CHILD D
SERIOUS CASE REVIEW
AND
DOMESTIC HOMICIDE REVIEW

Report into the death of

Child D aged 17

Died February 2016

Independent Reviewers: Sian Griffiths & Deborah Jeremiah

November 2017

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1. INTRODUCTION

1.1 The circumstances that led to undertaking this Joint Review

1.1.1 This Review was commissioned jointly by the Bristol Safeguarding Children Board and the Safer Bristol Partnership, following the death of a 17 year old boy, Child D, in February 2016. Child D died after being stabbed by his half-brother, who subsequently pleaded guilty to Child D's murder and was sentenced to life imprisonment in October 2016.

1.1.2 The Bristol Safeguarding Children Board's Serious Case Review Sub Group concluded that the case met the criteria for a Serious Case Review (SCR), as outlined in Working Together to Safeguard Children 2015[1], in that Child D was a child at the time of his death and there was information that:

> *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.*

1.1.3 The Safer Bristol Partnership also identified that the circumstances of Child D's death met the criteria for undertaking a Domestic Homicide Review (DHR) under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004. A DHR is:

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) by a person to whom he was related and who was a member of the same household.
(b) A member of the same household as himself,

With a view to identifying the lessons to be learnt from the death[2]

1.1.4 The Review takes as its starting point the government definition of domestic abuse as follows:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*
>
> - *Psychological*
> - *Physical*
> - *Sexual*
> - *Financial*
> - *Emotional*

[1] Working Together: HM Govt March 2015
[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews: Home Office (December 2016:5)

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, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim

1.1.5 A decision was made by the Chairs of the Bristol Safeguarding Board and the Safer Bristol Partnership to convene one Review combining the requirements of both a Domestic Homicide Review and a Serious Case Review. Advice was sought from the Home Office as to the methodology that would be used given the joint nature of this report and the approach to be adopted was subsequently agreed by the Home Office by e-mail on 5th December 2016.

1.2 Purpose of the Review and Methodology

1.2.1. The key purpose in undertaking this joint SCR and DHR is to ensure that learning can be identified following the death of this individual child[3]. Most importantly the purpose is to ensure the Review achieves the fullest understanding possible both of what happened but also why, in order to identify improvements and contribute to the prevention of future similar tragedies.

1.2.2. The methodology and format required of Serious Case Reviews and Domestic Homicide Reviews are different in some ways. This combined Review has been structured so as to balance the requirements of both. In particular the methodology was underpinned by a systems approach and unusually for a DHR did not include the use of Individual Management Reviews for each agency. The methodology and processes adopted are described in more detail in Appendix A of this report.

1.2.3. This Review examines the responses of all the relevant agencies that had contact with Child D and his family and considers whether there were gaps in services or wider learning about domestic abuse and the safeguarding of children. The main timeframe for the Review was identified as beginning with the first recorded incident which indicated the possibility of conflict or domestic abuse within the family and ending at the point of Child D's death, that is:

April 2013 – February 2016

1.2.4. This timeframe was identified as it was agreed it represented the period that would provide the greatest learning. Nevertheless, where there was significant relevant information prior to this point, which could improve our understanding of the family's experience, particularly in relation to any history of violence within the home, this was requested and has been included in the report.

[3] The word 'child' is used in this Review to refer to Child D in order to clearly identify his legal status and the resulting duties of agencies to protect him. It is recognised that as a 16 year old, this is not how Child D may have described himself and should not be taken as a wider comment on his maturity.

1.2.5. The full Terms of Reference are to be found in Appendix A. In particular these include three specific areas for focus within the Review

A: What does this case tell us about the multi-agency response to domestic abuse in families in situations when this is not intimate partner abuse?

- Are agencies equipped to recognise potential adolescent to sibling or parent abuse and is the professional response effective?
- How well do agencies recognise whole family working and the risks and needs of different family members, where there is domestic abuse taking place?
- How effective is the interface between the frameworks for children's safeguarding and domestic abuse services?

B: What does this case tell us about the effectiveness of safeguarding in relation to older children?

- For safeguarding children does the age of the child impact on the response of agencies?
- How do professionals balance the older child's need for autonomy with the duty to safeguard a child?

C: What does this case tell us about the system's response to families where there are multiple needs and potential risks, which individually are not assessed as meeting threshold criteria?

- How can professionals' best gain an accurate understanding of a family who may be demonstrating multiple risk factors, e.g. early sexual activity of a child; drug and alcohol abuse, criminal activity. What role does community intelligence properly play in gaining this understanding?
- How effective is the single and multi-agency early intervention for families with multiple risks?
- Are the risks associated with young people using or carrying knives fully understood by all agencies?
- How do agencies understand the significance of non-resident fathers in the lives of young people and what is the impact for young people.
- How can professionals work with families who do not engage?

1.2.6. In line with the expectations both of the SCR and the DHR, full consideration was given to the involvement and potential contribution of key family members and friends, including Brother D, within this review. With the exception of Child D's father, none of those contacted wished to be involved in this Review. The steps taken to seek their involvement are outlined in more detail in Appendix A.

1.2.7. Both of Child D's parents were asked their views as to choosing a pseudonym for Child D and other family members. Child D's mother initially said that she would wish to choose a name, but ultimately decided that she did not want to

use alternative names but preferred the style that has been adopted in this report. The Review considered it proper to follow the Mother's wishes in this regard.

Individual	Anonymisation	Age at February 2016	Race (as identified in service records)
Subject of Review	**Child D**	**17 years old**	Dual Heritage: Black Caribbean and White
Half Brother of Subject [4]	Brother D	19 years old	Dual Heritage: Black Caribbean and White
Half Brother of Subject	Brother D2	Adult (not in living household)	Information not available
Half Sister of Subject	Older Sister	Adult (not in living household)	Information not available
Half Sister of Child D	Younger Sister	4years old	White British
Mother of above	Mother	Adult	White British
Father of Child D	Father of Child D	Adult	Black Caribbean
Father of Brother D	Father of Brother D	Adult	Black Caribbean

2. THE CIRCUMSTANCES OF CHILD D'S DEATH

2.1. 17 year old Child D lived in Bristol with his mother, his 19 year old brother, Brother D, and his 4 year old Younger Sister. The family lived in settled accommodation and were established in their community. Prior to his death Child D had made plans with his local college to re-enrol in September to undertake a course he had previously been unable to complete. His girlfriend was expecting their child.

2.2. One night in February 2016 both Child D and Brother D had been out at clubs and bars in the city with their friends and had also spent time with Brother D's father. They had both consumed significant amounts of alcohol as well as illegal drugs. The two brothers returned separately to their home early in the morning, Child D accompanied by one of his friends. Child D arrived home first and became involved in a verbal argument with his mother who was angry that he had driven home in her car.

2.3. Shortly afterwards Brother D returned and a fight started upstairs between the two brothers. The fight continued onto the stairs during which time Brother D

[4] Child D, Younger Sister and Brother D were half siblings, but will be referred to as brother and sister during the report reflecting their family situation as it was lived.

stabbed Child D a number of times. Brother D then left the house. The Mother immediately called 999 and both police and ambulance attended. The police and subsequently paramedics undertook CPR at the scene, and Child D was then taken by ambulance to hospital. However shortly after arriving at hospital he was declared dead. The Post Mortem identified that several of the stab wounds were comparatively superficial but one wound to his chest was more serious and was the cause of Child D's death.

2.4. Brother D subsequently handed himself in to the police and was charged with murder. He pleaded guilty at Crown Court and was sentenced to Life Imprisonment with a minimum tariff of 11 years and 3 months.

2.5. Information was provided to the Review by a number of different professionals with knowledge of the family's local community that there was an 'outpouring of grief' following Child D's death. The local Youth Club was opened specifically following his death and there was a collection for the family. A 'big parade' took place in his memory and his funeral was attended by a very large number of friends and family.

3. CHRONOLOGY OF KEY EVENTS

Full chronologies were provided by all the agencies[5] known to be involved with the family. The resulting combined chronology was considered in detail within the Review and the relevant information is summarised here.

The information available to this Review is almost totally reliant on the records of the various agencies who were involved at different times with the family. Inevitably this means that the picture provided will be an incomplete one and cannot effectively describe Child D's experience from his perspective.

3.1 Summary of what is known about the family history and circumstances.

3.1.1. Child D had lived all his life in Bristol, the family having moved to their current address some years earlier. Child D's father lived separately from the family and had occasional contact with his son. The wider family included 2 older siblings (Brother D2 and Older Sister) who had previously left home, Brother D's father, who it is understood had limited routine contact with Child D, and also Brother D's wider paternal family. The level of involvement of the older siblings with the family is not known. It is understood that the Mother had been the main or sole carer for her children, with some contact but no regular involvement from the fathers of her children. Her brother was a regular visitor to the home and appeared to have a good relationship with Child D. There is very little information as to whether the Mother had employment outside of the home but it is known that she was reliant on benefits for much, if not all, of the time.

3.1.2. The Mother is recorded as being White British. Child D and his brother are both recorded as Black Caribbean and White. There is no information that

[5] The agencies concerned are listed in Appendix A

identifies faith as a significant feature in the family. There is also no information to suggest that any of the family members had any disabilities. Whilst there is evidence to suggest that the family were settled in their locality, in the absence of their own perspective the Review has little information about how either the mother or the boys experienced their world, family and community. One of the few insights is that the Mother was described by some as quite protective about the two boys and told staff at the college that she thought Brother D in particular was picked on, some of which she believed was due to racism.

3.1.3. Child D's Mother had herself been in the care system as a child and later had a history of involvement with drugs and possibly drug dealing, and was therefore known to the police. Following Child D's death it was discovered that cannabis had been grown in the house which, irrespective of who initiated this, could not have been without the knowledge of the Mother. The level and seriousness of the Mother's personal drug use is not properly understood, but it did not appear to have had a debilitating effect on her daily life.

3.1.4. Both Child D and Brother D had problematic school attendance, with Child D having a number of changes of school and for a period of a few months being described as home educated. In 2011 Brother D was excluded from school and received support from the Local Authority for his learning at home. They also both had some involvement with the criminal justice system as young teenagers. Throughout their childhoods there was a repeating pattern of not responding to appointments or letters with health services and on one occasion the Mother discharged 20 month old Child D against medical advice after he had been admitted for possible meningitis. In 2000 the family were noted by the GP surgery as a '*family of concern'*, which is an internal note that is kept on the GP System. The GP believes that this was triggered by the concern about health appointments being missed.

3.1.5. There is some information to suggest that the relationship between Child D and Brother D was not always easy. The Review has had a consistently positive picture of Child D from those professionals and other individuals who had contact with him. He has been described as '*a lovely, pleasant lad, very polite*' '*easy going and not one to get into fights'*. There were more expressed concerns about Brother D, particularly in relation to his use of violence. One of the professionals described him as a bright boy, who was very stern, unwilling to open up and who could be '*quite intimidating'.* The Mother is recorded as being friendly and pleasant, she had previous experience of social work, and came across as considered and helpful when she spoke to professionals. The Mother also had a history of depression and previous experience of domestic abuse. Information from the GP was that she used cannabis to help her sleep and when she was low in mood and there is some suggestion that she also used other prescription drugs.

3.1.6. Very little is known about the Younger Sister. Younger Sister was a premature baby, as a result of which she was under the neonatal team to monitor her development. Health professionals recorded concerns from the outset about her not being brought in promptly for checks ups and immunisations, as well as health visitors being unable to see her. The

housing provider had not been told when Younger Sister became a member of the household and they remained unaware of this until after Child D's death.

