SOUTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

into the circumstances

of the death of a woman aged 43 years

On 30th January 2014

Case No. DHR 5

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LIST OF ABBREVIATIONS

DASH	Domestic Abuse, Stalking and Harassment Risk Assessment Tool
DfEE	Department for Education and Employment – HM Government
DHR	Domestic Homicide Review
EHE	Elective Home Education
HELO	Home Education Liaison Officer
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
LBSS	Learning Behaviour Support Services
MARAC	Multi-Agency Risk Assessment Conference
MGF	Maternal Grand Father
MGM	Maternal Grand Mother
NHS	National Health Service
NICE	Nation Institute for Clinical Excellence
PKU	Phenylketonuria – a congenital genetic condition
SENCO	Special Educational Needs Co-ordinator – Education
SEST	Specialist Education Support Teams
SWCSP	South Worcestershire Community Safety Partnership
WHASCAS	Worcestershire Heath and Social Care Access Centre

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1. Introduction

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 43 year old woman on 30th January 2014. The woman's son, the Perpetrator, has been arrested and charged with her murder. He appeared at Birmingham Crown Court on 13th February 2015 and pleaded guilty to Manslaughter on the grounds of diminished responsibility. This was accepted by the Court and he was made subject to a Hospital Order.

1.2 Purpose of a Domestic Homicide Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section, a domestic homicide review means 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) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[2], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have*

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

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*

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- 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;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

1.3 Process of the Review

1.3.1 West Mercia Police notified South Worcestershire Community Safety Partnership (SWCSP) of the homicide on 21st February 2014. The Worcestershire Forum against Domestic Abuse and Sexual Violence acting on behalf of the Community Safety Partnership convened a DHR sub group meeting and considered the circumstances as known at that stage, and decided not to hold a domestic homicide review. A letter was sent to the Home Office to this effect on 18th June 2014. The Home Office replied that there should be a review and the sub-group of the SWCSP met on 8th July 2014 and commissioned a DHR. The Home Office were informed on 10th July 2014 of the intention to commission a DHR.

1.3.2 An independent person was appointed to chair the DHR panel and to be the author of the overview report.

1.3.3 Home Office Guidance[3] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

1.4 Independent Chair and Author

1.4.1 Home Office Guidance[4] requires that;

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair

[3] Home Office Guidance 2013 page 15
[4] Home Office Guidance 2013 page 11

should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

1.4.2 The Independent Chair and Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over 80 Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.5 DHR Panel

1.5.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Members of the panel and their professional responsibilities were:

Martin Lakeman	Strategic Coordinator for Domestic Abuse and Sexual Violence, Worcestershire County Council
Damian Pettit	West Mercia Police
Tom Currie	National Probation Service West Mercia
Ellen Footman	Designated Nurse for Safeguarding
David Hemming	Wychavon Community Safety Manager
Sarah Cox	Worcestershire County Council Quality & Safeguarding Services Manager
Siobhan Williams	County Council Safeguarding Children's Social Care
Jan Francis	Chief Executive Worcestershire Women's Aid (Independent Advisor)
Lyn Mills	Worcestershire County Council Health & Wellbeing (Administrator)

1.5.2 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

1.5.3 The Panel was supported by the DHR Administration Officer, Lyn Mills. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.6 Parallel proceedings

1.6.1 The Panel were aware that the following parallel proceedings were being undertaken:

- The DHR Panel Chair advised HM Coroner on 21st July 2014 that a DHR was being undertaken, and the Coroner has been updated on a regular basis.
- The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with an awareness of the issues of disclosure that may arise.

1.7 Time Period

1.7.1 It was decided that the review should focus on the period from 1st December 1990 (Pre-birth of the Perpetrator) to the date of the Victim's death on 30th January 2014, with an exception for agencies as per para 1.8.2. below.

1.8 Scoping the review

1.8.1 The process began with a scoping exercise by the panel to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly.

1.8.2 Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period.

1.8.2 The purpose of the extended period is to examine and identify what opportunities were available for agencies to intervene or challenge decisions that were made in respect of the Perpetrator and siblings by parents where concerns may have been escalated by agencies.

1.9 Individual Management Reviews

1.9.1 The following agencies were requested to prepare chronologies of their involvement with the Victim and her family, carry out individual management reviews and produce reports.

- West Mercia Police
- Health Trusts – including Birmingham Children's Hospital, Worcestershire Acute Hospital Trust, Warwickshire Health and Care Trust, & NHS England
- Education – to include River School (Independent Christian School), WCC Home Education, Parent Partnership Services
- Adult Social Care
- Children's Social Care
- Quantum Healing Hypnosis Therapy

1.10 Terms of Reference

1.10.1 The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

1.10.2 The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?

5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented?

1.10.3 In addition to the above, the following agencies are asked to respond specifically to individual questions:

- If the organisation that was providing Regression Therapy to the Perpetrator can be identified, a request to be made for an Individual Management Review/Report.
- Health and Education: Why did the family disengage with statutory agencies and what efforts were made to ensure the children's well-being and safeguarding was being considered (It is the family's view that this

point should read "Why did the family seek alternative services from statutory agencies?").

- Police, Mental Health and Adult Social Care: Were there any reasons to doubt the Perpetrator's mental capacity in relation to decisions being made?

1.11 Individual Needs

1.11.1 Home Office Guidance[5] requires consideration of individual needs and specifically:

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the Victim, the Perpetrator and their families? Was consideration for vulnerability and disability necessary?"

1.11.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.11.3 The review gave due consideration to all of the Protected Characteristics under the Act.

1.11.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

1.12 Lessons Learned

1.12.1 The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Children and Adult Serious Case Reviews and appropriate and relevant research particularly in respect of mental health issues.

1.13 Media

1.13.1 All media interest at any time during this review process will be directed to and dealt with by the Chair of the South Worcestershire Community Safety Board.

1.14 Family Involvement

1.14.1 Home Office Guidance[6] requires that:

"Members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
And:

[5] Home Office Guidance page 25
[6] Home Office Guidance page 15

"Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

1.14.2 The views of the family members and any family friends identified by the family will be taken into consideration. The family members will be invited to participate in the review process.

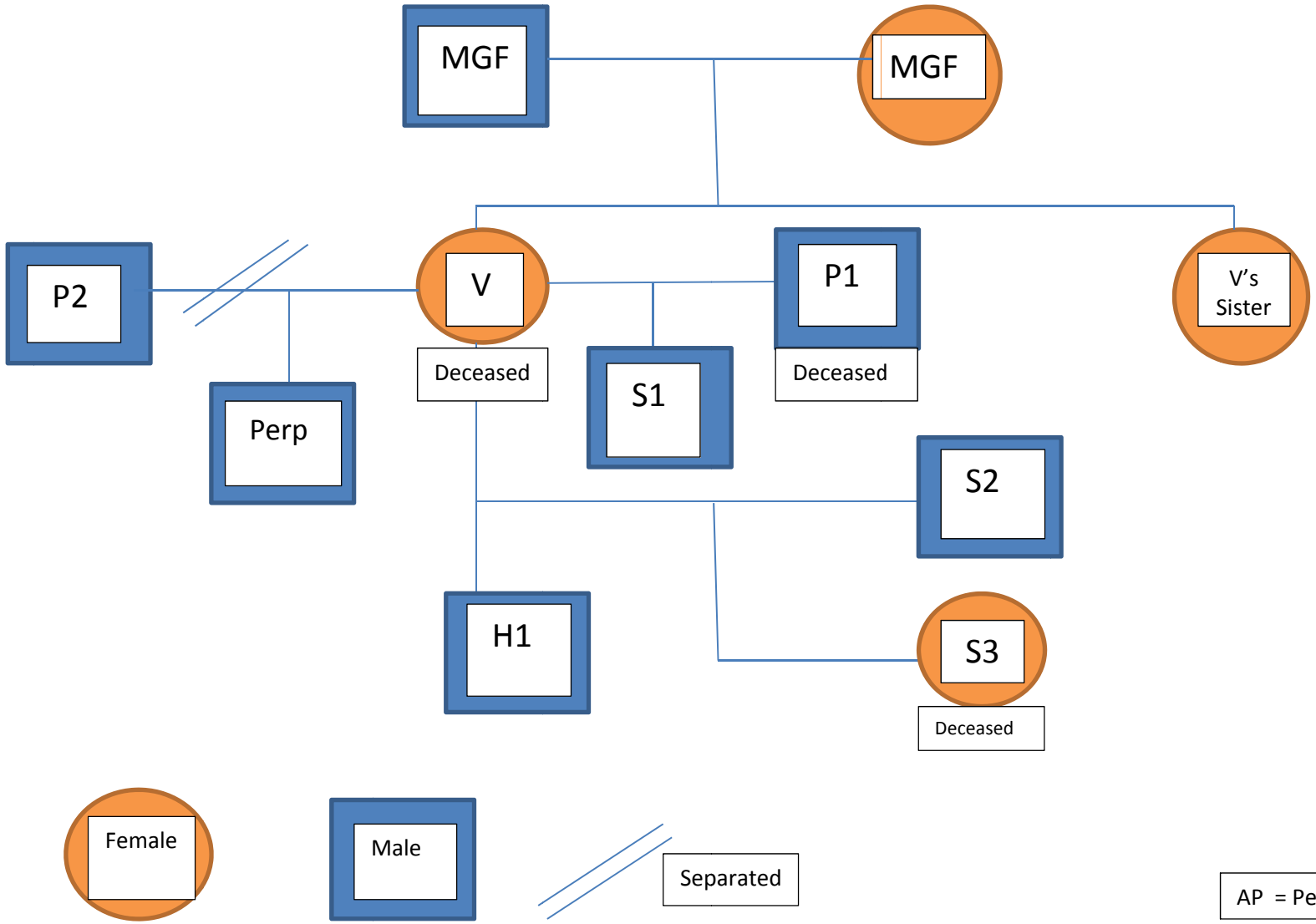
1.14.3 These Terms of reference will be considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.

1.15 Family in the Review

1.15.1 The following genogram identifies the family members in this case, as represented by the following key:

Victim	Female – Mother of Perpetrator
Perpetrator	Male – aged 23 years at the time of incident – son of Victim
S1	Male – oldest son of Victim
S2	Male – youngest son of Victim and H1
S3	Female – deceased, twin of S2
H1	Victim's husband and father of S2 and S3
MGM	Male - Maternal Grandmother of family
MGF	Maternal Grandfather of family
P1	Male - Former Partner of Victim and Father of S1
P2	Male - Former Partner of Victim and Father of Perpetrator

Genogram


MGF
MGF
P2
V
P1
V's Sister
Deceased
Deceased
Perp
S1
S2
H1
S3
Deceased
Female
Male
Separated
AP = Perpetrator

2.0 Summary of Key Events[7]

2.1 The family involved in this Domestic Homicide are white, British and although the Victim' religion is described by S1 as being Church of England; he stated that she was not a regular attendee at Church. The family lived in rented accommodation in Worcestershire. The victim's parents (MGM & MGF) lived in a nearby town but now live with the rest of the family.

