies. Doris's family thought that she had accessed support from ESDAS and it is not fully known why she did not seek advice. Agencies did not necessarily see Doris as a victim, as professionals did not fully understand the characteristics of someone who was being controlled and coerced. It appears that professionals linked domestic abuse to physical violence and therefore Peter was seen as the victim.

On asking Peter why he did not access DA services his view was "It was not geared towards men and he did not want to admit anything as he would feel weak". Evidence shows that the information and support offered by specialist DA services are gender neutral.

Information around relationship mediation services were not provided by any agencies that Doris and Peter and the family came into contact. Peter was asked why such services were not accessed and he indicated that he did not know much about them. The review has identified

that agencies did not fully support a family going through separation and crisis and that there are a number of support services in other sectors e.g. voluntary / charitable who could have supported the family and who also have an understanding of the risks in relationship break down including domestic abuse.

15.5 Lack of understanding of Domestic Abuse including Coercive Controlling Behaviour.

15.5i The DASH: Doris raised her concerns about Peter to the Police in January 2016 which suggests that she did not feel safe. She highlighted that she had hidden Peter's hunting knife and ornamental swords for Peter's protection but also for her own. A DASH was completed which was graded at Standard Risk despite indicators around separation, disclosures of Peter's stalking behaviour, jealousy and Peter's mental health including self-harm. If the DASH had recognised these indicators as key risk factors linked homicide, it would have been assessed as High Risk and Doris could have been referred immediately to the MARAC (Multi-Agency Risk Assessment Conference) for a full review of safeguarding options available and an automatic referral to ESDAS.

It should be noted that since the incident, the Police have had extensive training in DA including controlling coercive behaviour and DASH Risk Assessments. In discussion with the Police involved in KPE Four, they have all indicated that they would now see this incident differently and a referral to the appropriate services would be made.

15.5ii SCS involvement: This was limited, based on verbal information shared between the Police and themselves. At the first referral with the family, only support information was provided and no contact was made. If the DASH had identified the issues and concerns above, it is likely that there would have been more safeguarding concerns and interventions around the children.

15.5iii Mental Health: Professionals focused on the relationship breakdown between Doris and Peter as the cause of the mental health issues in their lives. At no time were they linked to possible domestic abuse, despite Doris saying she had been bullied and controlled for many years.

15.5iv Lack of seeing the 'bigger picture':

KPE Five *(Changes in the Children's Behaviour March 2016*) and KPE Six *(Assault on Lee and Peter April 2016)* involved the Police, SCS, health professionals and education (Lee's school). It is very clear that KPE Four *(Wellbeing of Parents and Children January 2016),* Five and Six were not linked together by the professionals involved.

Since KPE Four, the family relationships had deteriorated dramatically. Doris was struggling to cope with her stress and anger, getting up early to travel to the family home from her mother' house, taking the children to school and then going to work herself. Peter resisted the break-up of the relationship and was trying to control the situation through using the children, especially Lee, as a support and manipulating her against Doris.

KPE Five: Lee shared with her class teacher about Doris hitting her and she was given a Worry Book to record her concerns in. Sam had also started to show signs of stress and worry at nursery.

KPE Six: The chaos of the family at this time led to Doris's assault on Lee. This was a time that the family needed significant support. The judge who conducted the Family Fact Finding in June commented in his report that '*SCS failed to identify all the family's needs and the extra support they required'*. The neighbour who was asked to supervise Doris's first visit to the children after her Caution, said she felt she was '*left high and dry'* to manage a difficult situation on her own. Lee refused to meet her mother and the neighbour was uncertain what to do with no support. In her words '*Doris needed help for her anger and mental health'*.

The Police in their own internal investigations have already identified that if KPE Four and Six had been reviewed together and if a different decision had been made around the outcome to charge Doris, then there would have been the potential to offer further support to all the family.

Whilst the decision taken in January 2016 was thought to be in the best interest of the family, no ABE interview for Lee took place which would have allowed her to share her worries and concerns. The rationale was that there would be nothing gained by prosecuting Doris and that cautioning would allow the family time to try to work through their issues together.

15.6 Communication between the family and agencies.

Following KPE Six, Doris and her mother were left in limbo for several weeks about SCS agreed visiting arrangements to see the children. According to Doris's family and friends, this accentuated Doris's stress level. It has since been identified that during this period SCS was going through a restructure in service provision, which meant further pressure on staff and had resulted in a higher than usual number of agency staff being employed. Management oversight was identified as not being sufficiently robust during this period of change.

15.7 Communication between Agencies.

During KPE Six a lack of information-sharing was identified between agencies which would have been able to provide increased support. Health (GP), the Nursery and the School were not notified about the CIN assessment which would have been invaluable in providing information to help build up a more comprehensive picture of the family's needs. Lee's school have stated that if they had known the full facts of KPE Six they could have provided extra support for the family.

15.8 Were there opportunities for professionals that were missed, to routinely enquire about domestic abuse, coercive, controlling and stalking behaviour which should have led to a referral to a domestic abuse support service?

The IMRs and discussions with professionals have identified that there is still a lack of understanding around DA and especially coercive, controlling, stalking behaviour.

15.8i Health (GPs) felt that Doris and Peter's mental health issues were linked to the relationship breakdown and not to any wider issues. Doris and Peter visited the GP several times in the last six months of Doris's life, when there were opportunities to enquire about DA. On one of her visits, Doris disclosed that 'she was fed up with being controlled by Peter'. It would appear that this was not considered as DA and no referral was made.

15.8ii Doris's employer was unaware of her marriage breakdown and the KPE Six incident until May 2016. However, they did signpost Doris to ESDAS, as did several of her friends and colleagues. Doris chose not to contact the service at this time, despite her family believing that she had.

15.9 Awareness of the potential presence of coercive control and how this impacts on the behaviour of the victim and the perpetrator.