3.1.7. The significant key events known to agencies prior to the main timescale identified for this Review are as follows:

DATE	BRIEF SUMMARY OF EVENT
June 2001	2 year old Child D attends A&E with fractures to fingers.
June 2002	3 year old Child D attends A&E with injury to lower body.
July 2003	Referral to Children's Social Care (CSC) by Mother, allegation that an 11 year old had assaulted 5 year old Child D. Initial Assessment. Case closed September 2003.
March 2004	5 year old Child D attends A&E with burn to arm from inhaler caused by brother.
June 2006	9 year old Child D seen by GP with 'superficial' injury to face.
October 2010	12 year old Child D seen by GP with minor head injury having been punched in the face – not known by whom. Referred by school nurse.
June 2011	12 year old Child D seen by GP with mother who asked for him to be given an STI test. Information sought but not given re partner. Test negative. Referral made to CSC. Advice given by CSC, no further action
March 2011	Brother D receives 6 month Referral Order for Burglary of a dwelling
October 2011	Child D charged with Affray. Sentenced in November 2012 to 12 month Youth Rehabilitation Order
Feb 2012	Brother D receives Youth Rehabilitation Order for robbery/criminal damage
April 2012	Child D receives a Referral order for Handling Stolen Goods. Completed August 2012
April 2012	Education Welfare planning to take action re non-school attendance
August 2012	Child D receives Conditional Discharge for Possession Class B Drugs
January 2013	Brother D's Youth Rehabilitation Order revoked, replaced with Attendance Centre Order.

3.2 The significant events and involvement of agencies for the main period under review (April 2013-February 2016)

3.2.1. In April 2013 Child D was living at home and attending school. Information about Brother D at this time is limited, although there a record to say that he did have periods of time being educated at home following the exclusion in 2011 and also received individual support from the Local Authority with his learning.

3.2.2. The first significant event was an argument between the two brothers and their Mother in early April 2013 which led to the Mother calling the police.

Police Officers attended the house, but did not identify any offences and subsequently sent a Domestic Incident notification to Children's Social Care (CSC). The Police safeguarding unit also made a referral to the Victims Advocate Unit as had been requested by the Mother. However, there was no record that the Victims Unit did in fact call the Mother or that this was followed up either by the Mother or by any professional concerned. It was noted in the CSC Records that this was a domestic incident and there was recognition that the perpetrator, Brother D was a child. CSC concluded that no further action was required as the incident did not meet the threshold for involvement. The Mother was considered to have acted appropriately and had received advice about seeking support from the police.

3.2.3. The Police received an anonymous call on a second occasion in the early hours of the morning in April 2013 reporting that there was fighting and shouting at the house. Police attended and both Brother D and their older brother (Brother D2) were present, as was the Mother, but it is not recorded which other family members were in the house. There had been an argument but none of those present were willing to speak about what had happened. The Police gave words of advice and this was recorded as Anti-Social Behaviour.

3.2.4. The following month an abandoned 999 call was made to the Police who went to the address provided and found that a 15 year old boy, who was drunk, was in charge of his own 9 year old brother as well as 2 year old Younger Sister. Nearly an hour later the boy's parents and Child D's Mother returned to the house, which was the home of the boy's parents. A referral was made by the Police to CSC as a result. Child D's mother acknowledged that she should not have left Younger Sister with the 15 year old, but stated that they had only left because of an emergency in relation to other family members and the boy had not been drunk when the adults went out. The Mother told CSC that there had been social work involvement with her two older children, but there was no information about this on the computerised records. CSC concluded that given the Mother had acknowledged their concerns and as there had been no referrals for the family since the records were computerised there was no need for further action.

3.2.5. Child D had been subject to a Youth Rehabilitation Order since November 2012 as a result of an offence of affray. In August 2013 his Mother spoke to his YOT worker about Child D having recently disclosed another occasion when he had been subject to an assault as a young child which was causing him flashbacks. She was concerned about this and wanted to access some support for Child D. The YOT worker made a referral to CSC and a Strategy Discussion involving Children's Services and the Police took place. The conclusion was that no further action would be taken as Child D did not want the issue pursued. Child D also spoke to his GP about the assault and told the GP about the Police involvement. Although Child D was distressed, no referral for counselling or other support was made by the GP. It was suggested that he return to see the GP again in a few weeks, but did not do so and there was no follow up by the surgery. Neither is there evidence of any contact between CSC and the GP. Child D told his YOT worker that he did not want any support.

3.2.6. In September 2013 Brother D enrolled at South Gloucestershire and Stroud College.

3.2.7. In October 2013 a further referral was made by the Police to Children's Social Care, as a result of information that both the brothers were regularly using drugs, possibly in the presence of 2 year old Younger Sister. The Police subsequently also provided information that the brothers had been in a fight with each other and both attended hospital. Information from the A&E department of the local hospital was that Brother D had attended with a cut mouth following an alleged assault, although it is not clear if this related to the same incident. Further enquiries were made and subsequently due to the Police's '*significant concern*' about drug use and difficulties in making contact with the Mother, CSC decided that an Initial Assessment should be undertaken.

3.2.8. Enquiries for the Initial Assessment began in early November 2013 and were underway when 2 further referrals were made. The first was by a neighbour who reported that 2 year old Younger Sister had been seen walking alone in the street without a coat or shoes. The second referral was from the YOT team less than a week later informing CSC that Brother D had been remanded in custody following an alleged offence of Wounding with Intent[6] in which he was said to have stabbed someone at a party. Because of his age (17 years old), this meant that Brother D was now classed as a Looked After Child[7]. A Looked After Child Plan was initiated, but Brother D was bailed and returned home three days later. The Looked After Child Plan was not completed and there is no evidence that Brother D was seen by social work staff. Brother D was suspended from his college course due to the potential risk to other students given the nature of the charge against him.

3.2.9. The Initial Assessment was completed in December 2013 taking into account all three referrals. Brother D had been looking after Younger Sister when she was found walking alone in the street having got out of the house because the back door had been open. It was accepted that both Brother D and his Mother used cannabis recreationally, with the Mother stating that she would have one or two joints an evening which she said was never in Younger Sister's presence. She also said that Younger Sister shared a bed with her, which was the approach she had taken with all her children and which she was unwilling to change. The assessment's conclusion was that there were no significant concerns about the children or their mother's parenting capacity other than that Brother D should not be left in sole care of Younger Sister. A 'Partnership Agreement' was put in place, signed by Brother D and his Mother and this information shared with the Health Visitor. The agreement was as follows: "*Brother D is not to have sole care of Younger Sister at any point, including if (mother) just 'pops to the shops'".* The case in relation to all three children was then closed.

[6] Wounding/causing grievous bodily harm with intent, contrary to section 18 Offences Against the Person Act 1861

[7] All children who are remanded into custody become 'Looked After' by the Local Authority under Legal Aid Sentencing and Punishment of Offenders Act 2012.

3.2.10. The Social Worker had spoken to the Health Visitor during the Initial Assessment. The Health Visitor had no specific worries about Younger Sister's health or development but had not seen the family much during the year and recent appointments had not been kept. The Health Visitor was told by the Social Worker about the Mother's use of drugs and linked dangers of co-sleeping with Younger Sister and the Health Visitor agreed she would attempt to visit again and discuss this with her. On 11th December 2013 the Health Visitor contacted the Social Worker asking her to visit. She was informed that CSC had no concerns and that the case was about to be closed after a final visit.

3.2.11. At the end of December 2013 there was a further referral from the Police after an anonymous complaint about a party at the family home. It was said that people were under the influence of drugs and alcohol and that Younger Sister was present into the early hours of the morning. The referral was considered by CSC in relation to Child D and Younger Sister, although there was no apparent consideration of any impact on Brother D. No further action was considered necessary.

3.2.12. The Health Visitor recorded concerns about Younger Sister not being taken to her neo-natal team appointments. She discussed this in Child Protection Supervision and it was agreed that she should liaise with the Social Worker. The Health Visitor called the Social Worker concerned asking what the situation was in the home, particularly in relation to Brother D. The Social Worker said she would make enquiries and get back to her, but did not do so.

3.2.13. During the first 3 months of 2014 the Mother presented to health professionals on three occasions with injuries, or what might have been symptoms of injuries. She was seen first by paramedics following a 999 call in relation to having had 'bangs on the head', on another occasion at A&E with pain in her wrist and thirdly with an accidental scald to her wrist. In April 2014 she reported to the housing department that Child D had been assaulted, although there is no record as to who had assaulted him, and that there had been threats made towards her from someone in prison. However, she did not follow up these concerns and later could not recall some of the information she had given. There were other occasions across the three year period when the Mother attended, predominantly the A&E department, as a result of minor accidents.

3.2.14. In early summer of 2014 the Health Visitor again recorded that Younger Sister had missed her neonatal team appointments. She made several attempts to contact the Mother both by telephone and home visits without success, as well as contacting CSC to see if they were aware of the family situation, including that Brother D was still living in the home. The Health Visitor specifically asked for any information about safeguarding concerns or risks. CSC wrote back to say that they had no new information about the family but that the Partnership Agreement remained in place. Then in August the Health Visitor contacted the CSC First Response team, but was told that her concerns would not meet their threshold for involvement. The Health Visitor continued to attempt to make contact with the Mother and Younger

Sister and again in October 2014 discussed the case with her Child Protection supervisor. In November 2014 the Health Visitor again contacted the First Response team, with no outcome and finally wrote to the GP outlining the lack of contact since December 2013 and the involvement of CSC. CSC found no records of this contact from the Health Visitor but all contacts are well documented in the health visiting records.

3.2.15. Brother D re-enrolled at College in September 2014, but his attendance that year was very poor and when he reapplied to enrol in July 2015 his application was declined.

3.2.16. In February 2015 the Mother contacted the Housing Provider asking for a transfer following alleged threats to her and Child D from someone in prison as well as an incident when the Police were called when two boys were said to have kicked her door. The Housing Provider undertook a risk assessment and agreed an action plan with the Mother. However, she did not ultimately pursue the application which was therefore eventually cancelled.

3.2.17. The next significant event took place in May 2015 when Brother D was given an Adult Caution after an unprovoked attack in which he had punched a man in the face. A few days later Brother D himself attended A&E with a broken nose which he said had happened when he had tried to split up a fight.

3.2.18. During 2015 the Mother also sought help from her GP as a result of depression and was prescribed anti-depressants and advised to consider counselling, but did not take up this option.

3.2.19. In June 2015 the Mother called Police to the house when a verbal argument with Brother D escalated and she became worried he would cause damage to the house. There were no offences disclosed, but the Mother was given information about the support available from Lighthouse[8] who contacted her the following day, but she declined their offer to refer her to Domestic Abuse support services. The Mother had also declined to take part in a DASH (Domestic Abuse) risk assessment, although this would not have prevented the Police completing one without her direct input. A routine referral was sent by the Police to CSC and the Health Safeguarding Children Team, but it was not considered to meet the threshold for joint intervention between Police and CSC. The information provided was reviewed by CSC, but no further enquiries made and no further action taken given the information provided to them. In August the Police were also alerted when Child D was found with a facial injury which was suspected to have been the result of an assault. Child D would not confirm what had happened and no further action was therefore taken.

3.2.20. In August 2015 Brother D had an operation for an open fracture on his hand.

3.2.21. Later in August 2015 another significant event took place in the home. The Police were again called to the house during the night, on this occasion by Child D. When the Police arrived Brother D and his mother were initially

[8] Lighthouse is a commissioned witness and victim support service working within Avon and Somerset Constabulary.

found motionless on the kitchen floor, both of them with some visible injuries. Child D also had what was described as a severe cut to his arm, which he said had been caused by Brother D when he had tried to stop him taking his Mother's car. The Mother was described as intoxicated, but Brother D less so. Child D and Brother D then began arguing, with Child D telling his brother that '*he was an idiot to himself, but he cared about him and didn't want him to ruin his life by doing something stupid*'. Child D was described by attending officers as frustrated with his brother rather than angry with him. Brother D was arrested, but not ultimately charged as neither Child D nor the Mother was willing to make a complaint. During the incident, Child D was seen by one of the officers to be attempting to wash two knives in a child's paddling pool in the back garden. The knives were taken as potential evidence.