2.2 The victim had her eldest son, S1, as a result of a relationship she had with a man, P1, who she met whilst travelling in Norfolk. They both moved back to Worcestershire where they lived with her parents. At the age of 18 years, the Victim gave birth to S1. It is noted in Health records that the Victim was a poor attender at antenatal sessions during this pregnancy, and, according to MGF, she drifted off with 'hippy friends' for periods of time. It is also recorded that she had her own 'unconventional' views about most things such as Education and medical treatment.

2.3 Shortly after the birth of S1, the Victim and P1 went to live in Gloucestershire earning a living fruit picking, but this lifestyle affected S1's health and he was returned to live with MGM and MGF.

2.4 P1 was dependent on alcohol and drugs. He had numerous convictions for theft, violence and drug offences. It is suggested that the Victim was subject of domestic abuse at the hands of P1, but there are no such reports with West Mercia or Norfolk Police files to corroborate this. There is a record stating that in 1988, a woman describing herself as P1's wife made a complaint of domestic abuse but it is not known if this was the Victim in this case as the date that the Victim and P1 separated is unknown. P1 died of a drug related incident on 15th February 2008.

2.5 By 1990, the Victim had met P2, an Irish man, and they travelled together in Yorkshire. S1 was living with his MGPs and during this time the Victim became pregnant with her second child, the Perpetrator. Again the Victim moved back to her parent's house in Worcestershire with P2, although it is thought that P2 lived in a caravan until the Perpetrator was born. P2 then moved back to Ireland. He has not been seen as part of this review and there has been no contact between him and the family since.

2.6 There were no recorded concerns from the Victim about her first pregnancy with S1. However, hospital notes at the time of her pregnancy with her second child (the Perpetrator), indicated that the Victim expressed the view that she was unhappy about her first pregnancy and sought information about alternative delivery at home for the birth of the Perpetrator[8]. She was at that time living in cramped accommodation with her first child (S1) and her parents and sister, which may not have been suitable. The next of kin was recorded as her parents and a discussion took place regarding the Victim keeping the child. She requested aromatherapy instead of the conventional pain relief when in labour. She also indicated that she was coming to terms with this pregnancy which was unplanned. She failed to attend for a scan in March 1991.

2.7 However in March 1991, the Victim was undecided as to whether she wanted to keep the child once it had been born. Discussions took place about the possibility of

[7] Comments made by the family during the Author's explanation of the report are contained in boxes at relevant sections of the report

[8] A subsequent investigation by the Health Authority found that all allegations were unfounded and unsubstantiated.

adoption and a referral was made to a Social Worker at the hospital. By April she had again decided to keep the child.

2.8 In August 1991, Maternal Grand Parents contacted the hospital requesting that their daughter be kept in hospital as long as possible after the birth due to 'domestic disruption', but the family cannot recall as to what the disruption was. By 12th August 1991, the grand Parents stated they would welcome her home after delivery.

2.9 **The Perpetrator's medical problems**

2.10 The birth of the Perpetrator was a normal hospital delivery without complications, the delivery being conducted by a midwife as previously arranged. Both Mother and child were discharged after three days. Four days later, the child became unwell and was admitted to hospital suffering from bilateral hydronephrosis[9], a swelling of his kidneys, resulting in septicaemia and a reflux condition where a valve between his kidneys and urinary tract was missing allowing his urine to be returned to his kidneys instead of being passed normally. This infection, according to the Victim and her family, had been caused by the student midwife using dirty scissors to cut the umbilical cord. It is understood that following this allegation being made by the Victim and her family, an investigation was conducted by the hospital concerned, which failed to substantiate the allegation. This will be discussed further in the section of this report entitled 'Views of the Family'.

2.11 The aim of treatment for hydronephrosis is to:

- remove the build-up of urine and relieve the pressure on your kidney(s)
- prevent permanent kidney damage
- treat the underlying cause of hydronephrosis

2.12 Most cases of hydronephrosis will need to be treated surgically using a combination of techniques. The timing of the treatment will depend on whether there is an infection, because there is a risk that an infection could spread into the blood resulting in blood poisoning or sepsis

2.13 If hydronephrosis is present after birth, treatment will depend on the underlying cause. If it's caused by primary vesicoureteral reflux (where the valve in their bladder does not work properly) then it is unlikely to need treatment. This is because most children grow out of primary vesicoureteral reflux as they get older.

2.14 However, the urine inside their kidneys can make them more vulnerable to infection, so regular doses of antibiotic tablets may be recommended as a precaution. The child will need regular urine tests and ultrasound scans to monitor how they are responding to antibiotic treatment and to assess the swelling inside their kidney(s).

2.15 Surgery will be considered if the child does not grow out of primary vesicoureteral reflux, or if they get repeated infections, even if taking antibiotics.

2.16 Only 11 days after being born, and 8 days after being discharged from hospital, the Perpetrator was re-admitted to hospital with infections and transferred to Birmingham Children's Hospital. He was treated with antibiotics and eventually discharged on 11th September 1991. A letter between Consultants on 7th October 1991, indicated the child did have the absence of posterior urethral valves and gross reflux, also that the

[9] Bilateral hydronephrosis - literal meaning - "water inside the kidney" — refers to distension and dilation of the renal pelvis and calyces, usually caused by obstruction of the free flow of urine from the kidney.

antibiotics used (Gentamicin) had affected his hearing. His case was transferred to another Consultant for treatment for the reflux condition by injections.

2.17 Hospital Clinic notes indicated that the Victim and the Perpetrator (now aged 8 weeks) were seen at the Baby Clinic on 15th October 1991. The Victim stated that she had been advised not to have the child vaccinated, about which the Consultant noted his opinion as being:

> 'the whole thing looks a bit odd to me – particularly not having vaccinations – mother was determined not to have them."

2.18 There then followed several hospital admissions for the Perpetrator. On 17th December 1991 he was admitted with Bronchiolitis, treated and discharged within 2 days. On 28th December 1991, he was again admitted to hospital with a raised temperature. He was discharged on 31st December.

2.19 On 3rd April 1992, the Perpetrator was seen at Baby Clinic, where the Victim expressed concern about his distended abdomen and him passing lots of urine. She also queried as to whether her son was deaf due to the effects of antibiotics. Subsequent tests, three years later, proved that his hearing was normal. Suitable scans and X-rays were arranged and it was noted that he was also to be seen at Birmingham Children's Hospital regarding his growth problems.

2.20 In June 1992, there is a comment made in the medical notes following an out-patient's appointment, stating;

> 'his mother is clearly continually worried about every little thing'.

2.21 In July 1992, the Victim and her son were seen at the GP practice and a subsequent letter from a Consultant Paediatrician was critical that the GP had not performed a screen for a possible urine infection. It appeared that the Perpetrator was not growing well and had dropped from the 50th to the 10th centile. It was noted that his kidneys were abnormally small but continued to grow. There is a comment made in the notes:

> 'Diet somewhat restricted due to [mother's] vegetarian philosophy – advice given'.

It is the family's view that the Perpetrator was not a vegetarian and ate meat throughout his life.

2.22 The Perpetrator continued with his antibiotics during the remainder of the year and in October 1992, he was seen at Hospital, where his mother (the Victim) wanted to know;

> 'What is the safe dose of medication?'

2.23 The Victim had heard that the medication was 'under a cloud'. She was reassured that the side effects mostly relate to babies under 6 months old. In view of that, she decided to administer the lowest level of medication to work for his condition.

2.24 Between August and October 1992, the Perpetrator had developed considerably from not being able to sit on his own to crawling and pulling himself up to stand. It was thought he may need special shoes to support weak ankles when he begins to walk. By November 1992, he was described by a Consultant as being:

> 'a normal small lad as opposed to a child with growth problems'.

2.25 In December 1992, the Victim was having trouble coping with the demands from the Perpetrator, who wouldn't allow her to put him down. She was also sleeping with the child at night resulting in disturbed nights for both mother and child. He would also scream out with pain due to his urine retention, which subsided when he passed urine. There is no record that she sought any medical assistance regarding this condition. She felt guilty that she was not spending enough time with S1 and was very tearful and possibly depressed. It was decided that she needed support and a Health Visitor was informed. Unfortunately the Health Visitor's records for that period cannot be traced so what support the Victim got from Health Visitors is unknown.

2.26 In January 1993, the Perpetrator's bladder problem had improved somewhat and his screaming attacks had lessened, but there were still significant problems to warrant his being seen by a Clinical Psychologist. That appointment took place on 26th May 1993, when the Victim and her son were seen briefly, after arriving 35 minutes late. The Clinical Psychologist noted;

> 'Emphatic view of mother and grandmother that [the child's] difficulties arise from intermittent organic pain. They are frustrated with [Consultant Nephrologists] in BCH, who disagrees with them over this'.

2.27 The Clinical Psychologist suggested looking at emotional and behavioural difficulties that the child presented and not related to the physical pain. Another two appointments were arranged but the Victim failed to keep the first of these.

The family will say failed appointments were due to the Perpetrator being unwell and unable to attend.

2.28 At the second appointment on 17th June 1993, (after arriving 30 minutes late) the Clinical Psychologist noted;

> 'Considerable problems of separation in [the child's] relationship with mother whatever his medical status. Willing to see [mother and child] but highlighted that [mother] had timekeeping issues and finding a suitable day and time would be difficult. Considered home visit but same issues'.

2.29 On 30th June 1993, the Perpetrator were seen again at the hospital clinic, where it was found that his bladder problem had improved and the Victim seemed to be reasonably happy but it is noted in medical notes that the grandmother still had 'dark thoughts'. It was also noted that the Perpetrator refused to take his medication, but despite the grandmother's reservations there was a need to persist. He was only 2 years old at this time. It is interesting to note that professionals were noting in 1993, comments made by 'granny' and considered her views as 'dark thoughts' which appeared to be contrary to the views of medical professionals.

2.30 Towards the end of July 1993, the Perpetrator and his mother was seen again at Birmingham Children's Hospital where he screamed throughout the consultation. His pain was relieved when he passed urine. The Victim was convinced that an organic problem was the cause and it was not related to psychological issues or stress. The Consultant noted that the screaming must be stressful for the mother. The Consultant noted that this was a difficult case to manage and he wanted to rule out any organic problem before embarking on intense programmes of emotional or psychological support.

2.31 In January 1994, the Consultant Nephrologist had prescribed new medication for the Perpetrator but the Victim had stopped using it after a few days following a consultation with her GP. The Consultant was told that the Perpetrator was staying with his grandparents as his mother was finding it difficult to cope at home and with getting S1 to school. The Consultant noted:

> 'Saw [the child] today and as usual was totally puzzled'.

