

For Publication

Rotherham Safeguarding Children Board

Executive Summary of a Serious Case Review in respect of the Y Family
June 2007

Introduction

1.1 This Serious Case Review was commissioned following the death of Mrs. CY, a mother of 2 boys, in a domestic violence homicide and the suicide of her husband and the boys' father, Mr. DY. There were indications that the 2 children were at risk during the events that led to two fatalities. This Review was commissioned by Rotherham Safeguarding Children Board (RSCB) on 4 October 2006 in accordance with the Local Safeguarding Children Boards (LSCB) Regulations 2006. The report considers, with the benefit of hindsight, whether there are lessons that can be learned. South Yorkshire Police are conducting a domestic violence homicide review concurrently with this review and its individual management review report is being used for both purposes

1.2 This Review considers individual management reviews provided by South Yorkshire Police (SYP), Rotherham MBC Children and Young People's Services (C&YPS), Rotherham Health Trusts, Rotherham MBC Neighbourhoods & 2010 Rotherham Ltd, and the Choices and Options project of Rotherham Community Resource Programme Trust Ltd.

1.3 The members of the Serious Case review Panel for this Review have been:

Mike Cuff	Chief Executive & RSCB Chair
Joyce Thacker	Senior Director, C&YPS, RMBC
Pam Allen	Director of Children's Social Care, C&YPS, RMBC
Tom Kelly	Director of Inclusion, Voice & Influence, C&YPS, RMBC
Jim Stewart	Safeguarding Manager, C&YPS, RMBC
Sheila Hall	Safeguarding Board – Audit & Development Officer
Cath Ratcliffe	Chief Education Welfare Officer, RMBC
Angela Smith	Neighbourhoods & 2010 Rotherham Ltd, RMBC
Helen Smith	Police Sergeant, South Yorkshire Police
Kim Porteous	Senior Nurse Adviser, Child Protection (PCT)
Dr Ulla Trend	RDGH – Foundation Trust
John Radford	Director of Public Health
Judith Dodd	Independent Consultant & report author

2. Summary

2.1 Mr and Mrs. Y married in 1992 and had two sons, AY aged 10 and BY aged 8 years old at the time of their parents' deaths. All family members are White British.

2.2 Mr DY had three convictions for offences involving violence between 1987 and 1994, the last occurring during his marriage. South Yorkshire Police were called to a domestic abuse incident on 20 July 2003. Children and Young People's Services

were not notified of this incident. There were no further reported incidents until June 2006.

2.3 The couple separated on 11 June 2006 following an assault on Mrs CY (and another man who tried to intervene) by Mr. DY, for which he received a verbal caution. The boys lived with their mother in the family home and Mr. DY lived nearby. He continued to have access to the family home. Mr DY assaulted Mrs CY on at least four occasions, harassed and stalked her, and made threats to harm her and to kill himself and others. Mrs. CY is reported to have commenced divorce proceedings but there are no details of any court hearings or CAFCASS (Children and Family Court Advisory and Support Service) involvement.

2.4 Domestic abuse was a consistent feature of the couple's relationship and the Police were involved on a number of occasions between 11 June 2006 and 23 September 2006, during which time the situation deteriorated rapidly as the frequency and seriousness of incidents increased.

2.5 Both AY and BY attended the same junior school where their attendance was good. Research indicates that children are at risk of suffering long-term psychological and emotional damage from domestic abuse as a result of witnessing and hearing abuse being perpetrated against a parent and experiencing the fear and anxiety of living in an environment where abuse occurs. It indicates that domestic abuse always presents a potential for significant harm.

3. Overview of Agencies' involvement

South Yorkshire Police

3.1 There was considerable Police activity in response to complaints from Mrs. CY and efforts to support her. However, on certain occasions, there were some delays and inaction in the Police response to complaints, risk assessment and alleged crimes.

3.2 Between June 2006 and September 2006, SYP had nineteen contacts with CY and/or DY, which included eleven face to face contacts, eight of which were at the family home. Mr. DY was arrested twice, cautioned on one occasion for two assaults in June 2006 and received a "first course of conduct" warning in July 2006 for harassment. Mr. DY should have been arrested and interviewed in respect of Mrs. CY's allegation of common assault in September 2006. At the time of the deaths, a harassment claim and burglary allegation remained outstanding.

3.3 When S Yorkshire Police undertake risk assessments the SPECSS model for risk assessments is used. SPECSS is an acronym for Separation and child contact issues, Pregnancy/new birth, Escalation, Community issues and isolation, Stalking and Sexual assault. The entire aforementioned are considered "heightened risk factors" within this assessment model.

3.4 There were nine risk assessments by the Police which reached judgements that the level of risk was "medium." The Review has concluded that insufficient weight was given to the risk factors which were being presented or to the seriousness of the situation. It is important that risk factors are viewed objectively and that assumption and minimisation are avoided.