Coercive control is a term developed by Evan Stark[25] to help the understanding that domestic abuse is more than a "fight". It is a pattern of behaviour which seeks to take away the victim's liberty or freedom, to strip away their sense of self. It is not just women's bodily integrity which is violated but also their human rights.[26]

The government's definition of coercive and controlling behaviour is 'a range of acts designed to make a person subordinate and / or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence and escape and regulating their everyday behaviours.' It can be a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten victims.'[27]

Male perpetrators of domestic abuse can present as a victim as in Peter's case. Peter informed the police that Doris had hit him, which she admitted to, stating "he (Peter) knew what buttons to press. Often male perpetrators will hold a righteous position in relation to their violence and they will focus on the actions of others. These men can present as charming to seek getting professionals on side, indeed family and friends stated that Peter appeared charming to most people. [28] Doris admitted to the police that she hit Peter but often women retaliate in the context of violence against them, for example Peter would push and poke Doris. Women and men, in general are likely to perpetrate equivalent levels of physical and psychological aggression, but evidence suggests that men perpetrate sexual abuse, coercive control and stalking more. Peter admitted to stalking Doris earlier in their relationship, latterly, in her life Doris started to wear a wig when going out as she felt that Peter was following her. [29]

15.9i The Family

There is no doubt from the evidence provided by family, friends and involved services that Doris, Lee and professionals experienced coercive and controlling behaviour by Peter. Doris spoke to family and friends about how Peter would undermine her in front of people. Peter admitted that he had stalked Doris when they were first going out. When the relationship started to deteriorate in late 2015, Peter began reading Doris's phone messages so she changed her phone to "finger print only" recognition. Peter would goad Doris about her new partner, which then triggered retaliatory abuse by Doris on Peter. He also used 'gaslighting'[30] techniques to manipulate and

---

[25] Evan Stark: Author of Coercive Control: How Men Entrap Women in Personal Life
[26] Coercive Control: https://www.cedarnetwork.org.uk/about/supporting-recovery/what-is-domestic-abuse/what-is-coercive-control/
[27] Domestic Violence and Abuse: https://www.gov.uk/guidance/domestic-violence-and-abuse. Also
[28] Men as perpetrators and victims www.nice.org.uk
[29] SC Swan 2008 www.ncbi.nlm.nih.gov
[30] Gaslighting: A form of emotional abuse where the abuser manipulates situations repeatedly to trick the victim into distrusting his or her own memory and perceptions. Gaslighting is an insidious form of abuse.

undermine Doris for example snide comments about Doris letting herself go in front of other people and aligning the children, especially Lee against Doris. He used Lee as a friend and confidant during the break-up of the relationship. The professionals involved with Lee stated that her language was very adult and that Peter was controlling her and telling her not to tell the teacher 'too much'. Several examples have already been detailed in paragraph 5.4.2

15.9ii Professionals

Peter also attempted to control and groom professionals. He was initially charming to people he met and used this approach to try to control the professionals he came into contact with.

- **SCS:** KPE Six (*Assault on Lee and Peter April 2016)* identifies that Peter was dictating the visiting arrangements around Doris seeing the children. The written agreement with SCS stated that Doris must be accompanied by a supervising adult but a few weeks later through verbal arrangements, he changed this to unsupervised visits to allow him to go to work. This put added pressure on Doris, as she was required to rise early to arrive at the house, get the children up and ready for school, drive them to school and nursery and then go on to work herself. This added intolerable stress during the difficult breakdown in the relationship.

- **The School:** Peter would not adhere to the school policy of the requirement of making an appointment to see the teacher despite being told to - he wanted to meet on his terms, although he stated he was unaware of the policy (*Source: Meeting with Peter*)

- **Police:** Peter always presented himself as the victim and was certainly seen that way by the Police. His DASH (KPE Six) identified 13 positive indicators. Doris admitted she hit Peter but that he knew how to provoke a reaction (retaliatory violence). There was a general lack of understanding of the wider aspects of domestic abuse as identified in discussions with professionals and within the IMR. Physical violence was seen as the only form DA that they had knowledge about and understanding of ongoing coercion, control, manipulation and undermining is still not fully understood. The Police should be commended that senior management have made the understanding of DA, including coercive controlling behaviour, a top priority. Significant resources, staff and finance have been made available to ensure staff are trained, understand the dynamics of DA and the behaviours of victims and perpetrators. Front line Police staff have identified a change in their culture when dealing with DA.

- **SCS:** Recognition they have a training gap around DA and coercive and controlling behaviour. This will be addressed through the new structure around Family Resilience (*see section 14.2.1iii Family Resilience)*

Health: Health professionals including GPs have identified gaps in their knowledge and understanding, particularly when there is no physical violence involved.

---

https://www.healthyplace.com/abuse/emotional-psychological-abuse/gaslighting-definition-techniques-and-being-gaslighted/

15.10 Consideration of the protected characteristics of equality and diversity issues that appears pertinent to the victim or perpetrator.

15.10i Marriage

The breakdown in Doris and Peter's marriage was the trigger that led to Doris's homicide. It would appear that Doris was seen by professionals as the person who had an affair and broke up her marriage. At no point were other reasons considered e.g. DA including controlling coercive behaviour. The breakdown of a relationship and separation are high risk indicators of a DA homicide. The NSPCC Domestic Abuse; learning from case reviews 2013 highlights that trigger events which can lead to a violent incident includes relationship breakdown and post-separation contact [31].

15.10ii Sex (Gender)

Doris felt that she was never seen as a victim. Peter told the social worker that he was a victim of DA as Doris had hit him. Doris was seen as the violent partner, despite both parents admitting that they used smacking as a punishment and Peter using a long ruler to chastise the children.

In the criminal proceedings, the Defence highlighted that Doris was very tall in her high heels and physically strong and so would be able to look after herself. This highlighted the view that DA was all about physical abuse and did not consider emotional abuse.

Research also identifies that Doris died because she was a woman. Karen Ingala Smith stated in her paper Femicide; men's violence against women goes beyond domestic abuse. The ONS 2013/14 found women more likely than men to have been killed by a partner or ex- partner. 84 females (53%) had been killed by their current / former partner compared to a total of 23 men (7%) over the same time frame.[32]

15.11 Agencies that had no contact will investigate whether helpful support could have been provided and if so why this was not accessed.

Voluntary organisations were contacted to assess the availability of support in the community, including relationship mediation and domestic abuse outreach. .

Doris was signposted to ESDAS by a number of agencies and her family thought that she had made contact; it is unclear why she chose not to do so. She said she was aware of the service when given information by the Police but she may have felt she had enough support in her life at that time from family, her GP and through counselling, that to involve another agency would be too much. Doris never really disclosed to agencies that she was a victim; she always said Peter was only a danger to himself. Doris's family state that Doris did not recognise herself as a victim she only cared for others.

Peter did disclose DA by Doris to the Police, who provided him with information about ESDAS. Again he felt he did not want to access such services. This could be related to his comment to the Police saying he was embarrassed to disclose. In a subsequent meeting he said that publicity material was only aimed at women whereas ESDAS publicity is gender neutral ESDAS

[31] www.learning.nspcc.org.uk/domesticabuselearning 04/09/2018
[32] www.kareningalasmith.com/2015/05/18- femicide men's fatal violence against women goes beyond domestic violence

outreach workers work with men as well as women and can refer an individual to another outreach service if they would prefer a male worker..[33]

15.12 ***Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services***:

Since 2016, Surrey Police have embarked on an extensive DA training programme (DA Matters and DASH). This model of training should be adopted by other professionals e.g. social care and health professionals, and the countywide Safeguarding programme run by the Safeguarding Boards, to ensure a common understanding of the characteristics of DA, the services available in the community and how to signpost and support not only the victim but also the family.