2.32 In June 1994, the Consultant at the Hospital Clinic wrote to the family GP stating that the mother had stopped the Perpetrator's medication in March 1994, in favour of homeopathic remedies and she had reported that he was much better. The Consultant noted that both the Victim and the Perpetrator appeared calmer. The Victim attributed all of his previous symptoms to the antibiotics given as a prophylaxis. She had refused surgery for her son as she felt admission to hospital would upset him. She told the Consultant that the Nephrologist was not happy about this decision.

2.33 The Victim was told that the improvement may have been coincidental and the Hospital Consultant decided that there would be little to gain in confronting the mother about whether the homeopathic remedy had any beneficial effects.

2.34 In April 1995, a Health Visitor requested a development assessment of the Perpetrator, which was conducted by a Community Paediatrician. The result is noted as;

> '[The child] has global development delay with speech and language delay. Emotional insecurity, difficulty in separating from his mother, not yet toilet trained, long standing renal problems. Mother not keen for surgery. Note that following hearing loss due to Gentamicin, subsequent testing shows hearing to be normal'.

2.35 The note goes on to include that homeopathic treatment was being used and not antibiotics and due to his development delay and separation issues the mother had agreed to attend a specialist nursery for a period of input and assessment[10]. The Perpetrator was 4 years of age at this point. The Victim failed to keep the appointment arranged for 4th August 1995.

2.36 There is nothing in the chronology from August 1995 until January 1998. It is presumed that the Victim followed homeopathic treatment for the Perpetrator during this period of time. However there appears to be a lack of follow up during those 3 years with a child who had health issues and was not seen by any medical professional. From August 1995 when he was not taken for his appointment at the age of 4 years, until 1998, when he was 7 years old he was 'under the radar' of medical services and this could be seen as a missed opportunity for intervention.

The family say that once the Perpetrator was taken off antibiotics and prescribed medication he improved significantly. He was toilet trained at the age of 5 years and he was able to read and write. At the age of 7 years he had a thirst for learning and no longer had screaming fits.

[10] In those days it would be common practice, where children were approaching nursery / school age, for the community consultant paediatricians to take over the care of the child where special needs had been identified with their development. The hospital based consultant would therefore have no further contact with the child / family. The community consultant would share the care with the specialist consultants at BCH.

2.37 Much of the Perpetrator's early life was spent either as an in-patient or at out patient's appointments at Worcestershire Hospitals or Birmingham Children's Hospital. The Victim had stated she was told by a Doctor the child would not live beyond the age of 7 years and if he did, he would not survive through his teenage years. The family are certain of this. This statement is not supported by medical records.

2.38 In January 1998, Worcestershire County Council Education Department Special Education Support Team (SEST) requested a period of assessment to investigate difficulties the Perpetrator was having in language, understanding and thinking skills, reading and writing.

2.39 As a result of the assessment, in June 1998, actions for the Perpetrator's class teacher, Special Educational Needs Co-ordinator (SENCO) his parents and the Learning and Behaviour Support Service (LBSS) were raised. Hand-outs were provided for work on describing, asking, questioning, picture work and games to develop his social skills.

2.40 The Perpetrator's Education

2.41 Like his older brother, the Perpetrator started his education at a local Primary School, but he was slow learning to read. Not being satisfied with the schooling he was receiving the family moved him to an independent Evangelical school, which his older brother had already been moved to. The reason for the change given to the state school was that the family were to move out of the area. The Perpetrator progressed well, but the Victim was finding the school fees difficult to cope with, so she would offset them by working as a cleaner at the school.

2.42 In 2001, the older brother S1 was having problems at school claiming he was being bullied. Mother and H1 decided to remove both boys from the school and home educate them both. The Perpetrator was found in the corridor of the school whilst other children in his class were being taught inside the classroom. The school provided extra work for the Perpetrator and whilst S1 was ahead of others in his class there was no challenging work for him and S1 became bored at school. The Victim complained to the school but nothing was done so the boys were removed.

2.43 In September 2001, the Perpetrator and his brother S1 were removed from the Independent school by their mother to be electively home educated. The record shows that H1 and the Victim contacted the Home Education Liaison Officer to confirm their intention to home educate both boys

2.44 It is important to note that there was no Departmental Guidance on Elective Home Education until August 2007. Pre-2007 the DfEE had published a leaflet on home education in England and Wales which reflected basic practice.

2.45 All schools are required to notify the local authority when a child is being taken off roll to be home educated. The Local Authority during the timescales of this review had a duty to serve notice on parents when they are found not to be able to provide a suitable education. The Elective Home Education service contacted the parents to ascertain the arrangements they were making for their children in accordance with Section 7 of the Education Act 1996; this could either have been achieved through home visits or the request for written information.

2.46 When a family is confirmed to be providing a suitable education, requests for information would be made on an annual basis. In cases where the education is

deemed unsuitable, visits would be more frequent (3 successive occasions) until it was either deemed suitable or the child had returned to school. If the parent had not made suitable arrangements by the third contact then the Home Education Liaison Officer (HELO) would make a referral to the Education Welfare Service for a School Attendance Order

2.47 The records show that during the timescales of this report there were four WCC Home Education Liaison Officers who were in post whilst the children were being home educated. On every request for information regarding the child's education the parents were able to demonstrate that a suitable education was taking place by providing detailed evidence of their work. Parents informed the HELO of the Perpetrator's lack of confidence and learning difficulties and it was observed that his educational arrangements were suitable for his age, aptitude, ability and SEN.

2.48 The Perpetrator was 10 years of age at this time, and there were no concerns about the child in terms of risk to others which can be discerned from either the Home Education records or the records from the Learning and Behaviour Support Service or the report from the Special Education Support Team carried out at his previous school. None of the educational records reveal any concern about risk or safeguarding of any member of the family.

2.49 The remit of the Home Education Liaison Officer during meetings with parents and children at home or at an arranged meeting place has always been (and still is) to make assessments of the suitability of the education being provided by parents according to age, aptitude, ability and any Special Educational Need he or she may have. If there had been any concerns about the safeguarding of any member of the family she had met in the course of her work, the (HELO) would have referred the case to the Access Centre.

2.50 There is a record showing that the HELO at the time the Perpetrator became home educated requested of Social Services whether there had been any personal protection issues of which she should be aware, and the response was recorded that the family was not known to Social Services.

2.51 The Perpetrator and his older brother were home educated for the remainder of their school years. There was annual contact between the family and the Elective Home Education (EHE) Tutor, who, after examining course work and test sheets that were submitted, considered he was progressing well in all measured areas. There were however occasions when the Tutor did not see the Perpetrator, but this is not a requirement of the EHE scheme.

2.52 The Education IMR author helpfully points out in detail:

> "The Law and Guidance around Elective Home is very clear that it is not a legal requirement for the child to be seen during contact made with the family to ascertain the suitability of home education. If parents choose not to allow their child to be seen by the officer, the officer can request samples of work in lieu of a meeting. The Elective Home Education Officer's remit is to establish whether a suitable education is taking place, taking into account age, ability and aptitude and any special educational needs s/he may have. The LA Officer does not have the power to expect to see any child being electively home educated, but if in the course of identifying whether a suitable education is taking place, the EHE Officer has evidence for safeguarding concerns, the officer would then make a referral through the Access Centre to record and alert the appropriate agency to these concerns."

"It is not clear from the records whether the previous EHE Officer had met the [Perpetrator] in the course of establishing whether a suitable education was taking place. On 18th October 2005 (nine years before the homicide occurred) the EHE Officer, having looked at samples of work provided by the [Victim], and not having seen the [Perpetrator] at that October meeting., did record in her report that she had stated to the [Victim] …"it would be nice to meet the [Perpetrator] himself so that he can show me his work and receive further praise for his efforts."

"The EHE Officer did meet [the Perpetrator] with both of his parents seven months later on 17th May 2006, at the Parent Partnership Office in Worcester. There were no problems reported and there was no record made of any safeguarding concern. The notes show [the Perpetrator] as an active participator in the conversation about his education. He spoke about the books he was reading, his art work, about the archaeology club he belonged to and attended, and about his interest in history."

"There was no evidence from this or from previous records that [the Victim] was 'deflecting efforts to see [the Perpetrator]'. There are a number of reasons why a child may not be seen during a visit ranging from ill health, shyness, staying with relatives and anxiety. Of course the other reason may be because the child may be a victim of abuse. It is recognised that the absence of a child may give cause for the EHE Officer to be concerned; however, this will usually be where the child has been previously subject to a child protection plan or where there is other information available. However, without such information, we must not assume every child who is home educated is subject to abuse. Where the absence of a child gives reason for the Officer to be concerned then safeguarding procedures are followed accordingly. In this DHR, if the EHE Officer had been concerned then the Access Centre would have been notified, and as they were not notified it suggests there was no evidence for the EHE Officer to be concerned."

"In his final year of statutory education [the Perpetrator] was encouraged to make an appointment with Connexions for careers advice as he was undecided about what he would like to do when he finished his statutory education. The EHE Service concluded their involvement on the 30th June 2007 as he was beyond statutory school age and therefore had no further remit."

"Both of the records (18/10/2005 and 17/05/2006) show that the officer did show professional curiosity, in her expressed interest in seeing [the Perpetrator], and in that she encouraged [the Victim] to allay his fears about meeting a new person now that [the Victim] had met her. Although there is no obligation for electively home educating parents to ensure that the child is seen by the officer, []the Victim and H1] did co-operate with her implied request to bring him to the next meeting, which was after a period of seven months rather than after a year which would have been the usual contact period (Section 53 of the Children's Act 2004 Act sets out the duty on local authorities to, where reasonably practicable, take into account the child's wishes and feelings with regard to the provision of services. Section 53 does not extend local authorities' functions. It does not, for example, place an obligation on local authorities to ascertain the child's wishes about elective home education as it is not a service provided by the local authority)."

2.53 The Overview Author makes a recommendation about Elective Home Education within the analysis section of this report.

2.54 The Birth of S2 and S3

2.55 During 2001, the Victim became pregnant again. She had decided to decline any medical support during her pregnancy, which included declining any scans, although MGF stated that the Victim did see midwives throughout her pregnancy. Records indicate that she declined routine blood pressure monitoring, blood samples, urine tests and ultra sound scans. The midwife records that she explained the risks of not having proper antenatal care.

2.56 On 25th November 2001, the Victim was seen by the midwife who was allowed to palpate the Victim's abdomen, estimate the size of the pregnancy and listen to the foetal heartbeat. The Victim expressed a wish for a Home Birth and also to use alternative homeopathy therapy. She also wished for the cord to be tied with a ligature and not clamped. The Midwife referred the case to her supervisor of midwives who arranged a home visit and team discussion around the Victim's requests.

2.57 On 16th December 2001, a Midwife made a routine home visit and recorded that the house was in a state of chaos. The Victim declined routine blood test and urine tests but did allow abdominal palpating and listening to the foetal heartbeat. The midwife records that the examination, such as it was, was conducted in an easy chair as there was no settee, no bed and no linen. The Victim stated they had a bed frame and had ordered a mattress and bed linen.