3.2.22. An emergency ambulance also attended and paramedics treated the Mother and Child D at the scene. A referral was made by the Police to the CSC First Response team and the Health Safeguarding Children Team. The Mother stated that she did not want Brother D to return to the address and it was said that he would go to stay with his Older Sister. The Police view was that the Mother would probably allow him home and that '*nobody appears to be in fear of him*'. A DASH (domestic abuse risk assessment) form could not be fully completed for Child D who refused to co-operate with the assessment. The Police Officer therefore recorded this as a standard risk and stated that it was believed the incident was '*drug and alcohol fuelled'*. The Custody Sergeant and Inspector made the decision that this would not reach the CPS threshold for charging. Consideration was also given to the making of a Domestic Violence Protection Notice, the purpose of which is to prevent the perpetrator returning to the address. However, this was not pursued and the incident itself was mistakenly classified as an abduction offence, not domestic violence. Despite this Child D was offered support by Lighthouse, but he did not wish to take this up.

3.2.23. It is uncertain whether Younger Sister was at home at the time of the incident, as the attending Police Officers had not been told, and had not considered the possibility that there might be any other children in the house. With hindsight the officer who was dealing with Child D and the Mother reflected that this was a mistake, but at the time no one had said another child lived in the house and the Police's focus was on dealing with a potentially violent situation. On receipt of the referral, CSC made inquiries with the nursery attended by Younger Sister and were informed that she presented as a bright, happy child who had a good bond with her mother. She was about to start at the local infant school. The CSC records state that Younger Sister had not witnessed the incident as she was staying with Older Sister, information which they were given by Mother a week after the event. As Younger Sister was said not to have been present and because Mother had said that Brother D would not be welcome back in the house, CSC concluded there should be no further action. Information about previous contacts and referrals was also obtained and concerns about Brother D's violence and use of knives, drug and alcohol in the house, non-engagement with the Health Visitor for Younger Sister and concerns over the Mother's supervision of each of the children when younger were all noted.

3.2.24. The Social Worker also had a telephone conversation with the Mother who '*presented as concerned, appropriate and knowledgeable about the risks to her younger children around Brother D'.* On the basis that the Mother was believed to be acting in a protective manner; that Younger Sister was said not to be in the house at the time of the incident; that the mother had called the Police and that Brother D was said to be no longer welcome in the family home, it was decided that there would be no further action.

3.2.25. In September 2015 Child D enrolled at college on a bricklaying course, having previously undertaken an apprenticeship. The college concerned was the same one which Brother D had previously attended, but it was not known to the college that the two boys were related. However, Child D's attendance was poor from the outset and in October 2015 he was withdrawn from the course. Despite this, when Child D attended college unannounced at the end of November asking to see the Team Leader, he was given both time and advice by the team leader. Child D explained that his girlfriend was pregnant and there had been a lot going on at home. The Team Leader offered him a careers interview and gave him the option to return in March 2016 in order to begin the process of enrolment for September.

3.2.26. In November the Mother had a GP review in relation to depression and was restarted on anti-depressants which she had previously stopped taking.

3.2.27. In the early hours of the morning during February 2016 the police were called to attend the house where Child D had been stabbed several times by Brother D following an argument. The Police and then paramedics conducted CPR and Child D was taken to hospital. However, shortly afterwards Child D was pronounced dead. Brother D was subsequently arrested and charged with his murder.

4. CONTRIBUTION OF CHILD D'S FAMILY AND FRIENDS

As has already been noted, the entirely legitimate decision of all but one of the family and friends of Child D not to meet or contribute their experience to this Review means that our understanding of what was, or was not, happening within the household is significantly limited.

4.1. **Child D's Mother** was at the beginning unwilling to contribute to this Review. However, she spoke to the author by phone on more than one occasion and also gave her permission for Brother D's Probation Officer to talk to the author after they had spoken regarding the Review.

4.2. Before this report was completed, Child D's Mother spoke again to the author and maintained occasional contact over a period of weeks, but ultimately decided that she did not want to meet or take an active part in the Review at that time. The Mother felt that it would be impossible to describe Child D and his 17 years of life in a way that would do him justice and that it was better to keep her memories of her son private. She did however speak to the author about her love and support for both her sons. Her grief at the loss of Child D and distress about Brother D's actions and the consequences

for all concerned was very clear. Child D's mother is fierce in her support of Brother D, but equally fully accepts the justice of his sentence. She said that mostly the two boys were good friends, despite the previous incidents, but she was also critical of some of Child D's behaviour towards his brother. She described Child D as someone who was not at all an aggressive person, but that Brother D had a temper. She had worried that something could happen but never wanted Brother D to be prosecuted as '*it was family and you don't do that*'.

4.3. Although the Mother did not wish to meet in person, she did share with the author her feelings about the way that agencies respond to domestic abuse when this does not involve a relationship between two adults. She did not identify any other support services that she felt would have been useful to her. Her thoughts are included in Section 5 of this report.

4.4. Prior to publication of the report contact was again made with the Mother who agreed that she would like to meet to learn about what was in the report. The author and the Board Manager therefore visited her at her home where she was joined by a friend. The report was shared with the Mother and her friend, and the author identified particular aspects of the report and the recommendations that seemed to be of most significance. The Mother was given the opportunity to read the report in full on another occasion, but decided not to take this up.

4.5. During this meeting, the Mother spoke again of her view that the Police should have responded to violence in the home in the same way that they would have done if it had been violence from one adult to another. She talked about how impossible it felt for her to make a statement against her own son and her belief that if the Police had taken more decisive action with Brother D earlier on it could have made a real difference. The Mother also agreed with the thinking behind the recommendations in the report. Other comments and views from the Mother are included within the analysis section.

4.6. **Child D's Father**, who also lives in Bristol, met with the two independent reviewers and his willingness to share his thoughts about his son and what had happened is much appreciated. He explained that he did not see his son regularly, but that Child D would call in to see him and he would sometimes also go round to the family home. Child D's Father spoke with warmth about his son, describing him as '*a humble youth'* who made him proud *'as he had been through a lot and was trying to put effort into his life to be a better person'.* He felt that Child D had *'get up and go'* and had hoped that he would do well in his life. Child D's Father did not have any concerns about Child D using '*heavy'* drugs. He was aware Child D sometimes smoked cannabis, but had no reason to be worried about anything more serious.

4.7. Child D's Father found it very hard to understand how one brother could have killed the other and it was apparent that he felt a strong need for some answers. He described visiting the home a few months before Child D's death when the boys had a group of friends around. Brother D had invited

him to stay; something that he felt was a thoughtful gesture and also seemed to suggest Brother D might see himself as the '*man of the house'*. Child D's Father and Brother D's Father know each other well, and this was one of the reasons that he believes Brother D accepted him in the family. He said that Brother D's Father was also fond of Child D. Child D's Father believed that when the boys were growing up Brother D had tended to be the more dominant character and had bullied Child D to some extent, but he had got the impression that Child D had become more assertive with his brother as he had grown older, so that this was not such a problem. Child D's Father did not know that there had been previous incidents of violence from Brother D to Child D and would have wanted to tackle this with him had he known. He asked that why Brother D had been allowed to go back into the family home if he had previously injured Child D with a knife.

4.8. Child D's Father met with one of the lead reviewers and the Safeguarding Board Manager to read the report and offer any contributions prior to it being finalised. He was satisfied with the report, only raising the issue of not anonymising those involved, but accepted that this would not be possible.

4.9. **Brother D.** Contact was made with Brother D via the Probation Service and prison staff to explain to him that the Review was taking place and to see if he would be willing to contribute. Although he did not rule out the possibility initially, he ultimately decided that he did not wish to do so. He did not wish to take up the opportunity to read the report prior to publication.

5. ANALYSIS AND APPRAISAL OF AGENCIES' PRACTICE

This analysis will be organised to identify the learning under the structure of the three overarching identified Terms of Reference specific to this report. Inevitably there will be a cross over between some of the issues within the Terms of Reference. Therefore, where an incident or issue has been analysed under one section, this will not be repeated in later sections of the analysis.

5.1. What this case tells us about the multi-agency response to domestic abuse in families in situations when this is not intimate partner abuse.

5.1.1. The Terms of Reference of this Review specifically direct us to consider the significance and potential for learning in relation to non-intimate partner abuse. Legislation, statutory guidance and definitions of domestic abuse recognise that it does not only take place in intimate partner relationships, but can also be a feature of other family relationships. Research tells us that the majority of domestic homicides do involve intimate partner relationships[9], but that a smaller number include other family members. The circumstances of Child D's death, as well as information identifying previous incidents in the home, raise the possibility of domestic abuse and as such this is one of the key features of the Terms of Reference for this review.

[9] Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. (2016:7)

5.1.2. Nevertheless, despite the tragic outcome, we do not have a firm understanding as to whether domestic abuse, as it is generally recognised, was indeed a feature in Child D's home life. There is clear evidence that violent incidents and arguments took place and Child D's mother recognised this as presenting a future risk. The Mother talked from her own experience about the professional response to domestic abuse by a partner. She was critical that violence in the home when it was from a child was not approached as seriously. However, in the absence of a more detailed discussion it is not clear exactly how she might have defined what was happening in the home at this time. As a result, even with the advantage of hindsight it is difficult to identify a trail of events that would lead us, with confidence, to assert that domestic abuse was what was taking place within the family. This is not to suggest that there was not a potentially dangerous situation in the home or that domestic abuse was definitively not an issue. Alternatively, what was taking place in the home may have been a reflection of what is identified by Smith et al[10] in their recent work on Domestic Homicide:

> *"We want to differentiate between domestic arguing, which may or may not include violence, and domestic abuse, which is achieved through control through fear".*

It is therefore important to acknowledge that whilst this violence and what lay behind it may be an indicator of domestic abuse, there is also information to suggest that it could have been of a different nature, although no less concerning. The difference between the two forms of violence is significant in the way in which support, help and risk management are best achieved.

5.1.3. Our predominant understanding of domestic abuse, as reflected in statutory guidance and much of the research, is in relation to '*intimate partner violence'*. What guidance and information there is regarding '*non-intimate partner'* Domestic Abuse from other family members is almost entirely in relation to violence from an adolescent to a parent. There is currently no legal definition of adolescent to parent violence[11] and the knowledge base is at a comparatively an early stage, although one definition has been identified as helpful in the European research[12]:

> *''...any harmful act by a child intended to gain power and control over a parent. The abuse can be physical, psychological or financial"*

An additional definition refers to such violence having the following impact on the family:

> "*threatened, intimidated or controlled by it and if they believe that they must adjust their own behaviour to accommodate threats or anticipation of violence"*[13]

[10] Smith, Willams and Mullane (2014:3)
[11] Home Office (2015:3)
[12] Cottrell (2001) quoted in RCPV website.
[13] Paterson (2002) quoted in RCPV website

Both definitions clearly reflect the expectation that coercion or control will be a part of the abuse. There is no statutory guidance, national policy or procedures and very limited information relating to domestic abuse by other family members, such as siblings.

5.1.4. Prior to the incident which led to Child D's death the Police were called on 4 separate occasions following disturbances at the house. On two of these occasions Child D's Mother called the Police following an argument, once between herself and Brother D, the other time between herself and the two brothers; but there was no physical violence or injury either time. On the first occasion the Mother was unwilling to take part in a DASH assessment. Why it was not completed by the Police without her involvement is not known, but this will be explored further in relation to the August 2015 incident. On both occasions the Police sent a routine domestic abuse notification to CSC in line with standard procedure whenever the Police are called to a house in relation to a domestic dispute and a child is present. Significant numbers of such domestic abuse notifications are forwarded to Children's Social Care (CSC), with recent figures showing that these average around 500 notifications forwarded each month. In this context they do not routinely trigger action in the absence of other issues of concern. That the perpetrator was a child was noted on one occasion, but this did not lead to any direct action by CSC.