There is no doubt that Peter groomed and manipulated professionals. He refused to comply with school policy about making appointments to see teachers and tried to control the situation by simply turning up unannounced. He dictated the visiting arrangements for Doris to see the children to suit his own ends, despite having a formal written agreement that social workers and the family had approved.

Many professionals identified that they need training to better understand the concept of grooming and how to manage a person trying to influence and groom them. A number of professionals involved in this review also identified that they felt that they had insufficient knowledge about understanding and interpreting the" Voice of the Child." Professionals ignored the voice of Sam who was suffering from emotional trauma as identified by his nursery.

15.13 ***Consider whether Lee's welfare was promoted and protected through timely and effective assessments, including risk assessments, and response to needs were identified.*** *This includes application of thresholds, information sharing, use of assessment tools and timely interventions and recognition that those risks do not reduce at times of parental separation.*

15.13i The School: The class teacher had concerns about Lee and to support her she was given a "Worry Book" so she could write down her anxieties. Although the Worry Book provided an outlet for Lee, the school admitted that there was no agreed policy in place to monitor and act upon the information that she recorded.

When the situation with Doris and Lee escalated further, the Head teacher made the decision to inform Doris that she was going to refer the situation to SCS and submitted the safeguarding referral MARF[34]. Although a social worker visited the school and met with Lee after the referral, there was no further dialogue with the school about the assessment.

15.13ii SCS: The IMR indicates that following the school disclosure, it was agreed that a CFA[35] was the most appropriate step. The threshold for a Strategy Meeting involving other agencies at that stage was not felt to have been met, as the parents had now separated. This decision indicates that the social worker underestimated the risk of separation. Separation is a

[33] Male victim support: https://www.esdas.org.uk/help-for-male-victims
[34] MARF: Multi-Agency Referral Form
[35] CFA: Child and Family Assessment

high-risk factor for domestic homicide due a loss of control by the perpetrator. Before the children could be seen a further referral was received from Surrey Police relating to KPE Six and Doris's arrest. A Joint Section 47 enquiry took place with the Police by telephone. Health professionals were not included, which they should have been as this would have provided a more complete picture of the issues that the family were encountering during the relationship break up.

The CFA assessment was delayed as there were issues with staff sickness. At same the time there appears to have been a lack of resilience built into the SCS provision. Although the assessment was completed within the timescales as set by SCS in 2016, it has been concluded that a CIN Plan would have been put into place to support the children and the family had Doris not died. What cannot be predicted is whether such interventions would have helped the whole family. It is important is to ensure timely interventions and that there is a resilience in a service which covers staff absence to ensure assessments can continue and that families get the help when needed.

15.14 *Consider whether there is evidence that managers and supervisors understood the experience of children living with domestic abuse and the prevalence of the issue in the area.*

It would appear there is a lack of understanding by some professionals of the impact on children living in a household where DA occurs. SCS highlighted that the needs of Sam were not explored, despite living in a household where his parents were separating and being verbally and physical abusive. His deteriorating behaviour at nursery was evidence that he was experiencing the impact of domestic abuse (*Source: SCS IMR*).

Professionals assumed that, as Doris and Peter had separated, any risks around DA or harm to the children had been reduced. There was no recognition that this was a time of heightened, rather than reduced risk. A DA checklist was not completed when considering the needs of the children and if it had been, further intervention by professionals could have been considered.

Recent statistics suggest that around 70% of referrals to the Surrey Multi Agency Safeguarding Hub (MASH)[36] include issues around DA. The Surrey MASH was one of the first to introduce 'Operation Encompass' to notify schools each morning about a child's exposure to domestic abuse at home (and, in Surrey, also when they have been reported missing). MASH officers interrogate databases for the previous 24 hours (or 48 hours on a weekend) where a child under 18 was linked, involved in or a witness to domestic abuse. This information is shared with the Education Safeguarding Team who then pass it to the relevant school by registration time so appropriate support can be offered.

16 LESSONS IDENTIFIED FROM THE REVIEW

16.1 Domestic Abuse, including coercive, controlling and stalking behaviour and a lack of understanding of behaviours shown by victims and perpetrators: This review has identified that some professionals still see DA as physical violence between two intimate

[36] MASH: https://www.surreycc.gov.uk/social-care-and-health/concerned-for-someones-safety

partners despite the changes to the legislation in December 2015 which created a new offence of controlling or coercive behaviour in intimate or familial relationships[37].

16.1i The Police: Significant training has been delivered (DA Matters) across all levels of staff, including the contact centre, to ensure that front line staff have the tools to identify DA including coercive, controlling and stalking behaviour, understand the behaviour of the victim, including retaliatory violence and ensure that victims get the correct support. In discussion with the Police, the Independent chair felt that the officers were confident that they now had the tool kit to help them "do the job".

In 2018 Surrey Police were successful in securing the first 'victimless' conviction for coercive controlling behaviour in the country[38] based on evidence from the victim's interviews and hearsay evidence only. A*"victimless prosecution"* is one where no evidence is directly provided from the complainant in the court due to fear of reprisal.

More recently in February 2019, a Surrey Police investigation led to second male being jailed for rape and coercive controlling behaviour [39]

16.1ii The School: The School readily admitted that at the time of the concerns around Lee followed by Doris's death, their knowledge was limited around DA and what to do. Since 2016 the school has improved its processes and procedures and has invested significantly to ensure that safeguarding of the child is paramount. Staff now have the tools to ensure that they know how to identify DA and the support that can be offered to families.

The School has also demonstrated how to support a child following a loss of a parent and provision of ongoing support to Lee and Sam through the long custody process. It is felt that the school has developed excellent policies, procedures and tools to support children and families experiencing DA and child abuse. It is important that this is shared with the wider education community.

***16.1iii Promotion of a common understanding of DA*:** Health and SCS would benefit from a bespoke training package like the successful Police "DA Matters" programme. It would ensure a common process and 'language' across all agencies which would better support families experiencing abuse.

16.1iv Wider community: The review also identifies that the wider community does not fully understand DA and especially controlling coercive and stalking behaviour. Doris's family noticed that Peter could be controlling but were not fully aware of the situation until late 2015 when the relationship between Doris and Peter was deteriorating. There is still much more information required at a local and national level so the wider community can recognise

---

[37] The Serious Crime Act 2015 (section 76): https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

[38] Victimless prosecution" for controlling and coercive behaviour February 2018 https://www.kingsleynapley.co.uk/insights/blogs/criminal-law-blog/prison-sentence-following-victimless-prosecution-for-controlling-and-coercive-behaviour

[39] http://www.mynewsdesk.com/uk/surrey-police/news/man-jailed-for-rape-and-controlling-or-coercive-behaviour-360421

behaviour of a perpetrator and a victim and what they can do to support themselves (if they are a victim) or other people.