The view of the family is that the word 'Chaos' is an opinion and is out of context and they object to the use of this word. There had been a bed ordered and at this time they were waiting for it to be delivered. The family and the midwife were at variance over several issues.

2.58 Following her examination, the Midwife concluded that the pregnancy was more advanced than the 29 weeks worked out by calendar. The baby was in a breached position and there was a lot of fluid present. This caused concerns and this, together with the fact that the house was clearly not ready for the birth, caused the midwife to recommend against a home birth. The Victim said she would discuss the matter with H1. The Midwife explained that her supervisor would have to be informed due to the issues of non-conformity to regular care.

2.59 Three days later on 19th December 2001, H1 contacted the Midwife, stating that he and the Victim intended to continue with a home birth. He stated that they were not happy with the Midwife and wanted a replacement to care for them. Apparently the Victim had been worried about what she had been told by the original Midwife, in that the baby was in an unusual position and there was a risk. The Midwife was required to apologise to the family for her comments. The Midwife should not have been asked to apologise because she was following guidance around home birth and gave the correct explanation as to why the victim should not have given birth at home. The family stress that they consider these comments to be opinion.

2.60 On 27th December 2001, an acting Midwife Supervisor visited the Victim, who declined an examination but the foetal heart beat was heard. The Victim stated that she and H1 wanted a normal birth as possible, making decisions as the need arises. This they said would not put the life of herself or the baby at risk. They had decided 'what they would like and not like'.

The family say that the midwife was against the home birth request as the baby was likely to be born over the Christmas Holiday period and the midwife was reluctant to work over that period.

2.61 On 13th January 2002, at 34 weeks gestation, H1 reported that the Victim was not sleeping well and had Oedema of the legs. A Midwife attended but could not hear the heart-beat. A second Midwife was summoned who detected the heartbeat. The following week the Victim refused routine monitoring and stated she didn't wish to have pain relief during labour.

2.62 On 25th January 2002, a Midwife was called to the house by the Victim, who appeared to be in labour. Both the Victim and H1 refused to allow any routine observations of mother and the baby which prevented any professional judgements on the status of the mother's or the baby's health.

2.63 During the birth complications arose. The baby was presenting a hand, arm and shoulder. The Midwife rang 999 for an ambulance against the wishes of the Victim and H1. Once at hospital, the Victim realised that the only safe way to deliver the baby was by Caesarean Section, to which she consented. Whilst this operation was being conducted it was realised that the Victim had been carrying undiagnosed twins.

Again the family disagree with these comments. There were two midwives present, a senior midwife and another who had been at the birth of the Perpetrator. It was suggested that an ambulance was required and H1 enquired why? Once it was explained that there were complications he and the Victim agreed. In the ambulance during the journey the Victim gave verbal permission for a Caesarean Section and then once in hospital signed the necessary form giving written permission.

2.64 This was the first occasion that it was realised she was having twins. S2 and S3 were born premature at 36 weeks gestation. S3 started fitting within an hour, she had no heart beat and required assistance with breathing and was intubated. Her prognosis was very poor and this was discussed with H1. It was decided to monitor her situation over the following few days and see if continued intensive care would be appropriate.

H1 stated that the twins were discovered whilst the Victim was at home and the midwife who had been present during the birth of the Perpetrator attempted to push the first baby's arm back into the womb to keep warm. Apparently this midwife had not delivered twins at home before. The Victim did not want this particular midwife to be present

2.65 [redacted] be taken from her.

2.66 On 26th January 2002, S3 was diagnosed with severe brain damage which was likely to worsen without further intensive care. The parents agreed to continue supportive care. However S3 did not improve and the parents were informed of the prognosis. The Midwife noted that the parents, appearing to accept the inevitability of the situation stated that they were only expecting one child and will still have one when S3 dies.

H1 stated that he contested these issues during the complaint that the family had made to the hospital authorities. He had reconciled the fact that S3 was likely to pass away and the family came to the hospital to say their goodbyes.

2.67 On 27th January 2002, whilst both parents were cuddling both S2 and S3, H1 was overheard expressing the opinion that some of S3's discomfort was caused by the actions of the Midwife trying to push S3 back into the womb during the birth. He also stated that he thought that S3 would have died by now and people were attending the hospital to say their goodbyes to her. The following day, the parents agreed to no further anticonvulsant medication or oxygen would be given. They wanted a detailed explanation of the actions at the birth of S3 which a Consultant Paediatrician gave to them. There had been no signs of life at birth until 20 minutes had elapsed and she had suffered extreme oxygen starvation.

2.68 S3 died peacefully 4 days later and S2 survived. It is the family's view that the midwife 'panicked' when she realised that twins were to be born, and that the midwife was the same person that delivered the Perpetrator. Medical records do not support this.

2.69 The Victim and H1 made formal complaints to the Health Authority about the circumstances surrounding the birth of S2 and S3 and the death of S3. This was fully investigated and no evidence of mal-practice was discovered. The case was also referred to an Independent Convenor as the parents were unhappy with the result of the investigation,

2.70 Regression Therapy[11]

2.71 By the time the Perpetrator was in his late teens, he was experiencing significant problems with his eye sight, which, according to the family, was described as clouding or skin forming over part of his eye causing partial blindness[12]. No professional help was sought by the Victim to treat his eye problem. The family are of the opinion that the condition was caused by the prolonged prescribing of his medication years before and that at that age he had the capacity to seek or decline medical treatment for whatever aliment.

2.72 Due to the Victim's loss in faith with the medical services, she turned to 'regression therapy' for the Perpetrator. MGF told Police that it was because there was a belief that regression therapy would heal him.

MGF stated that he found Regression Therapy whilst searching the world-wide-web as an alternative treatment and the Perpetrator was attracted to it. Between the ages of 10 and 17 years the Perpetrator led a perfectly normal lifestyle.

2.73 The Victim went on a regression therapy course and in June 2013, she arranged an appointment for herself and her son to have regression therapy with a qualified dedicated practitioner of Quantum Healing Hypnosis. The Practitioner described to the Police the Victim's 'bizarre' behaviour at their appointment. She said the Victim told her she carries guilt for not making different decisions and that this related to her getting all her family to use a female homeopath who she now believed had poisoned them. She said she constantly suffered with noises in her head and that she spoke incessantly.

[11] 'Regression therapy' consists of apparently hypnotising a person who is taken back to their childhood or 'previous lives' for the purpose of finding out the causes of a present day illness. This is also called Quantum Healing Hypnosis.

[12] Whilst at a secure hospital awaiting trial, the Perpetrator has been diagnosed with double cataracts in his eyes.

2.74 The Perpetrator was booked to see the hypnotherapist the following day however, after they were late for the appointment, the Victim said she would take him home without having the session. The hypnotherapist was of the opinion that the Victim was putting herself before her son and didn't care whether he had a session or not. In the event the Perpetrator did have a session of hypnotherapy which the Victim was present at all times. The hypnotherapist describes how she kept shaking her head as if what her son was saying was untrue and that she began adding information to what he was saying.

The family refute that the Victim would have put herself first and considers these views as opinion. They say that it was the Perpetrator that drove the regression therapy and not the Victim. MGF described how he sought assistance for the Perpetrator's deteriorating mental illness from MIND some six months before the death of the victim. H1 was asked what the Family had done to address the Perpetrator's mental ill health to which he queried 'how does one deal with this with a 21 year old?' The Perpetrator was fine during November, December and January but deteriorated suddenly during a few weeks in February.

2.75 The hypnotherapist describes how hard she felt the Perpetrator had taken the death of his sister and that he felt attached to her spirit. When asked what was stopping him having the life he wanted he said 'eyesight, social interaction and drug side effects'.

2.76 The family would say that following this regression therapy that the Perpetrator's character changed but that his eyesight improved and his arthritic knee was cured completely. The family allege that the regression therapist had given him a means to self-help by quoting some word or self-hypnotising himself and that as a result his behaviour became increasingly challenging. This consisted of him assuming the identity of famous dead people like Edward Elgar or Winston Churchill. He also claimed he was Jesus and locked himself in the toilet saying he was the voice of God. H1 states the Perpetrator said he was hearing voices. MGM states that the Victim also 'regressed' her son herself and that 'people who had known him for a long time wouldn't have recognised him after July 2013.

MGF stated that his grandson's symptoms did not fit schizophrenia but his research indicated that they were similar to 'possession illness' – hence the use of name of famous people. H1 was convinced that possession illness did not exist and strongly believes that one day the Perpetrator will be diagnosed with the correct illness and therefore receive the appropriate treatment.

2.77 The Perpetrator in his later years

2.78 Once the Perpetrator had reached school leaving age and was no longer required to complete school work, he remained at home with his family. The family describe how he and his Mother were very close and due to his deteriorating eye sight he was dependent on his family to accompany him wherever he went on most occasions.

2.79 He demonstrated a skill and great pleasure in wood cutting and was a regular attendant at a local forest woodland trust centre, where he would use power tools and axes to cut trees down, harvest cut wood and also partake in woodcarving. He was nearly always accompanied there by his older brother and/or his grandfather, on whom he relied for transport. Whilst at the trust he passed a woodland management course and developed an interest in woodwork.

2.80 During his dealings with the Police following the death of his Mother, it is stated that the Perpetrator commented that he was never left alone. This comment appeared to insinuate this situation had caused him some frustration especially as his mental health was deteriorating.

2.81 Once an adult, the Perpetrator of course, could make his own decisions about his health and well-being. There is no evidence to suggest that he lacked the mental capacity to make decisions and he maintained the family's view and chose to avoid any medical intervention whatsoever.

2.82 H1 has since told the Author of this report that if urgent medical assistance was required the family would of course attend local hospitals, and if not so serious would have sought medical help from the Grand Parent's registered GP, but such occasions had not arisen. This view is supported by MGF.

2.83 The first brief contact the family had with the Police was in January 2010, when during the afternoon, the Victim contacted the Police saying that her husband, H1, had not returned home and was not answering his phone. She enquired if there had been any reported accidents. Police telephoned H1 who answered and stated he had just come from a meeting. There was no further action taken.

2.84 At 0300 hours on 22nd August 2013 the Perpetrator was found by a Police Officer patrolling in roads and lanes near to where the Perpetrator lived. The Officer saw that the Perpetrator was confused. It was raining and as the Officer spoke to him, the Perpetrator was unable to answer any questions put to him apart from stating the name of the house where he lived.

2.85 The Officer formed the opinion that the Perpetrator may have a mental illness and called for a 'First Responder' (medic) to attend because although the Perpetrator was conscious and breathing, he was not responding to the Officer. The Officer noticed that the Perpetrator was having difficulty seeing and could only make out shapes. The medic attended and found the Perpetrator did not require medical treatment.