5.1.5. Also on each occasion a referral was made to the relevant victim support provider, but this was never taken up by anyone in the family. The Mother had no memory of being offered such support. On the third occasion a neighbour called the police and it appeared that 16-year-old Brother D and his older brother (Brother D2), who did not live in the house, may have been fighting. The argument between the two was recorded as Anti-social behaviour. There is also a reference by the Police in October 2013 to a fight between the brothers leading to them attending hospital but it is unclear if this was a further incident.

5.1.6. **August 2015 incident:** The first three incidents took place over a two year period and were of a low risk nature, with no actual injuries recorded, so in themselves would not routinely be expected to trigger particular concern. However, the incident that the Police attended in August 2015 was considerably more serious, in that Child D had been slashed on the arm with a knife, as a result of which Brother D was arrested for assaulting him. As with all the previous occasions the family did not want any action to be taken and Brother D was not ultimately charged.

5.1.7. It is expected practice that Police should actively attempt to build a case to meet the thresholds for charging[14] in cases of domestic violence even if the victim is not willing to make a statement. However, the Custody Inspector concluded that there was inadequate evidence either to meet the threshold for charging Brother D or for consideration of a Domestic Violence Prevention Order.

[14] CPS (2014)

5.1.8. Having concluded that no charge was possible, and without the benefit of a fully completed DASH form, the attending Police Officer recorded this incident as a 'standard' risk. The DASH Form is the tool by which professionals, including the Police, identify the level of risk to a victim, which in turn impacts on the response of agencies. The risk management framework of the DASH is based on there being three levels of risk to the victim:

> Standard – current evidence does not indicate likelihood of causing serious harm.
>
> Medium – There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances.
>
> High – There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be risk of serious harm.

The risk assessment is achieved by asking a series of closed questions requiring a yes or no answer, although there is also space to record the victim's response. If the number of 'yes' answers reaches a total of 16 or more the case will automatically be referred to MARAC, if a total of 14 it is discussed in a pre-MARAC meeting which decides if it should be subject to a full MARAC. However, where the points threshold is not met, but a professional is sufficiently concerned about the level of risk, they can nevertheless refer this directly to the MARAC. It is a fundamental part of training for DASH assessment and is explicitly recognised in Bristol's MARAC Operating protocol that the DASH form is a risk assessment checklist, not a full Risk Assessment Form and that professional judgement in completing it is crucial.

5.1.9. What has become clear is that the DASH form, which is designed for use with intimate partner violence, was not fit for purpose in assessing risk in relation to sibling to sibling violence, abuse or coercive control. The officer completing the DASH assessment described how difficult it was to fill in the form both because Child D was unwilling to contribute to it but also because so many of the categories did not apply in this situation. This lack of a suitable risk assessment tool clearly placed officers at a disadvantage. However, given that a weapon had been used and that the perpetrator had been '*drug and alcohol fuelled*', professional experience and judgement might have concluded that the risk to the victim (Child D) was at least '*medium*' rather than '*standard*'. All DASH risk assessments are reviewed by the Police Public Protection Unit but in this case there was no evident reconsideration of the risk level as a result.

5.1.10. This Review recognises that the categorisation of risk on this occasion may well not have had an impact on the outcome in this case given the apparently firm position taken by the family as to the limits of their co-operation. However, it highlights an important learning point both about the limitations of the current DASH form and the significance of professional judgement. In September 2016 a joint report by the College of Policing,

Cardiff University and University College London made a number of recommendations about the risk assessment process used by the Police including a review of the domestic abuse risk tool used by front line Police Officers. It is therefore the recommendation of this report that action is taken by Avon and Somerset Police in tandem with its partners to review its risk assessment processes, including as they relate to non-intimate partner violence. **Recommendation 1**

5.1.11. The actions and decisions taken by the Police in relation to this incident, including not to take the case to the CPS for a charging decision, also require further consideration. The attending Police Officers were at the address within 5 minutes of the Police call out; they were able to manage the immediate demands of a confusing situation calmly and effectively. A DASH form was instigated, but as noted above was of limited value and the attending officers stated they had no information before they arrived regarding any previous incidents at the address. However, the potential seriousness of what had taken place was not fully recognised.

5.1.12. Avon and Somerset Constabulary has developed a Designated Investigations Team (DIT), which undertakes many of the investigations for cases coming into the custody suite. The DIT looks at the evidence provided by the arresting officers and any other evidence that they are provided with, such as witness statements or CCTV footage. The team will speak to the victim, although in this case Child D was unwilling to make a statement. The allocated team member collates the information and sends their investigation report to the Custody Inspector who makes charging decisions. The information provided to the Review by the DIT worker in this case suggested that he had undertaken the role that was required of him comprehensively, and was also well aware of the significance of Domestic Abuse.

5.1.13. The intention of the DIT is to provide a quick response when prisoners are brought into custody, to enable the arresting officers to return to their duties in the community. DIT staff, who are civilians, are not expected to actively seek out evidence, but to work on what they are provided with by the officers bringing the individual into the custody suite. The focus is to collate the information and identify whether the evidence exists to support a charge. The quality of the investigation report is therefore fundamentally reliant on the quality of the information provided by the arresting officers and the way that those officers have understood, and therefore responded to the case at the time. The issue of whether there are vulnerabilities in relying on a team, who although they may be individually experienced in investigation, are not actually warranted police officers and have quite a boundaried role, has been of some concern to this Review.

5.1.14. This system design (i.e. ensuring quick decision making following an arrest) is arguably not fit for purpose in cases of potential domestic abuse, particularly when a case does not fit a recognisable pattern of abuse and may need a more considered investigative approach. A DASH form was attempted but the possibility that this incident might highlight serious domestic abuse from one sibling to another was not considered. One

contributing factor to the decision regarding charging was the stated lack of medical evidence, and yet the injury had been seen, although presumably not photographed, by the arresting officers. This was an injury which we now know led Child D to seek hospital treatment the following week. In the absence of witness statements, such evidence can and often does form the basis of charging decisions in domestic abuse cases, but this was not the case here. It is also not apparent that neighbours, who we now know had witnessed some of what happened that night, were interviewed at the time.

5.1.15. The route which determined how this case was investigated reflects some of the same issues which were raised in the HMIC report of Avon and Somerset Constabulary's approach to Domestic Abuse in 2014.[15] Overall the report concluded that the public *'can be reasonably confident that the constabulary can identify and conduct an initial investigation into reports of domestic abuse including identifying safeguarding issues'.* However, it also identified some problems with the consistency of approach, and noted the lack of a clear view as to which team should investigate individual cases. What is apparent is that a good understanding and response to the level of risk within this family was unlikely to be achieved using an approach in which the strong driver appears to have been '*the type of crime and availability of resources'*[16] as it would appear was the case on this occasion.

5.1.16. Whether the charging decision was the correct one is inevitably very difficult to judge after the event. Equally, charging alone does not ensure the future security of the victim and will not always be either possible or appropriate. However, it is recognised nationally as a very significant aspect of the response to a domestic abuse incident both symbolically and practically:

"*Domestic Abuse crimes need to be addressed and investigated as seriously as other victim based and violent crimes*".[17]

It is widely recognised that many victims of domestic abuse experience a high number of incidents of abuse, before they seek help and that every opportunity should be taken to provide that help as early as possible. Recent research by Safer Lives[18] identified that 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse. It is in this that context the approach by SafeLives of '*getting it right first time*' has been developed.

5.1.17. It is also crucial to be aware of the extreme difficulty for a parent, in taking the step of making a statement to the Police about their own child. As already noted this family was consistent in their unwillingness to support any Police action after the initial crisis. The Mother was clear in her contribution to the Review that the family were not willing to make statements to the Police. However, she felt strongly that the Police could have taken more action even without relying on statements from the family. What this highlights is the importance in any situation of domestic abuse that the fullest

[15] HMIC, 2014
[16] HMIC (2014:10)
[17] HMIC 2014 p98
[18] http://www.safelives.org.uk/policy-evidence/getting-it-right-first-time

consideration is given to criminal charges in order to provide a clear message about the seriousness of these offences and the need to take every opportunity to '*get it right'* for the family.

5.1.18. This Review has not identified evidence that Brother D was intentionally violent or abusive to his Mother or that she was routinely afraid of him or felt controlled by him. A member of staff at Brother D's college, who was aware that some people could find him intimidating, described him "*not the sort of person who disrespected his mum"*. There is moreover, information that the Mother played a direct role in preventing and managing Brother D's behaviour, including calling the Police to bring an end to incidents and removing herself and other children from the home.

5.1.19. When the Police were called to the incident in August 2015 it was difficult for them to assess exactly what had happened. However, it appeared that the Mother, who had a cut to her lip, was effectively restraining Brother D. Child D although injured by Brother D did not appear frightened of his brother and the Police Officer described the event as unusual for a 'domestic' call out which generally involved officers '*managing hysterical or emotional people, but this was very different, everyone was very calm'*. Child D had become involved in an argument between his Mother and Brother D to try to prevent Brother D, who had been drinking and had no driving licence, from taking their Mother's car and he was then slashed with a knife by his brother. Child D was described as frustrated with his brother, who he felt was a risk to himself in wanting to take the car out. Whilst clearly a violent and frightening situation, the typical elements of coercion, control and intimidation did not appear to be in place.

5.1.20. Health professionals comprise one of the most significant groups in identifying domestic abuse. During the time period covered by this Review, including the years prior to 2011, the Mother did present either at the GP or A&E with a number of minor injuries. The professional opinion of the GP, both at the time and now, is that this did not constitute a pattern of injuries indicative of domestic abuse. Several of the injuries, e.g. scalds to the hands/arms, are typical of household accidents, more likely to be linked to alcohol use than domestic abuse. The injuries were of a comparatively minor nature and were not so frequent as to trigger concern. This is undoubtedly a reasonable assessment given the information available at the time. Nevertheless, had professionals linked these injuries with other information about what was happening in the home it could have led to a more inquisitive approach as to what else could be taking place, including the possibility of domestic abuse. This will be considered further subsequently.

5.1.21. The information available to the Review from the A&E departments has been quite limited, although an A&E Consultant was able to provide an overview of safeguarding practice within A&E. This included acknowledging the difficulties that staff have when someone presents at A&E in that they are unable to access GP information or information about attendance at other hospitals due to information systems not connecting. As such it would not have been possible for them to identify any pattern if, as was the case,

family members attended different hospitals on different occasions. In Child D's case the hospital had properly made a referral to CSC in August 2015 as a result of him attending to have his infected wound treating and informing them that it had been caused by his brother. It was acknowledged that it was unlikely that this incident would have been understood as potential domestic abuse and hospital staff would have purely viewed this as a safeguarding issue given Child D's age. Hospital staff contacted the police to confirm that the incident had been reported the previous week and also made a referral to CSC.

5.1.22. The limitations of information available to the Review means that it has been difficult to gain an adequate insight into the dynamics of the relationship between Child D and his brother, and from that, to better understand what resources might have helped this family. In particular identifying the line between difficult or problematic behaviour - 'normal' conflict between siblings, and abusive behaviour would require proactive and focussed engagement with the family over time, something which did not take place in this case. Ideally the Review would have been able to better explore and understand the dynamic between the brothers, particularly as they were growing into young men. Child D's mother described the boys as usually being very good friends, but said that Brother D could have a temper. Other than this perspective and a glimpse from Child D's father that Child D was starting to assert himself more with Brother D as he grew older, it has not really been possible to understand in any depth the brothers' relationship or how they interacted on a day to day basis.