16.2 Mental Health Issues relating to Doris, Peter, Lee and Sam: All the family experienced mental health trauma throughout the last six months of Doris's life. The mental health issues that Doris, Peter and Lee were experiencing seem to have been viewed in isolation and DA was not identified even though Peter admitted to being verbally abusive to Doris.
The mental health concerns were linked to the relationship breakdown and other possibilities such as DA were not considered or the impact this had on the safety of the children. Doris had sought help to try to work through her issues, especially in trying to control her anger. The GP offered Doris medication and talking therapy which she participated in. Peter was also offered support by the GP but he did not show any commitment to any support offered. This would appear to indicate that Doris was being proactive in supporting her own mental wellbeing whereas Peter would not accept that he may have some mental health issues to address. SaBP identified it would have been beneficial for Peter to have been offered an assessment and not just referred to the GP at that time.

Research indicates that mental health and ally types of domestic abuse are linked. Women who suffer abuse by a partner are more likely to suffer from depression and anxiety [40]. There is evidence to indicate that GPs still have a lack of certainty in suspecting domestic abuse which is coercive and controlling. Despite Doris telling the GP about "having had enough of the way Peter treated her" this was seen in the acrimonious break up of a marriage.

This would indicate that primary care professionals need further training and an understanding of all forms of domestic abuse, emotional, coercive control and stalking.

16.3 Lack of professional curiosity around DA including coercive and controlling behaviour: Much has already been written in this report about lack understanding of coercive and controlling behaviour by professionals which, linked to limited professional curiosity towards the family, led to a significant gap in information. There were disclosures by Doris to health professionals about control and Lee identified issues to her school around safeguarding but other family dynamics were not explored such as DA. With a better understanding of coercive, controlling and stalking behaviour through training, there will be better opportunities for professional curiosity.

16.4 Lack of understanding of the family dynamics during the breakdown of a relationship: The family was at crisis point in April 2016. Physical and verbal abuse was prevalent between Doris and Peter which was being witnessed by both children. The judge in the Fact Finding investigation stated that Doris and Peter grossly mishandled the breakdown of their relationship and failed to protect the children. (*Source: Fact Finding Hearing Approved Judgement*). The DHR recognises however that Doris had very limited scope for choice in the last 6 months of her life.

[40] Domestic Abuse Victims more likely to suffer mental illness-study Sarah Boseley www.guardian.com June 2019

Events in the life of the family appear to have been seen in isolation and not linked - no 'bigger picture' was seen. Professionals did not appear to support the family following KPE Four, Five and Six, despite concerns identified around the breakup of the relationship and concerns around stalking.

The Munro Review of Child Protection 2011[41] and Working Together to Safeguard Children 2018 highlight the need to provide early help as an effective approach to promoting the welfare of children, rather than reacting later. Following Doris's visit to the police in January 2016, there was contact with SCS but no further support was given, as this was the family's first involvement with the service. This was the policy at this time. With the new transformation programme being rolled out by SCS there will be the opportunity to support children and families at an earlier stage and with a specialist DA advisor within the team, the ability to sign post and support the family as a whole entity.

Further DA training for professionals should give them the tools necessary to understand behaviours of both victims and perpetrators and identify what to do and how to provide support.

16.5 Lack of understanding by professionals of grooming, especially relating to children and to the key professionals involved: Peter controlled and was grooming a number of professionals including teachers and social workers, through dictating visiting arrangements for Doris and turning up at the school without an appointment to talk to Lee's teacher despite being informed not to.

The school, the Police and social workers spoke about the children using 'adult language' and that they felt that Peter was influencing and grooming the children to be 'on his side'.
During the review, professionals readily admited that they needed a better understanding of grooming techniques. Better training and a common understanding would help professionals develop the tools to manage situations including challenging the person trying to groom them and what to do if they feel the person is grooming a child.

16.6 Lack of communication between agencies and the family especially relating to KPE Six: The review has identified that during KPE Six there was no communication between SCS and Doris and her mother for around six weeks, despite both trying to contact the social worker. This was a desperate time for Doris who was already suffering stress and anxiety from the breakdown of the relationship. She was separated from the children who she loved and was unclear when she would be able to see them again. The lack of communication and information added extra pressure. Doris's mother had also been heavily involved with the upbringing of the children and she had no communication about why she could not see them. The review identified that Lee did not want to see her grandmother as "Doris and her grandmother" ganged up on her.

Regular, honest communication between agencies and the family could have reduced the anxiety that Doris was enduring and help Doris's mother understand as to why she could not see the children. In future agencies should ensure that there are policies in place to

---

[41] Munro Review: https://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system

communicate promptly with families during times of separation of mother / father from their children in order to reduce anxiety and an escalation of stress and concern.

Consideration should be given to sharing information regarding Child in Need conferences with the relevant GP, to ensure they are aware of any Child Protection plan in place. GPs also do not receive notifications following a police attendance at a domestic abuse incident. The need to share information effectively remains, as ever, a multi-agency responsibility.

16.7 Lack of risk management around the assessment of KPE Four and KPE Six: The Review and especially the agencies involved with the family, identified that professionals needed to evaluate the risk around the decisions they made. If Doris had been charged and not cautioned (KPE Six) then extra support may have been made available to the family.

The significance of stalking was not identified at that time. Doris disclosed that Peter had previously stalked her and felt that he was doing so again just before she was killed, by following her and by reading her phone. Doris's family stated that Doris started to wear a wig when going out to disguise herself, indicating that she was fearful of Peter stalking her.. A study[42] (Monkton-Smith 2017) found stalking was present in 94% of the 358 cases of criminal homicides they looked at. Surveillance activity, including covert watching, was recorded 63% of the time. 85% of homicides occurred in the victim's home. In almost every case, the killer displayed the obsessive, fixated behaviour associated with stalking.

SCS went through a structural change during KPE Six. There needed to be robust risk management policies in place around the changes e.g. identification of pressure on staff, appropriate briefing of agency workers etc. to ensure that the quality of support to the children and familiy continued at the level expected to ensure adequate safeguarding.

16.8 A lack of understanding of how to listen to the voice of a child: This has been identified by SCS and will be addressed through the new structure around Family Resilience *(see section 14.2.1iii Family Resilience).*

16.9 Support for Professionals: It is apparent that professionals and work colleagues have been deeply affected by the tragedy relating to the death of Doris. It is important that organisations consider their duty of care to staff following such a tragedy. As an example of good practice, Doris's workplace offered counselling, time off and a phased return to work to those who worked closely with Doris. Sadly, experienced staff have left at least two of the organisations involved due to the ongoing trauma they experienced during and after the incident.