2.86 Police enquiries were made in the local area and Officers found a house with the name being quoted. The Victim told the Police that the Perpetrator had left the house intending to walk to his grandparent's house some three and a half miles away. They also explained that there were several things wrong in the house that were causing the Perpetrator difficulty, such as wasp's nest and mice, which made his movement around the house a problem due to his poor eye sight.

2.87 As a result of the Police Officer talking to the Victim, it became apparent that MGM and MGF had moved into the family home to assist the Victim to cope with the Perpetrator's behaviour. In a statement made to the police, MGM talks of the family contacting a Psychologist from the USA (probably via a website) who had taught the Victim how to make holy water and gave the family "words" to help cope with the Perpetrator. MGM explained that the psychologist was able to do this "through the Arc Angel St Michael who had got permission from the higher spirits to help people on earth".

2.88 It was described that the Perpetrator's behaviour was becoming increasingly aggressive and he had developed a fascination with knives which had to be locked away for the protection of the whole family. H1 explained how he had woken one night to find the Perpetrator standing over him in a trance like state, imitating a chopping action as if he was wielding an axe. After this MGM locked all of knives

owing to their concerns that he might hurt someone. This significant event and risk was not known to any agency prior to the homicide.

2.89 The Perpetrator would regularly go out walking for hours, sometimes from early morning until late at night and occasionally until the middle of the night.

2.90 From post incident Police records it appears that during one conversation with his mother, the Perpetrator told her she was going to die in her forties in tragic circumstances. This was apparently after visiting a particular museum in Stratford-on-Avon and seeing a graphic picture of a woman being murdered.

2.91 He was left with his family by Officers who submitted a Vulnerable Adults Report which was forwarded to West Mercia Police Vulnerable Adults Department. The referral was received by Worcestershire Health and Social Care Access Centre (WHASCAS) 8 days after the incident occurred and was categorised as not to require an immediate response. In fact enquiries into this referral did not commence until 10th September 2013, 11 days after the referral was made and 19 days after the incident occurred.

2.92 The process used by the customer advisors in the WHASCAS for Vulnerable Adult referrals was followed which included checking if there were any previous referrals regarding the Perpetrator, trying to establish his general practitioner and attempting to speak to the Perpetrator regarding the referral.

2.93 On 29th August 2013, after considering the event of 22nd August, a referral was made by West Mercia Police to Social Services about the Perpetrator being found in a confused state at 0300 hours.

2.94 During September 2013, WHASCAS made enquiries with all of the GP Surgeries in the area of which none had any record of the Perpetrator being registered. There followed 5 attempts by WHASCAS to contact the Perpetrator by telephone but on each occasion there was either no reply or the Customer Advisor was told to ring back.

The view of the family is that the Perpetrator may have been registered under his first surname, which was changed by deed poll when the Victim and H1 were together. The Perpetrator did receive postal information from GPs about sexual health etc. so he must have been registered with a local GP. Subsequent enquiries found he had been registered at another surgery under his father's last name but had not been seen for years.

2.95 Eventually, on 17th September 2013, the Victim returned a call from WHASCAS Customer Advisor. She explained that the Perpetrator was at work. His ongoing sight problems were related to health problems that he had had since his birth and that she was told that he was not expected to live beyond 5 years of age. The Victim added that her son was aware of the support services that existed regarding his sight but he did not want them. She added that he was not usually out of the house at 0300, and when the Police found him, he was not sure who they were and he was wary of them. She stated that her son is independent regarding his sight problems and did not need any support. She added that she would inform her son of the telephone contact so that he was aware that he could make contact for advice and assistance if necessary.

2.96 WHASCAS did not have any direct contact then or since with the Perpetrator.

2.97 During Christmas 2013, the family gave the Perpetrator the key to the shed where the tools had been locked away as a good will gesture. However, a short time later 2 knives went missing from the dish washer. The family stated he had apparently:

> "taken on the spirit of a troublemaker who did the opposite to what the family wanted him to do".

2.98 It appears that the Perpetrator had developed a hatred of his brother S1, and a few days before the end of January 2014 he told his mother he hated her and the family were all evil.

2.99 On 25th January 2014, the family went out into Birmingham and the Perpetrator went off on his own for some time. The family found him in a gent's toilet moving his eyes from side to side and moving his lips but without saying anything. He tried to lock himself in a cubicle in the toilet and also attempted to run away from the family but was prevented from doing so by family members.

2.100 The next incident of note also involved West Mercia Police. Between 18.15 and 18.18 hours on 28th January 2014, West Mercia Police received three calls from members of the public reporting a man lying on the grass verge at the side of the main A38 at Martin Hussingtree, near Droitwich, Worcestershire.

2.101 A Police Officer was sent and found the Perpetrator sitting in a lay-by. He stated that he had been walking for some time and was tired. He said he had been trying to get to his Aunt's house. The weather was very cold at that time although the Officer described the Perpetrator as being appropriately dressed.

2.102 The Officer contacted his mother and owing to his limited sight and the darkness of the hour, the Perpetrator was taken home by the Police Officer.

2.103 Once at home the Victim stated she was surprised that he was trying to find his Aunt's house, as the two families had not spoken for some time. She said that her son was doing National Trust walks and this is quite normal behaviour for him.

2.104 There was no referral made regarding this incident.

2.105 When interviewed by Police MGF stated later that day, 28th January 2014, the Victim gave the Perpetrator an ultimatum, which was he either continued with regression therapy or received conventional medicine at a local psychiatric hospital. His reaction to that was to punch his mother in the face, which was the first occasion that he had been physically violent to any member of his family. There was no report of this incident to the police or any other agency on that day.

2.106 The following day on 29th January 2014, his mother again gave the Perpetrator the same ultimatum. He became aggressive and refused to do anything or go anywhere. As a result the Victim telephoned the police to speak to the officer who had found him at Martin Hussingtree, the day before. The officer was on leave; however the Victim spoke to someone at the police station who advised her to take her son to the local hospital. (There is no record of this call in any West Mercia police systems and it is presumed this was just a non-recorded telephone conversation between the Victim and an Officer or Police Staff who answered the call).

2.107 The Perpetrator chose to go to the local psychiatric hospital and MGM and MGF started to drive him there. On route however, he changed his mind and promised to continue with alternative therapy. He was taken back home before reaching the hospital and for the rest of the day was described as being very quiet. The following

day, 30th January 2014, the Perpetrator went out walking early. When he returned at midday his mother was still in bed. She then spent time contacting a "medium" in order to arrange an appointment for her son. The "medium" refused to see her son saying she wasn't insured to treat such severe cases.

2.108 At that time, H1 was at work, MGF was out walking the family dog, which left the Victim, the Perpetrator, MGM and S2 in the house (it is not known where S1 was). The Victim called the Perpetrator upstairs to her bedroom to talk to him and whilst in the bedroom he produced a knife and stabbed his mother several times about the body. MGM and S2 went upstairs to see what the commotion was and saw the Perpetrator straddled across his mother on the bed repeatedly stabbing her with the knife. MGM and S2 pulled the Perpetrator off his mother but in doing so S2 was also stabbed by the knife.

2.109 MGM called the police who attended very quickly together with the ambulance service and the Victim was found collapsed in the hallway, lifeless and unresponsive.

2.110 The Perpetrator was found outside the house and he was arrested.

2.111 A post mortem was later performed by a Home Office Forensic Pathologist who found the Victim had been stabbed in the face, neck, front and rear of her torso, in both upper limbs and her left lower leg. One stab wound had damaged the subclavian artery which supplies the upper limb and is responsible for the blood located in the chest cavity which was the resulting cause of death.

2.112 The Perpetrator was charged with the murder of his mother on 31st January 2014 and was remanded in custody. Since that date he has been detained in a secure hospital awaiting appearance at the Crown Court as well as being assessed under the Mental Health Act 1983.

3.0 The Views of the Family

3.1 The Overview Report Author has contacted the family on several occasions, and has visited the family home on three occasions, the first being on 4th September 2014 and three other meetings to explain the findings of the review. The Author also had two lengthy meetings with MGF on 12th January 2015 and 24th July 2015. At the meeting on 4th September 2014 at the family home, the Author met H1, S1 and S2. H1 described how the Perpetrator had sought self-hypnosis techniques from a Past Life Regression Therapist in Wimbledon having accessed her over the Internet. This was at his own instigation.

3.2 In respect of the boys' education, H1 explained that S1 was moved to a private school and the Perpetrator joined him there after some time. Initially the boys were happy, but S1 was bullied and there was a new head and other new teachers. The Victim became dissatisfied with the school and the Perpetrator did not catch up following his illness in his earlier years which caused him to miss a significant amount of education. The school moved the Perpetrator down a class and had categorised him as having special educational needs. On one occasion the Victim had found the Perpetrator sitting outside his class at a table colouring pictures whilst the rest of his class were being taught inside the classroom.

3.3 H1 explained that the Victim was a Classroom Assistant[13] at both of the schools the boys attended and she had attended Worcestershire Technical College for Child

[13] There is inconsistency as to whether the Victim was a classroom Assistant, a cleaner or both at the school.

Care courses. H1 also stated that he had worked with the visually impaired and had started tutoring qualifications but had been online to develop learning systems. He stated that both he and MGF were Physicists.

3.4 H1 explained that the family had moved away from that particular GP's surgery as they were unhappy with the services and did not re-register with another.

3.5 In relation to the problems of the birth of the Perpetrator and S2 and S3, H1 states he was told by the Victim that following the complaint made to the Health Authority notes of the birth of the Perpetrator 'went missing'. As a result of that, when S3 died, he asked for and was given the medical notes and copied them. At a subsequent meeting/hearing, what was claimed was contained in the notes was different to those he had copied. No notes were produced. (It should be noted that all complaints that referred to the conduct of the midwife at the time of birth of the twins were referred to an Independent Convenor who found they were all unsubstantiated and unfounded).

3.6 The meeting with MGF on 12th January 2015 revealed that the Perpetrator used to read with the aid of a magnifying glass but when he was receiving hypnotherapy, his eyesight improved to such an extent that he no longer needed the magnifying glass.

3.7 MGF explained that the Perpetrator was adamant about his rejection of any involvement with doctors and support agencies. Indeed the charity MIND had contacted the Perpetrator on two occasions, but he had refused to talk to them. MIND had become involved due to MGF researching alternative options and came across the services MIND could offer and phoned for advice. He explained that in June 2013 something went wrong with the hypnotherapy process. The Perpetrator would be able to hypnotise himself by quoting words and he then appeared to be in a trace like state, sometimes for several days. His Mother would try to count him out of the trance, (an exit mechanism the Victim would try to use) but the Perpetrator would refuse to comply. Once removed from the trance like condition, the Perpetrator would not have any recollection of what had happened.

3.8 He confirmed the medical problems that the Perpetrator had as a very young child. He states that it was his wife (MGM) who the midwife asked to pass her scissors to cut the Perpetrators umbilical cord and his wife stated she saw the scissors were dirty. He also agrees with H1 that the notes of the birth went missing.