5.1.23. There is specific information that there were physical conflicts between the brothers, when it appears that Brother D was the aggressor. Child D also presented at different times with injuries, some of which were caused by his brother, but others of which happened outside the home. The professionals who seem to have the best relationship with and understanding of the boys (YOT workers and college staff) did not appear to have any concerns about Child D being controlled by or frightened of Brother D. Child D's father referred to some bullying from Brother D to Child D as they grew up, but he had not detected anything more worrying. The references to bullying and the content of some of the arguments which appear to suggest that Brother D did not like to be challenged, and possibly saw himself as the senior male figure in the home, could be evidence that there was some level of control taking place. However, without more information from the family, this remains impossible to assess.

5.1.24. There is credible information that Brother D has accepted responsibility for the death of Child D from very early on and that he continues to be highly remorseful, even traumatised as a result of what he did. Brother D presented himself to the Police the day after Child D died, he pleaded guilty to murder and there has been nothing to suggest to this Review that he has blamed Child D. There was evidently a pattern of violence outside the home in relation to Brother D, which based on the information available does not appear to differ significantly from his behaviour at home. This combination of factors suggests that Brother D's behaviour may have been primarily part of a wider pattern of risky behaviour, including both impetuous

and instrumental use of violence when challenged, combined with disinhibition due to alcohol or drug use. The implications for services for the risks presented by Brother D will be considered in the following section.

5.1.25. Irrespective of the underlying reasons for the violence, there was information that would be expected to lead agencies to consider the possibility of Domestic Abuse in this family at the time. None of the agencies who were involved and aware of the behaviour appeared to recognise the possibility of non-intimate partner abuse. It was noted by both the Police and CSC that a child was the 'perpetrator', but this did not lead to a fundamental examination of whether there was a continuing problem, what this might mean for the child who was the victim and whether there was a need for a more active approach or escalation of concerns. Although referrals were made to victim support services on at least two occasions, these appear to have been largely routine and it does not appear that determined attempts were made to proactively engage with this family when they did not take up the offers.

5.1.26. At the time of the incident in August 2015 Brother D was 19-years-old but Child D at 17-years-old was still a child, as a result of which a referral to Children's Services was made by the Police in line with required practice. As such the appropriate links were in place between the two services. Enquiries were made by CSC, including phone contact with Younger Sister's nursery, a telephone conversation with Child D's mother and reference back to an Initial Assessment undertaken in 2013. The enquiries stated that "*Brother D is an adult about whom there are significant past concerns in relation to a past history of GBH".* Brother D had at this point received an Adult Caution for assault 3 months previously, he had 3 convictions for offences involving violence, been charged then acquitted of a serious offence of wounding and come to the police's attention on 4 occasions for disturbances in the home. This history if it was known, should have triggered a greater level of concern about the potential risk he posed both outside and inside the home. It is perhaps also significant that the records refer to the incident as a fight between the two brothers, suggesting an equality between them and as such it is clear that domestic abuse was not adequately taken into account.

5.1.27. No further action was considered necessary on the understanding that Younger Sister was not in the house at the time and that Brother D was no longer welcome at home. It would appear that the Mother's assurances about this were accepted on face value and had a significant impact in the overall decision making by CSC. One important factor that should have been considered when assessing the Mother's perspective on her son's behaviour is how difficult it can be for parents to openly recognise that their child might be violent in the home.[19] There was an opportunity at this point to take a more active approach towards gaining a better understanding of the family dynamics and history. It is also evident that there was a lack of adequate recognition of the potential risk to Child D. This reflects consistent research[20] which has identified that adolescents, in this case a male of dual

[19] Home Office (2015:5)
[20] Khan, L (2017:4)

black/white heritage, are often not viewed as children who might be in need of protection.

5.1.28. There has been a shared recognition amongst the Review team and the practitioners who have contributed to the Review that there is a limited awareness of domestic abuse within services, beyond the more familiar intimate relationship abuse. Nationally there is a lack of focus on this issue, with limited opportunities for professional development or guidance as to good practice in these situations. This picture is also reflected locally. In 2016 the Bristol Safeguarding Children Board offered two training courses in relation to Parent Abuse, but there was limited take up and this is not something that is currently available locally. It is also the case that there are currently no services with specialist skills or experience of working with older children who may be experiencing domestic abuse or who might be abusing family members. **Recommendations 2 & 3**

5.2. What does this case tell us about the system's response to families where there are multiple needs and potential risks, which individually are not assessed as meeting threshold criteria?

5.2.1. This section of the analysis will be structured by identifying what needs and risks appeared to be present. It will then consider key opportunities to assess these needs as a whole and as such consider the needs of all the family members and whether the cumulative effect of concerns might impact on threshold decisions.

5.2.2. Although it would not have been apparent from the outset, there were a number of indicators to suggest that Child D and his family might have needs, or be experiencing difficulties, meaning that various services could, or should have been offered to them. It is important to recognise that these needs individually would not generally be expected to result in a formal requirement for further action and would also be unlikely to meet thresholds for any statutory involvement. As a result, whilst different services were involved at different times it did not appear that any one service gained an understanding of the family's situation as a whole and therefore what might be most helpful to them both collectively and individually. Whilst obtaining a full picture would not have been achievable or within the legitimate remit of many services individually, options such as triggering a CAF[21] in order to provide early help with the family's agreement, could have led to a more holistic understanding of what support and help was needed.

5.2.3. **Substance Misuse:** One of the aspects of this family that was often identified, but its significance never entirely understood, was that of illegal drug use. A mixed picture has emerged of the degree of drug use by family members and what was known about this. Both the Mother and the two brothers were known at the time to use cannabis. Mother had told her GP that it helped her to sleep and to manage her low mood. In retrospect the GP has identified that the Mother's use of prescribed painkillers should

[21] The CAF is a shared assessment and planning framework instigated with parental agreement when it is felt that children have additional needs which would benefit from a co-ordinated approach. The CAF was replaced by SAF in Bristol in April 2014.

ideally have triggered a conversation about substance misuse. Similarly there was limited exploration of the Mother's cannabis use when assessments were made in relation to parenting. There was some police intelligence prior to Child D's death to suggest that there may have been involvement in drug dealing, although neither the housing provider, nor the local beat Police Officer, both of whom would often be aware of community information about drug dealing, had any particular concerns about this family at the time. There were occasional parties and loud noise from the household, but on the limited occasions when Police were called, the Mother was co-operative and the noise controlled.

5.2.4. Cannabis is the most commonly used drug amongst young adults, with one in 5 self-disclosing drug use in the last 12 months.[22] As a result the use of cannabis in itself is unlikely to trigger significant concern about an individual or family. Nevertheless, there was also information known to the Police that the brothers were both using other drugs including 'Bubble' (mephedrone) and other stimulants. There is nothing to suggest that any of the family members considered themselves as problem drug users or sought help for drug use. With the exception of the Police, professionals did not view the family as having significant drug problems. However, during some of the incidents of violence, substance abuse was a feature, including the night of Child D's death when both the brothers had been drinking and using drugs, including cocaine. Alcohol had also been a factor in Brother D's previous violent offending.

5.2.5. Had either of the brothers wanted to seek support or advice about drug or alcohol use, it is reasonable to question how and where they would have sought help. One issue of concern is that Black and Minority Ethnic communities access drug services less than white communities. A report undertaken by Safer Bristol in 2012[23] identified a number of barriers to members of BME communities in accessing drug services in the city, including:

- Lack of information about advice and treatment services
- Lack of trust in the cultural competence of drug services
- Fear about the consequences of disclosure

5.2.6. Bristol Drugs Project whilst wanting to engage with a wide range of drug users recognises that it is primarily seen as a service for heroin users. Bristol has a particularly high instance of opiate and crack users[24] and the recent Bristol City Council Commissioning Strategy for drug misuse focuses its priorities on treatment and rehabilitation to a greater extent than outreach work, in line with the National Drug Strategy. There are some limited specialist outreach services for young people on the edge of harmful drug use but no specialist BME services.

[22] HSCIC (2016:18)
[23] Safer Bristol: June 2012
[24] BCC : June 2017

5.2.7. **Health**: The Mother was described as having a good level of engagement with the GP practice and she spoke in positive terms of trusting her GP and being willing to seek her help and advice. She is described as having a complex medical history including historic experience of domestic abuse from a partner and at that time she accessed health services. Mother had a history of low mood, she was treated for depression following a reported family death in 2014 and this continued throughout the period under review. The GP practice has recognised that despite the evidence of some degree of drug use combined with depression; this did not lead to a discussion with Mother about any potential impact on parenting or consideration of whether to refer on to other services. This has been an identified learning point for the practice.

5.2.8. It is also the case that both Child D and Brother D were seen by health services for a range of medical problems, many of them routine and unremarkable, but some of more significance and several involving injuries. In the years prior to the main time period for this Review there were at least three occasions when there were more worrying presentations to the GP in relation to Child D including one quite serious injury. On each of these occasions, one of which resulted in an Initial Assessment but no further action by CSC, current practice standards would have suggested a more robust response from professionals and more active offers of support to the mother and child.

5.2.9. These incidents will not be analysed in detail here as they are unlikely to contribute anything to our understanding of any history of domestic abuse nor, given the time since these events, would it be likely to impact on learning in relation to current child safeguarding practice. What is the case however is that these incidents could have provided important context when assessments were undertaken at a later stage.

5.2.10. There is absolutely no suggestion that Child D was subject to abuse at home, however they raise questions about levels of supervision as does the pattern of missed appointments with health professionals in relation to all three children.

5.2.11. **Offending:** Both Child D and Brother D had some contact with the criminal justice system. Child D had one period of supervision by the Youth Offending Team in 2011/12 following an offence of affray. Child D was not assessed as posing a significant risk of harm, had no previous history of violence and did not present worrying or aggressive behaviour or attitudes. The YOT worker was aware of some cannabis use but did not identify this as a major concern. He described Child D as bright and capable and appeared to have a positive and constructive relationship with him. It was a concern that Child D's school attendance was erratic but the school were keen to support him and maintain him in education. Child D mostly co-operated with the YOT, he was '*a gentle lad, polite and respectful*' and his Mother also presented as supportive. The YOT assessment was that Child D was not at high risk of re-offending, unless in the company of others in his peer group and based on the information available, this appears to be a reasonable assessment.

5.2.12. Brother D's offending profile was of greater concern than Child D's particularly because it involved a pattern of violence including the use of weapons. Brother D was subject to three Youth Offending orders between 2011 and 2013 and his engagement was not as positive as Child D's. Brother D was less co-operative and breached two of the orders, but was also personally much more challenging to work with. The worker who assessed Brother D in early 2013 identified concerns linked to impulsivity and disinhibition due to alcohol use and as a result concluded that Brother D had the capacity to cause serious harm. At the same time, it was also recognised that Brother D had the ability to manage his own anger and was able to regulate his own emotions as was demonstrated in his calm response to being arrested following the incident in October 2015. The risk assessment identified violence as a response to perceived provocation but not that there was a heightened risk to particular groups of victims, and noted that there were no concerns expressed by either his mother or his school.

5.2.13. **The significance of non-resident fathers:** This Review has been asked to consider the significance of non-resident fathers in the lives of young people. The information about Brother D and Child D's fathers (including direct information from Child D's father) suggests that they played a very limited role in the boys' lives. Some of the professionals raised the question of whether the lack of contact with their birth fathers had an impact, particularly in how Brother D viewed his role in the family and to what degree this might have been effected by his experience as young man of dual heritage. We have little information that would help us understand the quality of those relationships or to understand the impact or otherwise of the boys' fathers not being a resident part of the family.

5.2.14. We can say however that in relation to the role of fathers generally, research identifies good evidence that "*responsible and involved fathering ….has positive effects on the wellbeing of children well into adulthood"*[25]. The key to the significance of a father, is not in itself his being resident in the family, but being actively engaged with his children. Khan identifies a range of research regarding the role of '*ongoing engaged fathering'* including links with '*lower levels of impulsivity and inhibitory control*" and better interpersonal relationships. However great care needs to be taken in attempting to second guess what their relationship with their fathers meant to Child D and Brother D from a theoretical perspective.