17 CONCLUSIONS

This review has highlighted the tragic cost of coercive control and domestic abuse resulting in the death of Doris and the emotional and physical abuse suffered by the children. The incident has a wide and enduring impact upon families, friends, colleagues and professionals. Doris and Peter appeared to have a reasonable relationship until late 2015, although Doris mentioned she

[42] Monkton-Smith: Exploring the relationship between Stalking and Homicide http://eprints.glos.ac.uk/4553/

had felt controlled for years. There was then a rapid deterioration during their relationship breakdown and the separation resulting in the tragic death of Doris, the serious injury to Lee and the emotional harm to Lee and Sam.

17.1 During the six months prior to Doris's death a number of agencies had contact with the family. It would appear that agencies did not link events to see a 'bigger picture' and did not review the needs of the whole family during a time of relationship break up and separation. This contributed to the lack of understanding around risk in domestic abuse and how separation can be a key indicator of high likelihood of serious harm.

17.2 In 2016 there appeared to be a general lack of understanding by many professionals (and the wider community) regarding the breadth of domestic abuse and all its iterations. Section 76 of the Serious Crime Act 2015[43] created a new offence of controlling or coercive behaviour in an intimate or family relationship. The legislation is still in its infancy and it remains a slow process of raising understanding. This confusion perhaps explains why it is still primarily physical acts of violence that are focused upon in response to domestic abuse. There is much more information required locally and nationally about controlling and coercive behaviour so that communities and especially victims know how to identify such behaviours. Professionals need a common understanding and approach to DA including training.

The Police DA Matters programme appears to provide an excellent model in supporting cultural change and providing staff with the relevant tools to support the community in the future. All professionals working with families and children need to be empowered within a culture that encourages further insight, discussion and support outside of their respective organisations in order to raise concerns. As an example Doris did say to the GP that she had had enough of being controlled by Peter. The GP at the time did not probe further as they may not have been fully conversant with coercive behaviour and as such would not have understood this as domestic abuse.

This review identifies that it is imperative that agencies work together to provide a coordinated approach to supporting families through crisis. The relationship between Doris and Peter in the last six months of Doris's life was toxic. This had a profound effect on Doris, Peter and especially Lee and Sam. If professionals had worked together earlier to provide information and support to the whole family then the obvious stress that Doris was enduring may have been reduced, resulting in a better relationship with Lee.

Working together to Safeguard Children 2018[44] identifies that everyone who works with children has a responsibility to keep them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

[43] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship
[44] Working Together to Safeguard Children: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

It is imperative that agencies work together to provide a coordinated approach to supporting families through crisis. The recommendations below are designed to build upon the changes that have already begun in some agencies across all professionals to a common level where domestic violence or abuse and its nature are addressed more comprehensively and with improved understanding of its dynamics. This includes an understanding of the heightened risk of separation, coercive control, stalking behaviour, domestic abuse and child abuse and the tools in order to support the whole family.

17.3 This review has highlighted the wider issue that DA and child abuse has had on professionals attending the tragedy and supporting the family. Expert trauma support following such a terrible tragedy should be readily available to professionals, especially when vicarious trauma is suspected.

18. POST REVIEW LEARNING

This DHR and SCR has involved a number of parallel reviews which extended the time frame; two criminal court sessions, two Welfare hearings and several internal reviews. The Independent Chair and the DHR Panel have not wanted to undermine any of these proceedings and therefore arriving at a conclusion for these reviews has taken longer than was hoped.
Although the scope of this DHR/SCR ended after Doris's death (2 June 2016), due to the extended time period for carrying out this review, there are a number of valuable post review learning points for agencies to consider and act upon.

18.1 Children's memories of Doris
Feedback suggests that Lee still has difficult memories of Doris. Although in the past two and half years she has remembered Doris on Mother's Day and birthdays, she still seems to blame Doris for breaking up the family and she has memories of Doris "being horrible to Sam. Sam himself does not mention such difficult memories, possibly because he was much younger at the time of the tragedy.
It will be important for professionals involved with the children in the future to ensure their mother and father are represented fairly to them, without bias. As the judge comments in the Family Fact Finding report "Doris had many qualities with Peter saying she was a fabulous mother, being selfless, caring, loving and nurturing wife and mother".

18.2 Foster Care for Children following a tragedy.
Following Doris's death, the children were placed with foster family A. Sam complained to his social worker that his teeth were being cleaned so hard his gums bled. SCS carried out an Independent Review which considered eight concerns of which five were substantiated, two were unfounded and one was unsubstantiated. The overall investigation highlighted how the carers had been overwhelmed by the complexity of the children's needs and as a result was not able to provide the consistent therapeutic care they needed.

The learning from this investigation highlights the need for professionals to provide specialist support to foster carers to enable them to support the children in their care through significant

trauma. This will help foster carers to understand a child's behaviour and their reaction to a significant trauma in their life.

18.3 Wellbeing Support for Professionals across all investigations

There is a need to recognise 'vicarious trauma[45]' amongst professionals who provide support in tragic situations such as this.

18.3i As already identified within the report (*Paragraph 16.9*) this tragedy has adversely affected a number of professionals leading to retirement on grounds of PTSD or choosing to leave their positions due to the trauma they experienced supporting others. Many others required counselling and time away from work.

18.3ii It has become evident that the emotional impact on professionals has continued, especially around those still directly involved with the children, social workers and staff at Lee and Sam's school. A social worker initially working with the children became so involved with the tragedy that it led to the person leaving the service.

18.3iii The future caring arrangements for the children were agreed in September 2018 and they have now left this area. Lee was moving to secondary school and professionals who had supported her during this traumatic period were able to say their good-byes to her in July 2018 as a form of closure. As the Care Proceedings took place in September, Sam did not return to the school at all, which staff were only aware of the day before term started. There was no opportunity to say goodbye to the child they had supported during such a traumatic part of his life, which several staff found upsetting. Staff also felt that if they had been kept updated, arrangements could have been made for the necessary assessments to be shared with the new school.

18.3iv It is paramount that agencies consider the ongoing support required by professionals involved with the family post-tragedy. Ongoing clinical supervision and specialist trauma support may be required for a considerable period after the incident to safeguard the wellbeing of professionals.

18.3v There is also the need for social workers to keep professionals (e.g. school staff) updated (as appropriate) about the future family arrangements for children. This can allow the professionals to ensure that children have the correct assessments and are as well prepared for their future as they can be.