3.9 MGF alleges that the kidney damage to the Perpetrator was caused by 12-18 months of prescribed drugs about which, he says, a pharmacist said that a baby should not be on those drugs for any longer than 6 months. However, professional opinion has been sought by the Author from an experienced Paediatric Consultant who stated:

> 'Gentamicin is a powerful antibiotic when given by injection and is normally only given for a few days, at most a week or so. Gentamicin can also be used with ear or eye drops to treat particular infections. This would normally only be used for a few days or a week or so at most. I don't know why anyone would continue to need gentamicin drops for longer than this and would be correct for a pharmacist to query its long term use. It is possible that a specialist had identified a specific need for this long term but I don't know what that would be.'

3.10 MGF says that he was with his daughter, the Victim, when she was told that the Perpetrator would need surgery on one or more occasions to rectify his kidney problems but there would only be a 50% chance of survival and when his daughter questioned the Doctor, she was told that there were alternatives. MGF recalls that

this was not the Perpetrator's usual Consultant but another Doctor, perhaps a locum. As a result of this the Victim turned to homeopathy and other alternative medicine and this affected the Victim's view of medical people and the Health Service. He confirms that the Victim had a disagreement with a GP.

3.11 MGF is of the view that it was the same midwife who attended at the twin's birth, who had attended the Perpetrator's birth. He explained that S2 was much smaller than S3 and the family wonder whether or not S2 was a second conception once S3 had become an embryo. He said the midwife panicked when she realised there were twins and the midwife tried to stop the birth thereby causing damage to S3. (This is also unsubstantiated by a subsequent enquiry by the hospital).

3.12 MGF explained that the Victim and the Perpetrator were emotionally very close.

3.13 MGF and S1 would take the Perpetrator to the Woodland Trust where the Perpetrator would enjoy general woodland management, carving wood and cutting trees down. He also joined the Young Archaeological Society. The family say that there was a period of some years between the ages of 9 or 10 until his late teens when the Perpetrator was a 'normal' person. He was an avid reader and a very sociable young man. He did well at school and led a normal life. It was only in the latter years of this period of review that he became associated with regression therapy and his mental health deteriorated.

3.14 The Author explained the process and the necessity for the Domestic Homicide Review, to which his final comment to the Author was:

> "I hope my daughter doesn't get the blame for this. She did the best she could with a difficult set of circumstances".

3.15 There is no doubt that the parents, particularly the Victim, had strongly held beliefs about alternative therapies However, there are questions for agencies around consideration for safeguarding/well-being and when such views manifest into areas around the risk of significant harm to the child concerned. Although the H1 and MGF will say that the Perpetrator was an adult and could make his own choices, for most of the time that decisions were being made about his medical treatment he was a child and a young person within the meaning of the Children Act, and those making decisions had a parental responsibility for him.

The family add to the above that the Victim took alternative medical choices following a suggestion from a Doctor at Birmingham Children's Hospital. When the Perpetrator was older, 12 years and above, the GP had to listen to the child's wishes and opinion. These views could be over ruled by a parent.

When she was pregnant with the twins, the Victim only objected to ultrasound scans due to a fear of the ultrasound process causing problems with the pregnancy.

3.16 Prior to the presentation of this review to the Community Safety Partnership Board, the author together with a member of AAFDA (Advocacy After Fatal Domestic Abuse) spent time with the family examining the outcomes of the review. The family are content with the results of the review. They are also content with the use of the terms Victim and Perpetrator throughout this report. The term Perpetrator has been in the chronology since his birth in order to distinguish him from two other brothers. The family understand this and have no adverse comments.

4. Analysis and Recommendations

4.1 At a panel meeting on 17th November 2014, the Overview Author brought the panel up to date with the review process and the fact that H1 had been seen together with S1 and S2. The panel were concerned about S2's future and wellbeing and as a result the police representative on the panel made a referral to Children's Social Care for them to assess whether S2 had any safeguarding needs.

4.2 Liaison between the allocated social worker and the Overview Author took place and the Social Worker had kindly examined the few records that existed which confirmed much of what is contained in this report. In addition to what was already known, the Social Worker stated that early records contained the comments that the Victim was against conventional medicine. She could take offence if someone mentioned something she didn't agree with.

4.3 It is also recorded that Victim told her GP that the family were using homeopathic medicine and despite the GP surgery sending vaccination reminders during 2007, 2008, 2009, the Victim chose not to undertake diphtheria and all other immunisations for S1 and the Perpetrator. The result of the Children Social Care assessment is that there was insufficient evidence to meet any threshold of either Section 17 (Child in Need) or a Section 47 (Child Protection) procedure. It is acknowledged that the family's lifestyle was unconventional and alternative but the choices to live in that way have been made by adults, who have the mental capacity to make those choices. However, it has to be said that both S1 and the Perpetrator were children when some of those decisions were made.

4.4 It has been agreed between Children's Social Care and the family that there will be an annual contact with the family on the basis of offering any support for S2 that the family may wish to take advantage of.

4.5 At the time of the Perpetrators birth, 1991, there were no protocols in existence in relation to Health Agencies actively pursuing patients in relation to the possibility of domestic abuse within their relationships, so the question of domestic abuse in the Victims life at that time was not raised.

4.6 Since 1991 there has been considerable advancement in relation to a proactive approach across health and every other agency in recognising the signs and symptoms of domestic abuse and actively broaching the subject with patients.

4.7 It may be considered however, with the Victim's stance on her relationship with the medical profession, that at the time of being informed that there was a surgical remedy for the Perpetrator's kidney problem, which mother chose not to pursue, was a missed opportunity for professionals to consider if the decision was putting the child at that time or at any future time, at risk. The objective of the surgery was to correct his serious illness and although the Victim and MGF will say that they were told there was a 50/50 chance of success, this is not supported by medical evidence. The Perpetrator had unmet medical needs, which may have put him at risk of significant harm as a result of decisions made by his mother. He was under the radar of medical attention during which time his health issues were not attended to by any medical professional.

It is the family's view that the Perpetrator's kidney problem cleared when traditional medical care ceased so there was no requirement for any medical intervention.

The family say that the Doctor that told them there were alternatives to surgery for the reflux action by a Clinician who was not a surgeon or Consultant, but may have been Head of the Department.

4.8 A question raised by the Author at the meeting with the family was 'Is it possible for the Perpetrator to have grown out of the reflux condition?' Opinion was sought from an experienced Consultant Paediatrician, who after hearing the circumstances replied:

> 'The condition you describe is called 'vesicoureteric reflux'. It is quite common. Most children will naturally grow out of the condition although some severe cases continue to occur in adults.
>
> Treatment is often regular long term antibiotics to stop infections causing progressive kidney damage. Sometimes surgery is used as treatment. There are many different procedures including bladder injections and open operations. I don't know precisely what treatment he was on but it does not seem very likely that stopping the treatment made his condition get better. The most likely outcome was that his reflux got better naturally as he grew. Sometimes, without proper medical assessment, the reflux can continue 'silently' unbeknown to the patient. In that case severe kidney damage could slowly develop until the patient presents in adulthood with chronic renal failure. So it may be possible the he may still have the condition but does not know as he has not attended for medical assessment (Unless this has been done recently).'

The family's view is that whilst the Perpetrator has been on remand in hospital his kidneys have been examined and there is no lasting damaged diagnosed

4.9 The medical opinion is then, that it is more likely that the Perpetrator naturally grew out of the reflux condition as he got older rather than the improvement being as a result of is stopping taking traditional medicine.

4.10 Having identified the possibility of a missed opportunity, one has to consider the culture of the health service in 1991 and ask the question, "Would there have been, in reality, a challenge based on the possibility of safeguarding principles, to the parent who declines the offer of an operation?" It is suggested the answer to that question would be "no".

4.11 Looking at the family's situation with the knowledge and experience of 2015 and its current legislation, one might conclude that choosing not to have the operation, making no referrals regarding his poor eyesight, choosing not to seek medical support and assistance for a deteriorating mental state, would now in 2015, constitute a possibility of a risk of significant harm to a child, but in 1991 and for a few years after that, the situation was very different.

The family are of the view that by the time the Perpetrator's eye sight became problematic he as a 'man' of 16 years and over and attempting to insist that a young man of that age should seek medical advice especially when the person did not believe in the medical profession, was almost impossible.

The family are also concerned that a referral to Social Services mentioned that the Perpetrator's eye sight problem started when he was 10 years of age. Enquiries have been made by the Author and there must have been two referrals made, one emanating from the Review Panel Meeting and one from the Clinic where the Perpetrator was detained at after charge. It is confirmed that the referral from the Panel did not contain such information, the inference being that the referral from the Clinic contained inaccurate information about the eye sight problem.

4.12 There is no doubt that the Victim herself was of a very intelligent, strong character, determined and settled in her views and was unshakeable in relation to the opinions she had formed regarding the health service and medical professionals. She considered alternatives to traditional medicines and always researched everything she did. According to MGF, she would react, sometimes passionately, if her views were challenged and she was often able to achieve her own views. It is the family's view that she would try something that appeared to work and consider that to be good. They were all living with the Perpetrator's anguish and they were trying to do the best for him. They lived through what they describe as a rollercoaster period of the final six months where his mental health was so unpredictable.

4.13 There is evidence that the Victim's own mother (MGM) was probably of the same view. There is also evidence that the Victim's Father (MGF) and husband (H1) support the view of the Victim that the Health Authority had been neglectful in the care provided by the GP and also at the birth of the Perpetrator, S2 and S3.

4.14 In relation to the events around the birth of S2 and S3 in January 2002, safeguarding was by then, a much more understood subject by professionals from all agencies which was supported by guidance and a wealth of legislation.

4.15 During her pregnancy with S2 and S3 the Victim chose not to have any medical intervention other than palpation of her abdomen. She decided against blood tests, urine samples and scans, all of which, it could be argued, were necessary to safeguard not only the mother but also the unborn children.

4.16 If these circumstances were to arise in 2015, it would be expected that concerns would be identified and a referral would be made to Children's Social Care.

4.17 Safeguarding concerns could have been identified at the time of the complications arising at the home birth of S2 and S3 when the midwife, so concerned about those complications, rang for the assistance of an ambulance. Had the midwife not sought emergency assistance, then the lives of S2 and S3 would have been significantly at risk. It may be considered therefore that the possibility of ongoing safeguarding concerns for S2 after the death of S3 should have been considered. However one has to consider the culture of the health service at that time and ask the question, "Would there have been, in reality, a challenge based on the possibility of safeguarding principles, to the parent who allegedly question emergency assistance?" The answer then was probably no, but today the answer would be yes.

4.18 Having endured the traumatic experience of S3 passing away only 4 days after her birth, S2 and the Victim were discharged from hospital. Both the Victim and H1 received bereavement counselling and support from the hospital and then subsequently from a Bereavement Counsellor who they contact by telephone.