5.2.15. What is very apparent is that the role of the boys' fathers played little if any part in professionals' understanding of the family. There is minimal evidence of any questions being asked about their fathers or any consideration as to whether they were a significant part of their lives. The exception was one of the YOT workers who himself knew Brother D's father and identified as being part of the same community. For this worker, who was persistent in his attempts to engage with Brother D, it was in part the fact that he knew Brother D's father that improved his relationship with him, suggesting that this was significant to Brother D in some way.

[25] Khan, L (2017)

5.2.16. The conclusion of this report in relation to the fathers therefore, is less about what can be learned generally with regard to the impact of non-resident fathers on children, and more about understanding the significance for those children of the relationship with their fathers. The absence of fathers in professionals' minds, which is a regularly repeated lesson from Serious Case Reviews and wider research, is therefore the learning that should be highlighted here. As services in Bristol already clearly recognise this as an ongoing area for development, it is not considered proportionate or helpful to produce a further recommendation in this Review.

5.2.17. **Risks associated with carrying or using knives**. Public perceptions of young people who carry or use knives is strongly linked to involvement with gangs. No information has been provided to this Review that links either Child D or Brother D with gang involvement and specifically there is no intelligence from the Police to this effect. The only information in relation to the use of a knife as a weapon is in regard to Brother D, and there is no information available to us that evidences that he routinely carried a knife or, if he did, what his motivation for doing so was. We can look to research to help us understand what motivates young people to carry knives, and what there is suggests that:

> '*fear of crime, experience – direct or otherwise – of victimisation and the desire for status in an unequal society are the chief motivations for carrying a knife.'* [26]

What we do know is that Brother D was willing at times to use weapons against people both outside the family and within the family.

5.2.18. In the absence of any further information it would be unwise to reach conclusions about the wider significance of knife crime for young people and agencies within Bristol. What is however very clear was that there was a lack of recognition of the increased risk from Brother D as a result of his willingness to use weapons, irrespective of his intention or otherwise to cause harm. The concern that the Mother the mother raised in relation to use of knives was young people's apparent lack of awareness of how even an apparently small cut could be fatal.

5.2.19. **The family's perspective**: What was little understood was how the family themselves viewed their situation and whether they would have identified any needs or risks. It is evident that this is a family with considerable strengths and strong emotional bonds. Mother was evidently willing and able to access services, for example calling the police to deal with arguments or violence in the home and engaging with the GP practice. Mother was also equally able to make it clear when she did not want involvement from services and was effective in reassuring agencies that she would manage any problems herself. The Mother in her contributions to the Review acknowledged that she was not generally someone who would want to engage with services other than when she identified them herself. She impressed many of the professionals as sensible and concerned, there was no hostility and an apparent willingness to respond to any concerns that

[26] CCJS (2007:21)

were raised. What is apparent with hindsight is that this effectively kept agencies at a distance, whether or not this was recognised at the time.

5.2.20. Both Child D and Brother D were viewed as articulate young people with potential to develop their lives. Professionals evidently found Child D more open and responsive than his brother, who although not aggressive to professionals was much more guarded in his response to them. We do not have a clear view as to the degree to which the brothers' race impacted on their experience or their confidence in services. Child D's YOT worker told the Review that he had never got the impression that there were any problems for Child D in the community relating to race. On the other hand, Brother D's YOT worker, himself a black man, was of the view that Brother D would have been even more guarded with a white worker, or with someone from a very different background to himself. What we cannot know is to what degree their lived experience as young black men, and what has been described as the *'wear and tear' of everyday racism and discrimination*[27] may well have played a part in how far they, and particularly Brother D, were prepared to engage with professionals.

5.2.21. **The opportunities to assess the family's needs:** There are two particular episodes of contact when referrals to CSC led to further enquiries taking place and therefore providing an opportunity to better understand the family and consider how best to offer support or challenge. In particular this could have allowed for a more holistic response to the family, drawing together all the relevant information from across the agencies and identifying the separate and shared needs of the children of the family, and of the Mother.

5.2.22. **May 2013:** The referral from the Police to Children's Social Care in May 2013 related specifically to Younger Sister. The immediate concern was that 2 year old Younger Sister had been left in the care of a 15 year old boy who was drunk. What is clear from the records is that Mother's explanation for what happened was accepted with little or no question. That the Mother stated that it had been a mistake and it was not something she would normally do, was the key factor in the recommendation that no further action be taken. There is no reference to previous family history which would have identified that there had been previous incidences of young children being left unsupervised. These records predated the computer system being put in place and to have identified the detail would have required the old paper files to be accessed, a time-consuming process that realistically would only be done when there was a much more serious concern, or the need for a full Core Assessment. Nevertheless, it would have been possible to see from the computer system that there was some history with this family. Neither is there any reference to the domestic abuse referral from the police one month earlier in which Younger Sister's sibling was identified as the '*perpetrator*'. A primary reason for not taking any further action on that occasion had also been because the Mother was assessed as having acted appropriately.

5.2.23. Whilst a decision not to take further action on the basis of this one event, might well have been a defensible one, what is of concern is that there is no

[27] https://www.centreformentalhealth.org.uk/against-the-odds

evidence from the records that this decision was made on the basis of anything other than self-reporting by the Mother, with no obvious questioning or reflection on the credibility of the explanation given and no basis for knowing if the mother's reassurances would or could be followed in practice. There is no evident reflection on what family life might be like for Younger Sister or her siblings and no consideration as to whether there were other adults involved in their care. Given the passage of time since this event, we are not in a position to understand the full context for decision making. Proportionate decisions do need to be made about prioritising the time to deal with individual situations where the risk is not of the highest. However, the record of the social work involvement in this case is almost entirely descriptive and in itself does not demonstrate a clear analytical approach that is aware of its limitations as an assessment. Without analysis of the full information that is available, assessments will always be limited in their value.

5.2.24. **Initial Assessment Oct 2013:** When CSC undertook an Initial Assessment at the end of 2013, it was in effect in relation to three separate referrals: a Police referral regarding drug misuse, a further occasion when Younger Sister was not properly supervised, and Brother D being charged with a serious offence of violence and then remanded in custody. The decision by the First Response team manager to refer this to the duty team included clear recognition that there were risks to both brothers in the family and was an appropriate one.

5.2.25. However, what is noticeable about the ultimate assessment is that the predominant focus has become that of identifying any risk to Younger Sister rather than being equally on considering her older brothers' needs or what risks they might be exposed to. The rationale for undertaking the Initial Assessment on receipt of the first referral states: '*due to the age of child in the home and allegation that Bubble and Cannabis are being used, possibly in her proximity.'* Child D and Brother D are at this point aged 15 and 17 respectively and are therefore also children and whilst they are identified on the records as children themselves, there is little to suggest that their needs have been given equal priority. As before, it is noted that the Mother is very remorseful about Younger Sister being found on her own in the street and that a stair gate is going to be put up at the backdoor so this would not happen again. Child D was seen on his own in school, but there is minimal information about Brother D who was not seen alone as an intended appointment was overtaken by his remand into custody.

5.2.26. An Initial Assessment by its nature, cannot be a comprehensive assessment of all a family's needs. It is effectively a step in a process to decide whether fuller information is needed and justified. The team manager described the need to process referrals quickly, with the work being fast paced and the volume high, with a "*constant stream of new cases coming through the door"*. Nevertheless, there was room for improvement here particularly in the need for a more analytical and questioning approach to the information that the family provided and to the concerns being raised by the Health Visitor. The assessment is heavily reliant on the mother's description of

events, her assurance that she does not smoke cannabis near Younger Sister and that there will be no further problems in relation to supervising her. There is what can only be described as a level of naivety regarding what was originally described by the Police as '*significant drug use'*. The assessment states that the Mother is '*honest about her drug use'* although there is no explanation as to how this has been evidenced or if it is possible to do so. It similarly lacks analysis as to the boys' drug use relying on Child D's assurance that he used to smoke cannabis but doesn't any longer.

5.2.27. The capacity to manage the pressures of those teams in Children's Social Care which act as the 'front door' for referrals and the first layer of assessment, is a significant challenge both locally and nationally, demanding a high level of practitioner skill and organisational support, which in practice can at times be difficult to achieve. Bristol Children's Social Care has identified a number of developments that they consider have helped to improve the service provided at these key early points. This includes the First Response team taking on the role of information gathering and identifying any historical information before the request for assessment is passed to an allocated social worker. This is in recognition that initial information should be what directs the Social Worker as to where to 'dig deeper' and helps to identify patterns within individual and family behaviour. It has also since been recognised, and been identified in a previous SCR, that where 'Working (Partnership) Agreements' are put in place these need to be much more clearly linked to achievable goals that are understood and taken seriously by all concerned, including the implications if not adhered to. The Authority has also adapted Signs of Safety, a model for both assessment and intervention which the Review has been assured is beginning to evidence more critical thinking in assessment. It is in this context that the decision has been made that this Review will not offer a further recommendation regarding early assessment processes.

5.2.28. What has also been highlighted are some specific difficulties for Children's Services in the assessment of risk. It is stated in the Initial Assessment that both Child D and Brother D need to refrain from violent behaviour and that they should work with services to achieve this, demonstrating a limited understanding of behaviour change and management of aggression. The assessment identifies that Brother D could be a risk to Younger Sister given the severity of the offence he has been charged with. However, there is no specific assessment of Brother D's patterns of violence or his relationships within the home. In fact the only member of the family known to have been physically injured by Brother D was Child D. The risk that is felt to be posed by Brother D is managed by putting in place a Partnership Agreement that he will not have sole care of Younger Sister, something that will not in any event be monitored.

5.2.29. This episode identifies some important questions about the degree of experience within Children's Social Care required to undertake risk assessment and risk management of this nature. This Assessment was signed off by a manager and as such was considered to have reached expected standards, although with hindsight the manager recognises that

the situation was more complex than had been understood at the time. Assessing the risk of future serious harm is a difficult task even when practitioners have specialist training and have access to good risk assessment tools. What has been highlighted is that there is a danger inherent for Child Protection Social Workers in undertaking risk assessments regarding the risk of future violence by an individual, unless it is clear they have the specific knowledge and tools to do so. The unintended consequence can be to provide reassurance that risk is understood and being managed, when that is not in fact the case.

5.2.30. There was evidence of good practice in liaison between the YOT and Children's Services prior to the period covered by this Initial Assessment. However, what has been highlighted here, and recognised by the two services concerned, is that there was a gap in their joint working at the point when Brother D was remanded in custody and the Initial Assessment was taking place. Brother D was previously known to the YOT team and had been subject to formal risk assessments, which clearly identified that he posed some degree of risk. There was therefore a valuable opportunity here for CSC to benefit from the more specialist risk assessment skills of the YOT, but this opportunity was not recognised as such.

5.2.31. There also appeared to be some misconception by CSC that the YOT worker, who provided the initial information about Brother D being remanded in custody, had an ongoing role with Brother D, when in fact there was no actual role for the YOT at this time. When Brother D was released from custody after a few days, and therefore no longer defined as a Looked After Child, there was no further communication between YOT and CSC about him and as such no consideration as to which service, if either, might have a continuing role. It should be acknowledged that the statutory requirement to define and respond to a child as 'Looked After' whilst on remand, was a comparatively recent change to legislation and was not part of well-established practice. Given the brief period that Brother D was in custody, his status as a Looked After Child appeared to have been viewed as purely a formality, with the responsibility towards him coming to an end on his release. Whilst this was strictly true, what was missed here was a chance to consider his wider needs as a child, as well as the risks he presented following his release.