18.4 Process of a Joint DHR / SCR

18.4i There is no doubt that the decision to carry out a joint DHR / SCR review has been of benefit. The death of Doris (DHR), physical abuse towards Lee and emotional abuse towards both children (SCR) are inextricably linked as shown by the Key Practice Episodes described in Section 10. The family were in crisis during the separation; there was controlling and coercive behaviour, grooming of the children, domestic abuse between Doris and Peter and

[45] Vicarious trauma: Can occur in professionals who provide support to trauma survivors through listening to their pain, fear, and terror, which in turn has an impact on their own mental health. https://www.counseling.org/docs/trauma-disaster/fact-sheet-9---vicarious-trauma.pdf

physical and emotional abuse of both children. The Panel has been able to analyse events, agency support and lessons learned to develop more robust recommendations that hopefully can reduce such tragedies in the future.

18.4ii Carrying out such a joint review though has had its challenges:

- ***Different Status of the family members:*** Although all DHRs and SCRs have complexities, incidents in this review blurred the boundaries between victims and perpetrators. Doris is the victim of a domestic homicide but was Cautioned by the police for abuse towards Lee. Peter is the perpetrator of the domestic homicide which he admitted (although he was acquitted of murder) but he is also the father of the children and this needed to be considered as part of the SCR. The family of Doris are central to the DHR process and the children and Peter are central to the SCR.
- ***Different Processes for the Quality Assurance of DHRs and SCRs:*** The DHR process puts the *family of the victim* at the heart of a review and the SCR puts the *children* at the heart of its review and focusses on how agencies worked together to safeguard the children identifying areas of good practice and those requiring practice improvement. A SCR goes through its Quality Assurance process at the Local Safeguarding Children Board and Strategic Case Review Group and then via the National Panel at the Department of Education before the report is shared with the family member(s). DHR Draft Reports go to the family for any comments before being signed off by the Community Safety Partnership and then sent to the Home Office to be reviewed and Quality Assured. These different approaches have extended the time line for completion of this review. It has also been very difficult for Doris's family to understand the different processes and their status within the reviews.

It is not fully known how many joint DHR / SCR reviews have taken place to date. From a learning perspective, it is important that the family / parent have an early explanation regarding their status within each element of the review. ***It may also be beneficial for the Home Office and the Department of Education to consider any streamlining of the Quality Assurance Processes for joint reviews.***

18.5 Benefits of a Surrey-wide Designated GP for Safeguarding Children: The presence of this post has been of significant benefit to the Review. The GP had detailed knowledge and experience relating to domestic abuse including CCB and safeguarding of children. She has been able to challenge the health support that was provided to the family in a constructive manner and has been able to support achievable recommendations for GP practices. The Independent Chair has also found it of benefit to have one contact who she can discuss issues with in a constructive manner.

19. RECOMMENDATIONS

The following recommendations have been arrived at using a range of information sources:
IMR recommendations / learning from the Review / the Review Panel's discussion and deliberations.

19.1 Professional Practice

Recommendation One
The School, in partnership with Surrey Local Safeguarding Partnership, to develop guidance on supporting children and families during the breakdown of a relationship or family tragedy, which will include appropriate communication tools for children to voice their concerns.

Ownership: The School and Surrey Local Safeguarding Partnership.

Recommendation Two
Surrey Children Families and Learning (SCFL) to ensure that social workers are following procedures in supporting a connected person (non-professional) who supervises meetings between an adult and a child.

Ownership: SCFL (Surrey Children Families and Learning)

Recommendation Three
Surrey Children Families and Learning (SCFL) to ensure that social workers always involve health professionals in Section 47 investigations to ensure a complete analysis of the family issues in order for appropriate support and resources. To be made available.

Ownership: SCFL (Surrey Children Families and Learning)

19.2 Training - Local

Recommendation Four
Agencies e.g. Police, SCFL, health and other agencies working with children to have the skills to understand the complexities of working with the voice of a child and in the use of the tools available, to interpret what is being said in the context of the situation. This will enable professionals to assess any grooming or coercing of children by a perpetrator .

Ownership: Surrey Children's Services Academy

Recommendation Five
The Surrey Children's Services Academy, Surrey Safeguarding Children Board / Surrey Local Safeguarding Partnership and Surrey Safeguarding Adult Board to ensure, through DA and safeguarding training, that staff working with families and children have an in-depth understanding of coercive controlling behaviour. This should include awareness of stalking, perpetrator grooming of family members and professionals, retaliatory violence and violent resistance, which will enable professionals to have a better understanding of the risks relating to domestic violence.

Ownership: Surrey Children's Services Academy, Surrey Safeguarding Children Board/ Surrey Local Safeguarding Partnership and Surrey Safeguarding Adult Board.

Recommendation Six
GPs to be reminded, through DA training, to evaluate the risk to other family members when engaging with a patient where there has been a disclosure from within the family. GPs should be familiar with the new GMC Guidance around information sharing and the need to record on patient records any decisions and the rationale behind decisions to share information outside of these parameters.

Ownership: Surrey Clinical Commissioning Groups (CCGs)

Recommendation Seven
Surrey Domestic Abuse Management Board (DAMB) and borough Community Safety Teams promote and recommend to local businesses and organisations that they join the Employers' Initiative on Domestic Abuse and introduce work place domestic abuse policies to ensure that staff remain up to date and confident in their knowledge about DA and how to support employees.

Ownership: Surrey Domestic Abuse Management Board (DAMB) / Borough Community Safety Teams

19.3 Assessment of Risk

Recommendation Eight
SCFL to ensure that social workers carry out a thorough assessment of need for children. This will include issues affecting the family e.g. breakdown of family relationships, separation, mental health, DA including controlling coercive behaviour.

Ownership: SCFL

Recommendation Nine
SCFL / Surrey Children's Services Academy to ensure that all agency staff have support and management supervision including a robust induction programme into local procedures.

Ownership: SCFL / Surrey Children's Services Academy

19.4 Support for Professionals

Recommendation Ten
That the Police, SCFL, Education and Health ensure that they have sufficient clinical supervision (including trauma counselling) available on an ongoing basis to support staff who have been involved in a tragedy and if services are already available to ensure they are promoted to staff.

Ownership: DAMB

19.5 National and Regional

Recommendation Eleven

That Surrey continues to support Home Office campaigns which reinforce public awareness of controlling and coercive behaviour including the behaviour of victims and perpetrators through public campaigns in different media.

Ownership: Home Office / DAMB

Recommendation Twelve

Surrey DAMB to continue to reinforce public awareness of controlling coercive behaviour locally by campaigns in publications and public places.

Ownership: DAMB

19.6 National

Recommendation Thirteen

ES CSP to highlight the need for the Home Office and Ofsted to consider streamlining processes and to produce guidance for joint DHR / SCR reviews.