4.19 In relation to the deteriorating mental condition of the Perpetrator, there is evidence to show that in the weeks leading up to the Victim's death he was behaving strangely, becoming more aggressive, assaulted his mother the day before her death yet no consideration by the Victim or H1 to seek any medical or mental health assistance other than to take him to a local hospital but the Perpetrator persuaded MGP to return home before they arrived. It does not appear that the family had any plan to cater for what must have been an obvious deterioration in his mental stability.

The family say that the Perpetrator's deterioration was so sudden and took place over the last few days before the death of the Victim. They had no thought about the possible consequences. They say this was a grown man who had struck his mother and that sort of issue would be dealt with within the family in most family settings without involving any outside agency/people. S1 stated that he went away to work abroad the day before the death of his mother, and if he had any indication that his brother was dangerously ill then he would not have gone. The sudden rapid deterioration of the Perpetrator took the all by surprise and none of them would have predicted the outcome. Following the assault on the Victim, she attempted to ring the Police Officer who had found the Perpetrator on the roadside at 0300 hours, but was told that he was on leave and she was advised to take the Perpetrator to hospital which the grandparents tried to do. Their view is that the Victim did try to do something about his deteriorating mental condition.

4.20 The assault on his mother and his comments that he hated her were so sudden that it was not possible to escalate concerns within the family that the Victim was at risk at the hands of her son.

4.21 Following the referral by West Mercia Police to WHASCAS when the Perpetrator was found at 0300 hours, attempts were made to speak to him but the Customer Advisor for WHASCAS spoke to the Victim and it appears the Customer Advisor was dissuaded from speaking to the Perpetrator. It is considered that this matter should have been escalated to a manager for a decision as to whether the matter was pursued to the degree of speaking to the Perpetrator or left as it was being satisfied with the explanation given by his mother, which, in the case of a child would normally be accepted. This referral, however, was in respect of an adult who clearly had some problems that caused concern enough to make a referral.

The family's view is that the Victim would not have dissuaded the Customer Advisor from talking to the Perpetrator, the fact is that the Perpetrator did not want to speak to anyone about his problems, often not even his own family members.

4.22 In relation to Elective Home Education and its processes, there is evidence that although the Perpetrator was not seen on every occasion of supervision, it is clear from the EHE IMR that there is not a necessity to see the student on any occasion providing the required written work is submitted. There is a lack of understanding from agencies of the powers available to monitor children undertaking EHE. A similar comment has been made in a Significant Incident Learning Process (SILP) Review[14] for Worcester Safeguarding Children's Board. As a result of this SILP Review, the

[14] Case Review 8 – Worcester Safeguarding Children's Board – SILP Review – September 2014 page 4

Independent Chair of Worcestershire Safeguarding Children Board wrote to Edward Timpson MP, Parliamentary Under Secretary of State for Children and Families expressing views about similar issues that have arisen during this review.

4.23 The reply to the letter from S. Bishop, Independent Education and Boarding Team, stated that in view of a number of complaints the Government has received from Local Authorities, the Department is meeting some local authority groups. Copies of both letters are attached as an appendix.

4.24 In view of the Government's stated intent to address the issues which are clearly of concern in more than one Local Authority, and to add weight to the urgency to see change, Recommendation No1 is made. (See later)

4,25 Guidance and legislation regarding EHE states that whilst there are no duties placed upon Local Authorities to see the child for the purpose of monitoring EHE, the EHE Officer will make every effort to do so; however, where this is not possible the EHE Officer cannot enforce this.

4.26 S3.6[15] states 'Where a parent elects not to allow access to their home or their child, this does not of itself constitute a ground for concern about the education provision being made. Where local authorities are not able to visit homes, they should, in the vast majority of cases, be able to discuss and evaluate the parents' educational provision by alternative means. If they choose not to meet, parents may be asked to provide evidence that they are providing a suitable education.'

4.27 It is also important to recognise that EHE Officers do not have powers to investigate safeguarding concerns and such concerns must be investigated by those who have the appropriate authority to do so. Any and all professionals working with a home educated child should undertake their responsibilities to familiarise themselves with current home education law to avoid practice based on assumption. There is information regarding EHE available nationally, and from within the County Council, as the EHE Officer is available through the usual means of communication and is very accessible. Training opportunities are provided by the EHE Service and will continue to be provided.

4.28 The EHE Officer who came to post in 2007 recognised that home education may place some children at greater risk; however, the EHE Officer cannot make such a judgment as every parent, unless there is an Order in place denying them that right, has the right to home educate. Also, the EHE Officer does not hold risk assessment information about children. However, where there have been reported concerns then Children's Social Care would have access to such information and would therefore be able to carry out a risk assessment. The EHE Officer notifies the Access Centre of every child who was registered with the Authority as EHE so that they were able to make such a judgment.

4.29 A repeated concern raised by this and the SILP reviews was regarding the EHE Officer's 'professional curiosity'. However, in accordance with guidelines, legislation and local policy in both cases, it is the view of the IMR Author for Education that the professional curiosity shown was appropriate to the information available at the time.

4.30 Set out in Appendix 1 to this report, is the current EHE Guidance and Policy. This will not have been the same as Worcestershire's Elective Home Education Policy in

[15] DfE EHE Guidelines for Local Authorities 2013

place in 2005, which is no longer available. DfE non- statutory guidance on EHE was issued in 2007, but the powers of the local authority to see children have not changed.

Recommendation No 1

The Chair of the Safer Community Partnership writes to the Minister for Education expressing continuing concerns that the guidance for Elective Home Education is not fit for purpose and requires an urgent review by the Department of Education to ensure that a more positive supervision and monitoring policy is introduced.

4.31 During the course of this Review, it may be the case that the Perpetrator's family demonstrated a degree of 'disguised compliance' when the Perpetrator was found wondering alone firstly late at night, then later at the side of a major roadway. On both occasions the Victim was spoken to and assured the Officers that she would take advantage of the advice and services being offered, but none of the services were accessed and even after numerous calls by Adult Social Care attempting to speak to the Perpetrator, the Victim said that she would pass on the details for him to contact the service as and when he felt necessary, but in reality the Perpetrator did not want to speak to anyone.

4.32 In April 2014, West Mercia Inter-Agency Child Protection Procedures introduced a new Chapter entitled 'Working with Hostile, Non-Compliant Clients and those who use Disguised Compliance'. This Chapter sets out procedures for professionals who experience difficulty when dealing with parents with regard to the way they respond to the professionals and the advice and guidance the parents receive.

Recommendation No 2

All agencies to ensure that all front line professionals are aware of the West Mercia Inter-Agency Child Protection Procedures especially the Chapter adopted in April 2014, 'Working with Hostile, Non-Compliant Clients and those who use Disguised Compliance'.

The family are content for this recommendation to be made but stress that at no time were they hostile towards anyone. They understand that the recommendation can be seen as a method of promulgating the dissemination of the Inter-agency procedures.

4.33 It is appreciated that this guidance refers to Child Protection issues and a recommendation is made suggesting that the Adult Safeguarding Board considers implementing similar guidance regarding adult children of parents. It is acknowledged that when working with families that appear to have disengaged this can be extremely challenging for professionals. Where possible offers of support should be made and alternative support services should be considered.

Recommendation No 3

Worcestershire Safeguarding Adult Board to consider formulating guidance similar to West Mercia Inter-Agency Child Protection Procedures 'Working with Hostile, Non-Compliant Clients and those who use Disguised Compliance' when works with adult children and their parents.

4.34 For whatever reason, the Victim chose to move the family from the services of GPs and almost all other health services. The MGF and H1 would say that in the event of medical attention being necessary, contact with the grandparent's GP would have been made or in the case of an emergency, assistance from A&E would have been sought. He fell under the radar of medical services as a child which may have put him at risk. There was no follow up from the surgery he had left regarding any other surgery he may have registered with.

Recommendation No 4

NHS England will alert GPs locally to ensure any non-attendance of appointments are robustly followed up through the organisations 'Did Not Attend/Was not brought Policy'. GPs should ensure their Practice has a documented process in place to liaise with HV/SN's about transfers in or out of their Practice of children where there are safeguarding concerns.

4.35 A similar action was recommended in the 'GW' Domestic Homicide Review Action Plan. It was not something that could resolve locally and remains outstanding as it relates nationally to the Patient Data System which works on a 'pull' mechanism. Until a child/person is re-registered, a GP does not know until the notes were 'pulled' that a child/person had moved practices. The system currently relies on HV/SN receiving notifications of transfers of patients to new GP practices, as well as the liaison between health professionals and discussion of families of concern at Practice safeguarding meetings. The following recommendation is therefore made in this review.

Recommendation No 5

NHS England will raise the issue of 'de-registration' at a national level as it pertains to the wider national patient records system with a recommendation to work towards an electronic solution of monitoring of de-registration.

5. Changes to agency systems

5.1 It should be noted that in February 2014 NICE issued guidance[16] entitled "Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively'.

5.2 This guidance has been acted upon in Worcestershire and many of the recommendations are being progressed in partnership. An extensive programme of training and awareness raising is being seen across health including inputs to F1 and F2 doctors, GP's, A&E professionals, Midwives, Specialist Cancer Teams, Consultants and Physiotherapists.

5.3 As part of this work they have undertaken a pilot within the main Worcestershire hospital (subject of this review) with the co-location of a Specialist Independent Domestic Abuse Advisor, (IDVA) who works across the hospital but with an emphasis of working within A&E, midwifery and alongside mental health professionals.

5.4 In addition the Worcestershire Forum against Domestic Abuse and Sexual Violence has worked with the hospital on a number of campaigns and conferences at the

[16] Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively - NICE February 2014

hospital and, most recently, the Hospitals across Worcestershire were fully engaged in the White Ribbon campaign during the International 16 days of action.

5.5 The Forum has also worked alongside the Local Safeguarding Children's Board and domestic abuse e-learning is freely available to all health professionals as a part of their ongoing professional development.

5.6 It should be acknowledged that much work has been done to raise awareness of the specialist domestic abuse services across Worcestershire during the last two years and demand as a result of this, has at times increased by some 79%. Specialist resources have been developed with the involvement of survivors and these are widely available across the county and promoted through the media.

5.7 Individual agencies have made recommendations particular to their own agency within their respective IMRs, which are replicated with the Action Plan to this report. All agency recommendations are pertinent to this review and are supported by the Author and the Panel.

5.8 West Mercia and Warwickshire Police have now begun a process of implementation of Multi-Agency Safeguarding Hubs (MASH) across the two forces areas, where referrals, information and intelligence is shared between agencies immediately, risk identified, assessed and managed.

5.9 In 2013 a Domestic Homicide Near Miss Review was undertaken by Worcestershire Acute NHS Trust following the attempted murder of a pregnant woman.