3.5 Information was passed to Children & Young People's Services, with delay on occasions, and not always with sufficient clarity about the dates incidents had occurred or with fully completed risk assessments. There was no verbal communication between SYP and C&YPS at any stage. The children were not seen by Police or Social Care. The Child Protection Register was never checked as required by child protection procedures.

3.6 Police work was ongoing at the time of Mrs. CY's death. An alleged burglary of Mrs. CY's parents was assigned for further investigation. It was not classed as a domestic violence incident. The Safer Neighbourhoods Team (SNT) was also made aware of the situation in order to monitor the address as part of local policing. Also, in September 2006, an officer prepared a hand over package for the Rotherham Response Team (RRT). On the day of her death SYP responded to a report by Mrs. CY about damage to her car two days earlier. No further action was taken due to a lack of evidence.

Social Care

3.7 CYPS have records of receipt of nine faxes relating to eight incidents from SYP involving the Y family between June 2006 and September 2006 but had no active involvement with the family. None of these referrals resulted in further enquiries being made of other agencies or professionals, an initial assessment being undertaken or any contact being made with the family.

3.8 The CYPS Front Desk Service received nine communications from SYP, including a duplication of one referral in 9 August 2006. The SYP review refers to an incident in July 2006, witnessed by AY and BY, having been referred to C&YPS who state they did not receive it, although two subsequent referrals noted it.

3.9 There were delays in Social Care inputting to their client information system, and the first three referrals were inputted out of order.

3.10 The escalation of incidents and high risk indicators were sufficient to warrant a multi-agency initial assessment. That would have ensured further information being gathered and the children being seen which could have triggered child protection enquiries under section 47, Children Act 1989. Thresholds applied by C&YPS in this case were too high. Decisions appear to have been made in isolation rather than considering the recent history, and the potential cumulative effects on the children. Also, staff shortages should not have influenced decisions or prevented necessary action being taken.

3.11 The legal definition of significant harm was amended on 31 January 2005 to take account of the impact on children of domestic abuse and this needs to be embedded further in policy procedure and practice.

School

3.12 The School had the most contact with BY and AY. School had regular contact with CY and DY and had witnessed the effects of violence on CY who had raised concerns about the boys' behaviour.

3.13 School was in a good position to alert other agencies to growing concerns by calling a multi agency meeting including school nursing and CPLT and/or EWS staff, and triggering a response from Social Care. Written chronological records of contacts with the parents should have been kept.

3.14 The school referred the children to the BEST worker prior to parents' deaths. However, staff did not appear to recognise either the links between the deteriorating behaviour of AY and BY and domestic abuse or child protection concerns. They did not record relevant information, nor follow child protection procedures in relation to seeking advice and sharing information. The fact that a family appears "well off" must not lessen the significance of domestic violence in assessments of children's welfare.

PCT

3.15 Health professionals did not identify any child protection concerns, nor were any concerns brought to their attention by any other agencies.

3.16 During the school nursing assessments of BY, enquiries should have been made regarding his soiling, enuresis, speech difficulties, and growth fluctuations which can be indicators of emotional difficulties. A holistic assessment should have been undertaken, including liaison with school staff. Further consideration should have been

given to presenting issues and guidance was not followed in relation to a paediatric referral.

3.17 Mrs. CY had a total of ten GP contacts in 2004. An investigation into the possible causes of her anxieties may have linked them to her home situation and prompted further assessment.

Rotherham Community Resource Programme Trust Ltd. (Choices and Options)

3.18 Choices and Options is a voluntary organisation which supports victims of domestic abuse. The Police referred Mrs. CY to Choices and Options in August 2006. Staff at the project completed Victim and Child Risk Assessment Indicator questionnaire. This determined a high level of risk to Mrs. CY and staff offered advice and support to her. Options such as going into a refuge, rented accommodation or moving in with family were discussed and declined

3.19 In late September 2006 Mrs. CY informed the project about, and expressed her concern as to, Mr. DY's reaction to an injunction being served. The worker advised Mrs CY to seek advice from her solicitor and to call the Police if necessary. Later that same day Mrs. CY contacted the project to say she had concerns about her children.

3.20 This case has highlighted the importance of an ongoing dialogue with the Police following a referral about an ongoing matter and also referral of concerns to C&YPS.

Conclusions

South Yorkshire Police attempted to support Mrs. CY but there was a lack of co-ordinated assessment and action. The Social Care Team operated too high a threshold for involvement and the significance of the pattern of referrals was not identified by any agency. A more joined up multi-agency approach would have alerted the school, health professionals and Choices and Options, the specialist voluntary service, of escalating issues in the family and prompted collaboration to respond to Mrs. CY and her children's needs.