Ownership: ES CSP

Recommendation Fourteen

ES CSP to highlight to the Home Office the current underdevelopment of interpersonal violence interventions for relationships that are in the process of breaking down.

APPENDIX ONE

DHR PANEL MEMBERS

ORGANISATION	ROLE	NAMED OFFICER
Surrey Police	Det Superintendent	Clinton Blackburn
	Force Domestic Abuse Advisor	Bridie Anderson
Surrey Safeguarding Children Board (SSCB)	SSCB Partnership Support Manager	Amanda Quincey
SCC Children's Services	Head of Safeguarding	Siobhan Burns Sam Bushby
Surrey and Sussex Healthcare Trust	Adult Safeguarding Lead	Fiona Crimmins
Surrey - wide GPs	Designated GP for Safeguarding Children	Dr Tara Jones
Surrey and Borders NHS Foundation Trust.	Safeguarding Adults & Domestic Abuse Lead	Debra Cole
East Surrey Domestic Abuse Services	Chief Executive	Michelle Blunsom Miatta Marke
Lee and Sam's school	Pastoral and Safeguarding Lead	Withheld to avoid identification of children
East Surrey Community Safety Partnership	Community Safety Manager	Hilary New Amanda Bird
Borough Council	Senior Manager for Leisure and Regulation	Ben Murray Justine Chatfield
	Community Safety Officer	Sarah Crosbie
	Independent DHR / SCR Chair	Liz Borthwick
	Independent DHR / SCR Coordinator	Debbie Stitt

East Surrey Community Safety Partnership

APPENDIX TWO

BOROUGH DOMESTIC HOMICIDE REVIEW and SERIOUS CASE REVIEW PANEL December 2016

TERMS OF REFERENCE

1. This Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

2. This legislation places a statutory responsibility on organisations to securely share sensitive information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.

3. A Serious Case Review (SCR) will run alongside this process to ensure full consideration of all factors leading to the death on 2 June 2016. As this will be both an SCR and a DHR, the Panel will seek to work jointly with this process to avoid duplication of contact with, or requests for information from, agencies, family members, friends and colleagues.

4. The DHR will strictly follow the East Surrey Community Safety Partnership (ES CSP) DHR protocol, which is based on Home Office guidance[46]

5. The statutory purpose of the DHR is to:

   a) Establish what lessons can learned from the domestic homicide regarding how the local professionals and organisations worked individually and together to safeguard the victims of domestic abuse;
   b) Identify clearly what those lessons are, both within and between agencies, how they will be acted on, and what will change as a result through a detailed Action Plan;
   c) Apply these lessons to service responses including changes to policies and procedures as appropriate;
   d) Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.

6. The statutory purpose of the SCR is to:

   a) establish what lessons are to be learned from the case about the way in which local professionals and organizations work individually and together to safeguard and promote the welfare of children;
   b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

[46] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

c) improve intra- and inter-agency working and better safeguard and promote the welfare of children.

7. The agreed timeframe for information to be secured and reviewed is **five years prior to the event i.e. from May 2013**, unless there have been significant events prior to this.

8. The DHR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g. SCR, IOPC referral, internal agency disciplinaries) may use information from the DHR process to support their investigations.

9. The Panel notes that the DHR process may be suspended as necessary to avoid the risk of activities prejudicial to criminal proceedings. The trial is scheduled for December 2016. *(This was subsequently rescheduled to May 2017).* **The DHR will then recommence after the verdict has been issued.**

10. In addition the following areas will be addressed in the Individual Management Reviews (IMRs):

i. *Identification of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services.*
ii. *Awareness of the potential presence of **coercive control** and how this may have impacted on the behaviour of the victim and perpetrator. The Panel may invite input from experts in this field.*
iii. *Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator*[47]
iv. *Agencies that had no contact will investigate whether helpful support could have been provided and if so why this was not accessed.*
v. *Consider whether agencies working with the family adopted a 'child- centred approach', viewing family conflict and incidents of domestic abuse through the eyes of the child.*
vi. *Consider whether the children's welfare was promoted and protected through timely and effective: assessment including risk assessment and response to the needs identified (this includes application of thresholds, information sharing, use of assessment tools and timely intervention) and the recognition that risks do not reduce at times of parental separation.*
vii. *Consider whether there is evidence that managers and supervisors understood the experiences of children living with domestic abuse and the prevalence of the issue in the area.*

11. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it

[47] e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

being passed to the chair of ES CSP. If an SCR is completed, the Surrey Children's Safeguarding Board procedures will be followed.

East Surrey Community Safety Partnership

APPENDIX THREE

Police Recommendations

Recommendation 1
For the Detective Inspector and Detective Sergeant to have the findings of this report shared with them and in particular the findings attributed to each.
Update - *Action completed.*

Recommendation 2
For the DA portfolio lead to satisfy herself that the number and scale of DA cautions is appropriate in light of MOJ guidelines.
Update *A review of the DA caution policy has been carried out and updated following the incident. Action completed.*

Recommendation 3
For Public Protection DS/DI/DCI decision makers within CPD training to receive an input from the Domestic Assault Subject Matter Expert (SME) on the use of DVPNs, and the force policy of use of cautions. If agreed for the PPSU to ensure compliance.
Update *SME continue to refresh the DVPN training for all ranks in the organisation.*

Recommendation 4
This case shows the importance of decision makers in Public Protection being current in their training and knowledge of child abuse and domestic abuse. Where needed refresher courses for experienced staff should be considered in this fast changing environment.
Update *More specific appropriate training is currently being explored with all Detectives.*

Recommendation 5
In light of this case and recent HMIC feedback, for the DA Lead to determine if specific supplementary training and guidance is required within the Safeguarding Investigation Unit team involved.

Recommendation 6
For Custody Inspectors to satisfy themselves that their staff are confident in their knowledge on the MOJ guidelines in giving cautions for DA offences.

Recommendation 7
For consideration of making the published force caution procedure for DA offences more user friendly, rather than referral to lengthy national guidance documents.
Update *The DA policy has been updated into one single document. At the time of the incident there were over 20 policies.*

Recommendation 8
For the Gold commander to consider whether this report and / or learning identified is shared with any stakeholders or family members involved in this case.
Update: *The Det Superintendent involved in this case has offered to meet the family.*

Recommendation 9
For the Post Incident Manager to be provided with a copy of the report so welfare support can be provided to those who fall under the process.