5.10 An action from this review was to strengthen the questioning of pregnant women, by midwives, in relation to whether the women had experienced any Domestic Abuse from either their current or past partners. A guideline was developed and adopted into practice, which required midwives to question the woman about her experiences of Domestic Abuse from not just her current partner but also historically from previous partners or relationships. This continues to be an operational guideline within the Trust.

5.11 There has been a programme of training during 2014 to raise awareness of Domestic Abuse within the Trusts Maternity Services and also Emergency Departments. There is also a pilot project currently running whereby an Independent Domestic Violence Advocate (IDVA) is operating on a part time basis from one of the hospital Emergency Departments. The IDVA will also become involved with any cases referred by staff from other relevant areas of The Trust.

5.12 The Trust has a lead midwife for Domestic Abuse and also a senior nurse within the Emergency Department, who has a specific interest in and involvement with the pilot project for Domestic Abuse. The Trust also has representation on the local Multi Agency Risk Assessment Conference (MARAC).

6. Conclusions

6.1 The Victim was killed by her middle son in the most tragic of circumstances. The incident was witnessed by the MGM and her youngest son who was also injured in the stabbing incident.

6.2 From the information gathered by IMR Authors, there is evidence that the Perpetrator had significant health problems at birth. There was a period from about 5 years of age until his later teens when he was without significant medical needs and the deterioration in his mental condition only manifested itself during the six months prior to his mother's death

6.3 It appears that medication given to the Perpetrator during his early years could have had an effect on his hearing, but that may have been a choice between treating his reflux condition against the possibility of causing damage to hearing. In any event later examination of his hearing showed no ill effects. His eye sight deteriorated as he grew older in his later teens. The family will say they found it difficult to tell a16 year old youth to go to the opticians for treatment to his eyes when the family considered that he was quite capable of making those decisions himself, especially when the Perpetrator was terrified of Doctors and other medical professionals and had been from a very early age. He associated medical professionals with pain.

6.4 The Perpetrator, his older brother and younger brother all received (and the younger brother is still receiving) Elective Home Education, which, as stated above has its own concerns in terms of supervision of the student. Considering that this whole family were outside any contact with any agency other than EHE, it was an opportunity missed for the only professional involved with the family to make an assessment of all three boys' welfare. It has to be acknowledged, however, that S1, S2 and the Perpetrator have grown to be highly intelligent men with a significant gift for music. S1 runs a successful I.T. business. The family make it clear that there were no concerns with EHE with any of the three boys.

6.5 The Perpetrator's mental condition deteriorated so quickly, especially in the last few weeks before the death of the Victim, that it took the family by surprise. Whilst his behaviour became extremely disorientated and strange and even resorted to violence against the Victim for the first time, the family were intent on dealing with this on their own. They did not appreciate the seriousness of the situation and a sudden act of extreme violence caused the death of the Victim. The family add that any decisions that the Victim made regarding the medical and mental health of the Perpetrator were made in the best interest of him and those decisions would have been thoroughly researched and justified.

6.6 The death of the Victim was totally unpredictable and unpreventable.

List of recommendations

Recommendation No 1 **Page 35**

The Chair of the Safer Community Partnership writes to Minister for Education expressing continuing concerns that the guidance for Elective Home Education is not fit for purpose and requires an urgent review by the Department of Education to ensure that a more positive supervision and monitoring policy is introduced.

Recommendation No 2 **Page 36**

All agencies to ensure that all front line professionals are aware of the West Mercia Inter-Agency Child Protection Procedures especially the Chapter adopted in April 2014, 'Working with Hostile, Non-Compliant Clients and those who use Disguised Compliance'.

Recommendation No 3 **Page 36**

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Recommendation No 4 **Page 36**

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Recommendation No 5 **Page 36**

NHS England will raise the issue of 'de-registration' at a national level as it pertains to the wider national patient records system with a recommendation to work towards an electronic solution of monitoring of de-registration.

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Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively - NICE February 2014

Statutory Guidance for Local Authorities in England to Identify Children not Receiving Education

The Education Act 1996

APPENDIX 1

1 Section 2 - The Law: The Education Act 1996

The Responsibility of Parents

Section 7 of the Education Act 1996 states the parent of every child of compulsory school age shall cause him to receive efficient full-time education suitable-

(a) to his age, ability and aptitude, and

(b) to any special educational needs he may have,

either by regular attendance at school or otherwise."

2. Section 2.2 The Responsibility of the Local Authority

Worcestershire County Council has a duty to identify, so far as it is possible to do so, children, who are of compulsory school age, in their area who are not receiving a suitable education[1]. S436A Education Act 1996

3. To ensure the Local Authority is able to fulfil its duty, parents will be asked to provide the Local Authority's Elective Home Education Liaison Officer with information regarding educational arrangements they are making for their child once they are confirmed to be home educated. The EHE Officer will offer every parent a home visit to explore educational provision being made, however, acknowledges parents' right to choose alternative methods to provide the Officer with information. Once the provision is deemed suitable the Local Authority will make contact with the parent on an annual basis to confirm the child's educational arrangements.

4. Although the Local Authority does not monitor home education on a routine basis it will need to be satisfied about the overall suitability of the child's education. Therefore, if, at any point, the EHE Officer has concerns about a child's educational provision they will contact the parent detailing the concerns and request the parent provides information about the arrangements either through a home visit or otherwise. If the EHE Officer remains unsatisfied with the provision they will offer the parent contact time to review the provision and offer supporting guidance to equip them to make the appropriate improvements to the provision. If on three consecutive occasions the provision is deemed unsuitable and/or the parent does not respond[2] to the request, the EHE Officer will notify the Children Missing Education (CME) Officer for further investigation. If this proves to be unsuccessful then the CME Officer may refer to the Education Investigation Service to begin the School Attendance Order[3] proceedings.

[1] Statutory Guidance for Local Authorities in England to Identify Children not Receiving Education
[2] Phillips v Brown (1980).
[3] S437 (1) The Education Act 1996

5. **Section 6 - Safeguarding**

Local authorities have a duty under section 175(1) of the Education

Act 2002 to safeguard and promote the welfare of children; this section states:

> "A local authority shall make arrangements for ensuring that their education functions are exercised with a view to safeguarding and promoting the welfare of children."

6. The Education Act 2002, Section 53 175(1) does not extend local authorities' functions. It does not, for example, give local authorities powers to enter the homes of, or otherwise see, children for the purposes of monitoring the provision of elective home education.

7. The Local Authority understands that early help is the most effective way of promoting the welfare of children rather than being reactive to situations[4]. In consultation with parents and the child (where appropriate), the EHE Officer may identify targeted services which may be able to contribute to promoting the individual needs of the child. In every instance the EHE Officer will not act without prior consent from the parent unless they have reason to believe the child may be at significant risk of harm[5].

8. Section 53 of the Children's Act 2004 Act sets out the duty on local authorities to, where reasonably practicable, take into account the child's wishes and feelings with regard to the provision of services. Section 53 does not extend local authorities' functions. It does not, for example, place an obligation on local authorities to ascertain the child's wishes about elective home education as it is not a service provided by the local authority.

[4] Working Together to Safeguard Children 2013
[5] Children's Act 1989

South Worcestershire Community Safety Partnership

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ACTION PLAN

Overview Report Recommendations

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
Recommendation No 1 The Chair of the Safer Community Partnership writes to the Minister for Education expressing continuing concerns that the guidance for Elective Home Education is not fit for purpose and requires an urgent review by the Department of Education	Worcestershire Community Safety Partnership to write to HMG	Chair of Worcestershire Community Safety Partnership	June 1st 2015	Letter written to Edward Timpson 25/6/2015 Further letter sent to Nicky Morgan MP on 10/3/2016

to ensure that a more positive supervision and monitoring policy is introduced.				
Recommendation No 2 All agencies to ensure that all front line professionals are aware of the West Mercia Inter-Agency Child Protection Procedures especially the Chapter adopted in April 2014, 'Working with Hostile .Non-Compliant Clients and those who use Disguised Compliance'.	All agencies	Training Managers for all agencies Martin Lakeman – Strategic Coordinator for Domestic Abuse WCC	May 2015	This learning outcome has been shared with all agency reps. Via e mail sent 8.5.2015 for cascading. The wider report will be shared when authorised to publish when permission from the Home Office is granted.
Recommendation No 3 NHS England will alert GPs locally to ensure any non-attendance of appointments are robustly followed up through the organisations 'Did Not Attend/Was not brought Policy ' . GPs should ensure their Practice has a documented process in place to liaise with	NHS England	Ellen Footman	June 2015	All GP's sent briefing bulletin to highlight learning from review.

HV/SN's about transfers in or out of their Practice of children where there are safeguarding concerns.				
Recommendation No 4 NHS England will raise the issue of 'de-registration' at a national level as it pertains to the wider national patient records system with a recommendation to work towards an electronic solution of monitoring of de-registration.	NHS England	Helen Hipkiss action by September 2015	September 2015	Issue to be highlighted nationally at NHS strategic group.

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ACTION PLAN

Individual Management Report Recommendations

Agency: West Mercia Police

Recommendation	Action Required by Agency	Implementation Lead	Target Date for Completion	Summary of action taken and date
Recommendation No 1 Incidents involving personal vulnerability should be appropriately researched on police systems to ensure all available information can be considered.	West Mercia Police		September 2015	The actions contained within this DHR are with the newly formed Strategic PVP Team, who will undertake to broaden the work around response to vulnerability. In particular, there is a Vulnerable Adult lead DCI DAVIES who has incorporated the actions within the MH and Sec 136 work stream. HAU will take on the role of lateral checks for adults or where there is Domestic. DARA's will

				also undertake a review of the full circumstances and make an assessment of appropriate referrals.
Recommendation No 2 Officers to be reminded that incidents involving vulnerable adults should involve the recording of a Vulnerable Adult Incident unless there is good reason not to do so.	West Mercia Police		September 2015	As above. West Mercia Police And Warwickshire police are currently undertaking a learning needs Assessment which will deliver training around vulnerability to all front line staff. The ACPO Sponsor is T/DCC Manners.
Recommendation No 3 Incidents involving vulnerable adults should be brought to the attention of the Safer Neighbourhood Teams) who, where appropriate, can offer assistance and coordinate service as and when required.	West Mercia Police		September 2015	As Above. HAU will be responsible for dissemination of all information to SNT's that help protect vulnerable people and to gather intelligence. This is part of the Worcestershire MASH terms of reference. This is envisaged to be live in Worcestershire by September 2015.

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ACTION PLAN

Individual Management Report Recommendations

Agency: Worcestershire Children's Social Care Services

Recommendation	Action Required by Agency	Implementation Lead	Target Date for Completion	Summary of action taken and date.
Recommendation No 1 Where a child is withdrawal from traditional services notification should be made to Children's Social Care Access Centre, so that any pattern of withdrawal from a number of services, especially health can be considered in the context of potential risk of significant harm to the child.	NHS England Education Worcestershire Acute NHS Trust Children's Social Care To inform training		September 2015	