5.2.32. Whilst there are evidently established pathways for communication between Children's Services and the YOT, the experience in this case highlights that there is nevertheless room for further strengthening of the working relationship. Whilst the statutory roles of each organisation are different, many young people will be known to both services. The advantages of further improving professional understanding of their different roles as well as potential for increased sharing of skills and knowledge has been recognised arising out of this Review and is subject to a recommendation. **Recommendation 4.**

5.2.33. **Engagement:** It is self-evident that when agencies identify that young people and their families may be in need of support and help they must

seek the involvement of those family members in order to meet these needs:

'We define engagement here as the process by which a practitioner and a young person and/or their family connect in an authentic relationship, committed to achieving certain goals together. Such relationships can be considered the bedrock to effective practice, but they often appear to be missing when we review how young people have been supported.[28]

Despite the generally positive view of the Mother in this family, it is now evident that there often existed a disconnect between how services hoped the family would work with them, and to what degree the family were in reality prepared to engage with those services. Services too often were not set up to proactively seek engagement in that support would be offered, but without either a clear system or the capacity to work creatively to engage the family's trust or interest in responding. The YOT was the one service which could to some degree require the co-operation of the family but, certainly in relation to Brother D, putting this into practice was more difficult to achieve. Comprehensive assessments were made by the YOT in relation to risk and plans outlined for what was needed to manage that risk. However, for the YOT worker whose role it was to put this into practice, the focus was in reality on achieving attendance and a basic level of engagement.

5.2.34 We have not been able to gain a really clear view of what, if anything, would have made a difference to the different family members' willingness to engage with professionals. The Mother's description of herself was of someone who could be quite hard to engage, and yet she also spoke very positively about the support she had gained over the years from some professionals. From listening to the Mother talking about those positive relationships there were some key qualities that made a difference: a straightforward, down to earth approach, professionals doing what they said they were going to do and having a realistic understanding of her life and experience. This Review considers that irrespective of what could or could not have been achieved in this case what it nevertheless highlights is the crucial importance of relationship building when working with families where there are both needs and challenges.

5.3. What does this case tell us about the effectiveness of safeguarding in relation to older children?

5.3.1. What is noticeable is that at times there was too little sense of Child D and his brother of being understood as children who might need a safeguarding or other protective response, in contrast for example to the clear view of their much younger sister who was always considered in terms of protection and vulnerability. The 'perpetrator' of violence was easily recognised as such, but there is less evidence that these two teenage boys were routinely recognised or responded to as having support needs or vulnerabilities. This lack of recognition of the dual aspect of the brothers' needs and presenting risks would at times appear to have been as a result of individual professional's judgements or assumptions. But more importantly it was reflected in the lack

[28] Research in Practice (2014:26)

of accessible resources for adolescent boys, resources such as dedicated domestic abuse provision or accessible support after distressing life events. The Mother felt strongly that there were too few services for boys and that the closure of many local services in recent years, particularly the youth service was a real loss.

5.3.2. It was not the case that the Review identified that there were negative perceptions of either of the brothers or that their wider needs were never recognised. On the contrary Child D was almost always described in positive terms. Brother D seemed largely unknown to most professionals but those who did know him better, notably the YOT workers and college staff, whilst recognising that he could be challenging, nevertheless spoke of him non-judgementally, often with respect, and attempted to offer support as well as challenge. The response to Child D by the YOT when he identified problems arising out of events that had happened when he was younger, was very positive and showed a clear understanding that this was a vulnerable young person as well as one who had committed offences. It is also apparent that the college had in place good systems for providing support to the young people and was able to offer a high level of social and personal care.

5.3.3. It has been recognised for some time that adolescents who come to the notice of statutory agencies such as the Police, criminal justice agencies and Children's Social Care can challenge those services' established ways of working. A very high proportion of Serious Case Reviews relate to adolescents and as such have highlighted the '*complexity and range of the risk factors facing teenagers*'[29]. This review particularly draws attention to the need to develop a constructive practice model both with young men or boys who may not engage with services or who present risks to others as well as those who more obviously present as vulnerable. A recommendation has been made to consider this as a thematic strategic area for the SCB. **Recommendation 5**.

5.4 Concluding Remarks

5.4.1. Child D and his family in many ways were not identified as presenting a particular cause for concern to agencies and were not well known to those agencies. Whilst there were known to be incidents of violence in the home, some of which were referred to by services as 'domestic abuse', this generally remained little more than a label without an accompanying sense of curiosity about what it might mean or whether there might be a continuing cause for concern. Nevertheless, over a long period there were indicators for a number of services that this family might have needs, individually and collectively, which would benefit from further understanding and support. There were also times when better steps could have been taken to encourage the different members of the fam to engage with services in a way which they might have found helpful and to understand the nature of the risks within the family Whether the family would have welcomed such an approach is at least questionable, and other than in relation to one or two specific occasions, they would have been entitled to refuse to engage.

[29] Ofsted 2011

5.4.2. In relation to the incidences of violence in the home, there was a basis for taking a more active approach with the family. Whether domestic abuse was or was not a feature in their lives, the level of risk that came with Brother D's willingness to use violence, and in particular his willingness to use weapons, required greater understanding, more consideration of what was taking place in the family and a more proactive response.

5.4.3. The very understandable question was raised by Child D's father as to why, having previously injured Child D with a knife, Brother D was allowed to return to the home. It has been clearly recognised in this Review that a different professional approach to understanding the family pressures was needed and other steps could have been considered. Yet, in the absence of a criminal charge and without real parental commitment to exclude Brother D in the long term, there was no basis for professionals to have required his removal from home. For a parent to exclude a child from their home, other than for a short period, is a profoundly difficult decision. It is very much a solution of last resort and in any event may not in itself lead to a reduction of risk. Clearly none of those concerned, professionals or family members believed that they were at this point.

5.4.4. The risk assessment undertaken by the YOT in relation to Brother D's violence, suggests that it was related to situations in which he was frustrated or lost his temper, rather than being related to specific individuals and as such it would have been difficult to predict how and when it would be repeated. The evidence suggests that the family, particularly the Mother, genuinely believed that they could manage any risk themselves without the involvement of professionals, other than purely to deal with immediate points of conflict. Even if there had been a significant change in how the family situation was understood by professionals, it is unrealistic to conclude that there was a clear course of action that could have prevented what ultimately happened.

5.4.5. These events have nevertheless led to valuable learning in relation to work with families in the future. The primary lesson is without doubt the need to pay significantly more attention to forms of violence within the family that do not fit into familiar categories of domestic abuse.

6. RECOMMENDATIONS

The approach of this Review has been to establish the key areas of new learning leading to a focussed number of recommendations that highlight significant aspects of the way the multi-agency systems can improve work both with domestic abuse and the safeguarding of children.

Where there is evidence of agencies putting in place improvements in relation to identified areas for learning, these have been identified in the body of the report, but no recommendation put in place. Given that the Review has reflected on a significant period of time, it has identified a number of historical areas where safeguarding practice was not of the standard we would consider acceptable today, or where practice and standards have since changed and are judged differently.

One particular issue that has been repeated in different ways relates to gaps in the way agencies recognise and respond to the needs of young males who have expressed distress or trauma as a result of life events. Although it is recognised that this is not an area for complacency there have been some significant changes in practice, so for example, early sexual activity would now be considered a cause of concern and be subject to referrals on to specialist services.

The recommendations are as follows:

Recommendation 1: Avon and Somerset Constabulary should work with its partners within the Community Safety Partnership and Bristol Safeguarding Children Board to review the effectiveness of its Domestic Abuse Risk Assessment model and investigative practice regarding non-intimate partner abuse.

Recommendation 2: The Community Safety Partnership and the Safeguarding Children Board should work with partners, including the Bristol Safeguarding Adults Board, to develop practice, knowledge and skills across agencies relating to non-intimate partner abuse and to consider whether there is a role for specialist services.

Recommendation 3: The Community Safety Partnership and the Bristol Safeguarding Children Board should recommend to the Home Office that guidance, research and strategy relating to a broader spectrum of domestic abuse other than intimate partner abuse is developed nationally.

Recommendation 4: Children's Social Care and the Youth Offending Team to draw on the learning from this Review to identify ways to further develop their approach to, and arrangements for, joint working.

Recommendation 5: The Bristol Safeguarding Children Board consider identifying working with adolescent boys as a thematic priority in its strategic plan.

APPENDIX A: PROCESS AND METHODOLOGY FOR THE REVIEW

1 Timescale for undertaking this Review.

1.1. The decision to undertake a combined review was made in August 2016. As is required, on 19th August 2016 the Department of Education was informed that the SCR was being commissioned as part of a joint review. On 16th August 2016 the Home Office was similarly informed.

1.2. The expectation for both a DHR and SCR is that reviews will be completed within a reasonable timescale and for a DHR that wherever possible this would be 6 months of the decision to undertake it. An open competitive process was followed in order to commission the independent lead reviewers as a result of which the first meeting to plan the Review took place in October 2016. Agreement then was required from the Home Office with regard to the methodology (see below) and this was received in December 2016. It is therefore acknowledged that it has not proved possible to meet the ideal timescale of 6 months.

1.3. The Review was jointly quality assured in August 2017 and subsequently received by a Joint Meeting of the Bristol Community Safety Partnership and the Bristol Safeguarding Children Board in September 2017.

1.4 The Draft report was submitted to the Home Office and considered by the Quality Assurance Panel in March 2018. Their feedback, published at section 7 of Appendix A of this report, was received in May 2018. The Panel's feedback was considered by the report authors and a Joint Meeting of the Bristol Community Safety Partnership and the Bristol Safeguarding Children Board in June, where minor amendments to the report were agreed prior to publication. A small number of other additions were made to the report following the meeting with the Mother prior to publication.

2 Confidentiality

The content and findings of this Review were strictly confidential during the Review process. Information provided was only available to the identified participating officers and professionals and their line managers until the Overview Report was approved for publication by the Home Office Quality Assurance Group and the Bristol Safeguarding Children Board.

3 Dissemination of the Report

3.1 On final completion the report will be sent to the following bodies:

- Bristol Safeguarding Children Board
- Bristol Community Safety Partnership

3.2 The following agencies will also receive copies of this report:

- Avon and Somerset Constabulary
- Bristol City Council Children and Families Service

- Bristol City Council Housing
- Bristol City Council Education and Skills
- Bristol City Council Targeted Services
- Bristol Clinical Commissioning Group

4 Purpose and Terms of Reference for the Review

4.1. The purpose of the Domestic Homicide Review is to:

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

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

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

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

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

f) highlight good practice.

4.2. The purpose of the Serious Case Review is outlined in Working Together as follows:

Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. (Working Together 2015, p74)

4.3. The guidance further identifies that SCRs should be conducted in a way which:

• recognises the complex circumstances in which professionals work together to safeguard children;

• seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

• seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;

• is transparent about the way data is collected and analysed; and

• makes use of relevant research and case evidence to inform the findings.

4.4. It is not the role of either a DHR or a SCR to act as an inquiry into how the victim died, or who is culpable. These are matters for the Criminal and Coroners courts. Neither is it the Review's role to initiate disciplinary or other employment procedures, as these remain the responsibility of the employing organisation.

4.5. **Terms of Reference for the Joint Review** were established as follows:

a) Decide whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented the death of Child D.

b) Review current responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened to support the victim and review national best practice in respect of protection of individuals from domestic abuse.

c) Consider whether there are issues of race, gender, religion, disability or other individual needs that were significant in the circumstances and how services responded.

d) Examine the roles of the organisations involved in this case; the extent to which the victims or perpetrators had involvement with those agencies, and the appropriateness of single agency and partnership responses to the case to draw out the strengths and weaknesses and to assess whether there are any gaps in support.

e) Establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard the wellbeing of Child D and any other relevant others, within the immediate family unit.

f) Identify clearly what those lessons are.

g) Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in order to improve practice to better safeguard victims of domestic abuse.

And consider

A: What does this case tell us about the multi-agency response to domestic abuse in families in situations when this is not intimate partner abuse?