APPENDIX FOUR

EAST SURREY DOMESTIC ABUSE SERVICES (ESDAS)

https://www.esdas.org.uk/ **Tel 01737 771350**

Associated services include Independent Domestic Violence Advisors (IDVA) at MARAC[48] and Surrey's Specialist Domestic Violence Court (SDVC). The Volunteering Project aims at harnessing the skills and experiences of survivors of DA to help others recover from abuse and reintegrate into their local community. Children and young people services include 1 to 1 work, group work, Play Therapy and expert consultancy to professionals in particular Children's Social Care. They are one of only 30 areas in the country to manage Identification & Referral to Improve Safety (IRIS) Project - a primary care enquiry and referral pathway which identifies survivors of DA at the earliest opportunity and ensuring they have access to specialist support.

Between 1st April 2017 and 31st March 2018 the service received **2,538 adult referrals**, dealt with **13,004 contacts from clients,** undertook **653 face-to-face outreach appointments and joint visits** with clients. They advocated for clients at **617 multi-agency meetings** and liaised with partner agencies on behalf of clients on **7,858 occasions**

Breakdown of cases:

- **1,190 cases** were **classified as either high or medium risk** of harm based on the DASH Risk Assessment Checklist.
- **35 individual children and young people cases** including **25 one-to-one meetings**
- Advocated for children at **143 meetings** including Case Conferences, family Group Conferences, *etc.*
- Provided **73 parent consultations with non-abusive parents**
- Provided **122 individual consultancy sessions** to Assistant Team Managers, Social Workers and Family Support Workers based within the East Surrey Social Care Team

Volunteers:

- **32 Volunteers provided 1,311 hours of their time to support users** at court hearings and a range of appointments.
- They befriended service users and their children and supported service users through the ESDAS Group Work Programme. Their roles include: co-facilitating the Support Group, Freedom Programme and Recovery Toolkit, providing emotional and practical support during groups and acting as positive role models for the children and young people attending.
- They helped with a range of awareness raising and fundraising activities and attended internal and external training courses to further their development.

As well as providing direct support to survivors and DA and their children ESDAS also provides support to friends and family of those affected by DA and advice to any agency or professional trying to support someone experiencing domestic abuse. Working with ESDAS

[48] MARAC - Multi-Agency Risk Assessment Conferences

is on a consent basis and users have the right to remain anonymous when accessing our services.

APPENDIX FIVE

SURREY CHILDREN'S SERVICES ACADEMY

Objectives

The purpose of the Academy is to act as an engine for improvement in practice and partnership working. Specifically it will work to:

- Ensure all staff have up to date knowledge and skills to fulfil their roles: there needs to be a 'back to basics' approach to ensure that practice is informed by a strong knowledge and skills base in terms of understanding risk, undertaking assessments etc.
- Introduce and embed new skills, values and ways of working in Surrey to staff in all agencies that work with children and families. These fundamental basics will be within a new model that is fundamentally about building family resilience and a strengths-based approach. The new model and approach need to be understood by the whole workforce as well as each person understanding their roles and responsibilities to make them work.
- Drive culture change and develop a shared language and values: the Academy should play an important role in building a shared commitment across agencies and professional boundaries towards better outcomes for children and achieving these through earlier intervention and prevention. The shared language will reinforce this and ensure effective communication across different parts of the workforce. We want to create an open, collaborative, learning culture.
- Drive up and help maintain professional standards: the Academy needs to work very closely with heads of profession like the Principal Social Worker to tackle development areas revealed in practice audits, performance appraisals, Serious Care Reviews etc. It is also important for training to be up to date and refreshed to reflect changes in law and best practice nationally. We want to embrace the concept of a learning culture - everyone, at every stage of their careers, needs to keep on learning and being open to new ideas.
- Build effective leadership skills and capacity across children's services that can lead and sustain change: if front-line staff are trained in new ways of working and this is not reinforced by managers and leaders back in the workplace then staff are likely to revert to previous practice. It is therefore important for managers and leaders to prioritise their own development so that their own practice is up to date and they can mentor their staff. In addition we need leaders who think across the whole system and not just their service or team. The expectation therefore will not only be of continuous professional development but that career progression will hinge on having undertaken the necessary learning to equip managers for the challenges they will face as they move up the career ladder.
- Develop better understanding between agencies of each other's roles and responsibilities, more effective ways of working together and confidence to work in multi-agency teams - managers and staff need to understand and value partners' contributions. It is important for individuals to have an understanding of different perspectives and to 'walk in the shoes' of partners. They must also understand how to work effectively as part of a real or virtual multi-agency team and what the team is aiming to change for that

child or family. The focus at all times must be the child, and that means joining up effectively around the child's needs and not letting the boundaries between teams and agencies to get in the way.

- Improve retention by making Surrey a good place to work. Remuneration is only one factor in attracting and retaining staff. Feeling valued and supported are key. The aim of the Academy is to invest in people's development and help them feel supported throughout their careers. There is clear evidence from other local authorities that these elements have an impact on recruitment and retention. If more staff can be retained this will also reduce spend on agency staff.
- Support the pace and sustainability of the transformation programme for children and families by embedding new ways of working: the improvement programme for children needs to have an impact quickly and for the changes made to be sustained into the future. Establishing an Academy will provide a vehicle to reinforce and embed good practice.
- Keep abreast of new practice - the Academy will have a responsibility to forge and maintain relationships with regional, national and international experts, and to bring their learning into Surrey. This will include holding regular speaker events so that staff can be inspired by hearing from leaders in their fields and challenged to think how they can use this learning in their practice.

Model

The Academy is still in the design phase but some elements are clear. As will be apparent the vision for the Academy is something much broader than simply a vehicle for delivering training and development – although that will be central to how it achieves its objectives.

- The aim is to create a virtual ‘hub and spokes’ model. The Academy will be the hub providing overall co-ordination of learning and development and ensuring that whole workforce training is in place. It will be responsible for all learning and development relating to children and families in the Council and will support the children’s workforce into and through their Surrey careers. It will also connect with and inform learning and development programmes and networks in different agencies and services. This will ensure that the core family resilience and family safeguarding approaches being adopted in Surrey are reinforced in all agencies and that there is a strategic understanding of workforce development needs with capacity and resourcing across the system to address these.
- The Academy will report into the Director of Quality Assurance, reflecting the strong links between quality assurance and learning and development.
- To drive forward the design of the Academy and ensure we have good engagement from partners and staff we are establishing:

1. A strategic stakeholder group with membership from across the Council and from partners to shape proposals on scope, direction and priorities.
2. A reference group of staff and managers from across the workforce to provide ideas and feedback, help shape the content and act as ambassadors for the Academy in their services.
3. A mechanism for regular input from children and young people and from foster carers.

4. The offer to managers and staff will include conventional training courses, plus e-learning, a library of resources that can be accessed, opportunities for work shadowing and coaching and regular events with external speakers who are regional or national? experts in their fields.