Local arrangements in Rotherham have been strengthened by the introduction of Multi-agency Risk Assessment Conferences in high risk domestic violence cases and the establishment of the Independent Domestic Violence Advocacy Service. They are being strengthened further by action being taken in respect of the following recommendations.

4. Recommendations

To all Members of the Board:

1. Where referrers have not received an acknowledgement of referrals within three working days, contact should be made with Social Care
2. Audits should be undertaken to evaluate the quality of practice in order to ensure appropriate standards are maintained. This should include quality assurance of all relevant documentation, case recording and assessments to ensure consistent application of thresholds and accurate analysis of presenting evidence. Consideration should be given to introducing a system of peer audits as part of this process
3. The quality and effectiveness of single agency domestic abuse training should be evaluated to ensure it is fit for purpose and addresses the impact on children of domestic abuse on children and its links with significant harm, the identification and interpretation of threat and the inappropriateness of subjective judgments.
4. Attendance for relevant staff at single and multi agency child protection training should be mandatory and systems should be established to monitor attendance and to ensure individual records are current.
5. Systems should be established to confirm that staff have received and understood relevant policies, procedures and subsequent amendments which should be monitored via supervision and appraisal processes.
6. By 30 April 2007 Rotherham Safeguarding Children Board, in conjunction with the Rotherham Domestic Violence Forum, should launch the Safeguarding Children and Young People affected by Domestic Abuse Protocol which includes the extended definition of significant harm
7. RSCB should review the content of multi agency child protection training to ensure sufficient focus is given to the impact on children of witnessing and/or hearing domestic abuse
8. RSCB should consider the role of the School Nursing Service in domestic abuse cases when revising the multi agency Child Protection Procedures

Children and Young People's Services (Social Care)

- 9 Staff should be reminded of the timescales for decision making required by the Framework for the Assessment of Children in Need and their Families and adequate resources provided to ensure compliance at all times.
- 10 Information should be recorded accurately on the client information system and all entries cross-referenced appropriately.
- 11 Contact should be made with SYP where domestic abuse reports are incomplete, inconsistent and where there is either no risk assessment or the level of risk identified does not appear to reflect the circumstances of the case.
- 12 Written contacts/referrals should be acknowledged within one working day of receipt.
- 13 In cases of domestic abuse GP's and school nurses should be contacted when initial assessments are undertaken and/or child protection procedures invoked.
- 14 Social Care Procedures and Practice Guidance should be revised to ensure they are consistent, compatible and clarify thresholds for intervention in situations of domestic abuse.

- 15 Audits should be undertaken of management decision making in relation to domestic abuse cases to ensure consistency and appropriate application of thresholds.
- 16 Enquiries should be made as to whether electronic records can be secured without subsequent modification where serious case or management reviews are being considered.

Children and Young People's Services (Education, Inclusion, Voice and Influence)

- 17 The governing body of the school concerned must ensure that all staff are trained in the application of Rotherham Child Protection Procedures in cases of domestic abuse, information sharing and appropriate record keeping.
- 18 Learning from this case should be shared with Rotherham's school community.

Health (Primary Care Trust)

- 19 Where school nurses undertaking health assessments identify concerns, the reasons for those should be explored and referrals made in accordance with practice guidance. This should include liaison with school staff to ensure holistic assessments are completed

Choices and Options

- 20 The quality of risk assessments should be evaluated to ensure that staff are able to identify child protection concerns and prioritise domestic abuse cases appropriately.
- 21 Staff must be trained in the requirements of the Rotherham Child Protection Procedures in relation to referring child protection concerns to Social Care.
- 22 Where levels of risk are deemed to be increasing in referred cases, contact should be maintained with SYP to ensure that current information is shared.

South Yorkshire Police

- 23 Where there is evidence that an offence has been committed, officers attending domestic abuse incidents must take positive steps to arrest the alleged offender within three days. If the pilot Priority Arrest Scheme (subject to positive evaluation) is adopted across all SYP force areas, it will ensure liaison takes place with the Duty Inspector for action to be taken when that timescale is not achieved.
- 24 Officers attending domestic abuse situations should verify information in relation to the whereabouts of children and Child Protection Register checks should be undertaken in accordance with Child Protection Procedures.
- 25 Officers attending domestic abuse incidents should complete all risk indicators to ensure the level of risk reflects the evidence being presented and should indicate in writing whether children have been seen.
- 26 Supervisors should complete domestic abuse risk assessments within 24 hours of an incident and should ensure the identified risk is based on current information, facts and intelligence.
- 27 Domestic abuse risk assessments should be sent to Social Care agencies within one working day of an incident occurring with a clear indication of the action expected.

- 28 Referrals to other agencies (including Choices and Options) should include all relevant information to ensure that priority is given to high risk cases.

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