- Are agencies equipped to recognise potential adolescent to sibling or parent abuse and is the professional response effective?

- How well do agencies recognise whole family working and the risks and needs of different family members, where there is domestic abuse taking place?
- How effective is the interface between the frameworks for children's safeguarding and domestic abuse services?

B What does this case tell us about the effectiveness of safeguarding in relation to older children?

- For safeguarding children does the age of the child impact on the response of agencies?
- How do professionals balance the older child's need for autonomy with the duty to safeguard a child?

C: What does this case tell us about the system's response to families where there are multiple needs and potential risks, which individually are not assessed as meeting threshold criteria?

- How can professionals' best gain an accurate understanding of a family who may be demonstrating multiple risk factors, e.g. early sexual activity of a child; drug and alcohol abuse, criminal activity. What role does community intelligence properly play in gaining this understanding?
- How effective is the single and multi-agency early intervention for families with multiple risks?
- Are the risks associated with young people using or carrying knives fully understood by all agencies?
- How do agencies understand the significance of non-resident fathers in the lives of young people and what is the impact for young people.
- How can professionals work with families who do not engage?

5 Methodology

5.1. The Review was led by Deborah Jeremiah and Sian Griffiths, both of whom are Independent Social Work Consultants and between them have significant experience in undertaking Serious Case Reviews and Domestic Homicide Reviews. The lead reviewers have previously worked together using a collaborative process to undertake a SCR and DHR regarding a family working together to identify the evidence and share analysis, but providing two separate reports. The report author, Sian Griffiths, has also previously authored a joint SCR and DHR. Both independent lead reviewers have undertaken Home Office DHR training. Both the independent lead reviewers are independent of the case and of all the agencies involved.

5.2. Whilst the underlying purpose and significant aspects of the approaches taken by DHRs and SCR's have much in common, there are some differences and these have been accommodated within this joint review. The DHR statutory guidance requires a specific methodology, including the provision of Individual

Management Reviews by each agency involved. Previous statutory guidance in relation to SCRs took a similar approach, however since 2013 there is no longer a requirement for SCRs to use a specific model or to commission Individual Management Reviews. Instead, the guidance requires that case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

The SCR guidance allows the use of any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro[30].

5.3. A joint commissioning and scoping meeting took place with the Independent Reviewers, the Safer Bristol Crime Reduction Manager, the Bristol Safeguarding Children Board Manager and Children's Services Safeguarding Service Manager. This meeting concluded that a joint Review, rather than two separate reviews would be the most effective and proportionate approach to adopt. The BSCB had previous experience of undertaking SCRs using systems methodology and it was agreed that this Review lent itself to such an approach. This was subsequently agreed with the Home Office and specifically it was agreed that the joint Review would not include the commissioning of Individual Management Reviews. The approach has been mindful throughout of the Home Office Guidance and incorporated the other key expectations of that guidance, including the use of a full chronology.

5.4. Whilst the Review was not conducted as a SCIE Learning Together Review, the Independent Reviewers who are both accredited in that approach, and would wish to acknowledge the significant impact their knowledge of SCIE Learning Together had in their design of the methodology. A 'systems approach' to learning recognises the limitations inherent in simply identifying what may have gone wrong and who might be 'to blame'. Instead it seeks to identify which factors in the work environment support good practice, and which create unsafe conditions in which poor practice is more likely. The purpose being to move beyond the individual case to a greater understanding of safeguarding practice more widely. A significant feature of the methodology was working in such a way as to minimise hindsight.

5.5. A Review Panel consisting of the Independent Reviewers and Senior representatives or Safeguarding Leads of the following agencies was established:

[30] Working Together (2013:67)

Agency/Organisation	Name	Role
	Deborah Jeremiah	Independent Lead Reviewer
	Sian Griffiths	Independent Lead Reviewer
Bristol City Council, Children's Services	Fiona Tudge	Service Manager, Safeguarding and Quality Assurance
Bristol City Council, Public Health	Sue Moss	Public Health Principal (Mental Health and Social Inclusion)
Bristol City Council, Targeted Services	Justine, Leyland	Youth Offending Team, Manager
Bristol City Council, Education and Skills	Laura Gajdus	Safeguarding in Education Team Manager
Avon and Somerset Constabulary/Lighthouse	Chris Parr	Team Manager
Avon and Somerset Constabulary	Tamara Duddin	Detective Sergeant, Safeguarding Unit
Children's Community Health Partnership	Lindsey Mackintosh	Designated Doctor for Safeguarding Children

5.6. The BSCB Business Manager and Project Support Officer supported and contributed to Review Team meetings as well as to the overall process of the Review.

5.7. Consideration was given at the outset, and reconsidered during the course of the Review, to inviting others who might bring a specialist knowledge, particularly in relation to Domestic Abuse, to be members of the Review team. No Domestic Abuse services had had direct contact with the family and the local relevant services were not able to provide a member of the Review Team. However, the Review Team included two members (Sue Moss and Chris Parr) with a specific remit relating to Domestic Abuse and the support of victims. The Review was also able to access other more specialist contributions during the Review, including from the IDVA.

5.8. The Review Panel met on 7 occasions, two further meetings took place jointly with relevant practitioners also present.

5.9. The Review began by gathering the necessary evidence included production of a multi-agency chronology involving all the services and agencies who had relevant contact with Child D and his family. All relevant voluntary sector and statutory agencies were contacted at the outset to check for any involvement with Child D and his family. As a result full chronologies were provided by the following agencies:

- Avon and Somerset Constabulary

- Bristol City Council, Children's Social Care (CSC)
- Bristol City Council Targeted Services (Youth Offending Team)
- Bristol City Council Education and Skills
- Bristol City Council, Housing Options
- Bristol City Council Housing Delivery
- Bristol Clinical Commissioning Group (for GP Practice)
- North Bristol Trust Hospital
- South Gloucestershire and Stroud College
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust

5.10. There then followed structured interviews led by the Independent Reviewers with the following 12 individuals who either had direct contact with the family or who were able to provide particular insights into their organisation's practice

- Avon and Somerset Police, Police Constable
- Avon and Somerset Police, Designated Investigation Team officer
- Bristol City Council, Housing Manager
- Bristol City Council, Youth Offending Team workers (2)
- Bristol City Council, Children's Services Social Worker
- Bristol City Council, Children's Services Team Managers (2)
- General Practitioner
- South Gloucestershire and Stroud College, Learning Mentor
- North Bristol NHS Trust, A&E Consultant
- Independent Domestic Violence Advisor

5.11. The Review also had access to a range of primary documentation including:

- Statements collated by Avon and Somerset Constabulary in relation to the criminal prosecution for murder in 2016.
- Post Mortem Report
- Children's Social Care – various records and assessments
- Youth Offending Team – various records and assessments
- Bristol Clinical Commissioning Group Overview Report regarding GP practice
- Health Visitor records.

5.12. The professionals who had taken part in individual interviews were then invited to attend a practitioners' event alongside a small number of other professionals who were believed to have additional useful information to contribute. The purpose of the event was both to check the accuracy of the information that had been collated by the lead reviewers and also to contribute to the analysis and learning.

6 Involvement of Child D's Family and Friends.

6.1. As is established practice in both SCRs and DHRs, Child D's closest family members were identified as far as this was possible at the outset. Letters were sent to them in November 2016 informing them of the decision to undertake the Joint Review and they were provided with information about the Review and leaflets regarding specialist support. It was agreed that the initial family members who would be invited to contribute, including contributing to the Terms of Reference, would be Child D's mother and father. Both parents were subsequently contacted again in January 2017 on behalf of the Review Team, by the Police Family Liaison Officer. At this point Child D's mother declined to be involved.

6.2. Child D's his father agreed to meet with the lead reviewers in March 2017 and his contribution is included in the report. In line with the requirements of the DHR, arrangements were also made for Child D's father to meet with one of the Lead Reviewers and the Safeguarding Board Business Manager to read the report before it was finalised and sent to the Home Office for Quality Assurance.

6.3. It was also agreed that the Independent Reviewers would contact Brother D to ask if he would wish to contribute and a letter was delivered to him in prison by the Probation Service in January 2017. Brother D's Offender Manager in the community spoke to Brother D, who did not feel able to contribute at that time, but he did not exclude the possibility of doing so in the future. After a period of time the Independent Reviewers again arranged for the Brother D's Offender manager in the prison to speak to him, but he still felt unable to contribute and did not wish to read the report in advance of publication.

6.4. The absence of the family's voice in this Review was felt to represent a significant gap and in April 2017, Brother D's Offender Manager was asked to speak to Mother again to see if she would now be willing to speak to one of the Independent Reviewers. Child D's mother considered this and spoke to Sian Griffiths on the phone, but she felt that her focus was at this point on supporting Brother D and as such she still did not wish to take part in the Review. She also stated that Brother D was not at a point where he would want to contribute. The Mother agreed that the Independent Reviewer could contact her again by text later in the process.

6.5. In July 2017 the Independent Reviewer again contacted Child D's Mother, but she still did not wish to take part. Nevertheless, she agreed that she could be contacted when the Review was in a near final draft for an opportunity to read the Review and make any contributions at that stage. The Independent Reviewer as agreed again made contact by text with the Mother at this stage and there followed a telephone conversation after which the Mother decided she would like to meet, both to contribute to the report and to read the draft. However, she later decided she did not feel able to meet, but would inform the Reviewer how she wanted her children to be referred to in the report. Whilst there continued to be contact by text and phone between the Mother and the Independent Reviewer, the Mother did not in the event identify the names she

would want to be used. The Lead Reviewer wrote to her at the point of sending the report to the Home Office for Quality Assurance, informing her of the process and confirming that at any point prior to publication it would be possible to meet.

6.6. Following the Home Office Quality Assurance process and prior to publication the Mother was contacted again and met with the Author and Board Manager to discuss the report. The Mother did not wish to read the report in full prior to publication.

6.7. The Review had also identified that other than the parents and Brother D, there were other close individuals who might wish to contribute. Letters were therefore sent to Child D's older brother and sister, his girlfriend and one of his friends who had been identified by services, as well as to Brother D's Father. Letters to Child D's girlfriend and friend were delivered personally by the Police Family Liaison Officer who also spoke to Brother D's father. Whilst initially both Child D's girlfriend and Brother D's father each considered they might be willing to take part, both subsequently declined.

6.8. Information about the publication date for the report was shared with all the identified family members.

7. Home Office Quality Assurance Panel Feedback.

Home Office

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Stuart Pattison
Crime Reduction Manager
Bristol City Council
Neighbourhoods Directorate
Housing Delivery
Crime Reduction Team

14 May 2018

Dear Mr Pattison,

Thank you for submitting the Domestic Homicide Review (DHR) report for Bristol (Child D) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21 March 2018. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel noted this was a combined DHR and Serious Case Review and commended the decision to merge the reviews. The Panel concluded this has resulted in a comprehensive, probing report which identifies helpful learning and which is supported by good referencing of research. Engagement of family in the review has provided useful insight including how agencies respond to non-intimate partner abuse. The Panel particularly liked the careful consideration of the dynamics and history between the siblings.

There were, however, some other aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The Panel felt there may have been value in interviewing the school to help inform the review;
- The review makes reference to a number of individuals ("Brother A", "Child D's friend", "Child E" and an "older sister") but they are not introduced and it is not clear who these individuals are and the context in which they appear;
- It may have been helpful to examine in more detail the issues facing the mother with complex needs and what support was available to her;

- Please review paragraphs 3.2.12 and 3.2.14 as the incorrect child is referenced;
- The Panel felt pseudonyms rather than the anonymisation method used would allow a reader to more easily follow the narrative;
- There is no mention in the report of whether the family were offered specialist advocacy support;
- The action plan is missing target dates, key milestones and outcomes;
- Please review the report for typing errors before publication.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley
Acting Chair of the Home Office DHR Quality Assurance Panel

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