social care
institute for excellence

Analysis of statutory reviews of homicides and violent incidents in London

Appendices to the report for the Mayor of London's Violence Reduction Unit

About SCIE

SCIE improves the lives of people of all ages by co-producing and sharing the best available knowledge and evidence about what works in health and social care practice.

The Social Care Institute for Excellence (SCIE) is a leading values-driven improvement agency. In recent years we have evolved from a largely government-funded body to a fast-moving, high-profile commercial organisation and thought leader.

We are independent and people-focused, operating at policy and practice levels with a huge database of 'what works' and good practice resources. Working beyond and across social care and health and children's and adults' sectors, we contribute to the development and implementation of better care, support and safeguarding at national and local level. We support commissioners and providers in developing and embedding practices which are innovative, have impact, and enable effective scrutiny and accountability.

What makes us special

We:

- are driven by co-production principles and ways of working, and in children's services by hearing the voice of the child
- operate at policy development, strategic and operational levels, with a golden thread of what works in practice
- benefit from huge reach and a vast knowledge and evidence base, including e-learning tools and resources
- offer a range of flexible and tailored input (training, consultancy, topic expertise, research, evaluation, facilitation, coaching)
- work in highly collaborative ways, including levering in others where this might lead to better solutions and outcomes.

www.scie.org.uk

About the Violence Reduction Unit

Announced by the Mayor in September 2018, the Violence Reduction Unit (VRU) is bringing together specialists from health, police, local government, probation and community organisations to tackle violent crime and the underlying causes of violent crime.

Supporting London to tackle violence at its roots

We believe that violence is preventable. The VRU is taking a fundamentally different approach to violence reduction – one where the public sector institutions and communities that make up London act together to help cut violence.

www.london.gov.uk

Contents

Introduction

This report summarises findings from research commissioned by the Violence Reduction Unit (VRU) with the aim of mapping and understanding violence in London. The VRU was established by the Mayor of London, Sadiq Khan in September 2018. It brings together specialists from health, police, local government, probation and community organisations to tackle violent crime and its underlying causes. The VRU has commissioned research. These are:

- A Strategic Needs Assessment – This will help highlight the key challenges around violence and associated impact across London. This will then help focus the VRU priorities by setting out the strategic needs through both an evidence-led and emerging-trends approach. This strategy will lead delivery to aid violence reduction across London.
- An analysis of Homicides and Serious Case Reviews – A thematic review of homicides across London, to establish key causation factors, common patterns and to help bring forward recommendations for the VRU and partners to consider in developing a longer-term strategy.

The research is being delivered through a partnership between the VRU, Behavioural Insight Team (BIT) and the Social Care Institute for Excellence (SCIE) with expert advice from the University of Bedfordshire.

This research has considered learnings from high-level analysis of violence across London through a Strategic Needs Assessment, which is complemented from an in-depth analysis of statutory reviews conducted after certain kinds of deaths and violent incidents. These have been used to explore patterns in the characteristics and contexts of these incidents, and how professionals responded to them. This research is not definitive and is considered to be part of an ongoing research programme.

Analysis of statutory reviews of homicides and violent incidents in London

The aim of this piece of work is to undertake a review of statutory reviews of homicides and serious incidents of violence in London. The four types of review that have been considered are:

- Domestic Homicide Reviews
- Independent Investigation Reports (formerly known as Mental Health Homicide Reviews)
- Serious Case Reviews (now known as child safeguarding practice reviews[1])
- Safeguarding Adult Reviews.

[1] Statutory guidance in relation to what were formerly known as Serious Case Reviews was changed with the public of new Working Together guidance in July 2018. However, all of the cases reviewed had been carried out under the previous guidance, so we are continuing to use this terminology.

This piece of work is one of the first to bring together learning from different types of statutory and mandatory reviews[2]. The methods for the review are based on the Contextual Case Review© approach[3], which applies the principles of contextual safeguarding to case review, and the Learning Together systems model for case review.[4]

The summary report provides an overview of findings with recommendations. For further detail on methods and analysis of reviews, the appendices provide higher level of detail.

[2] See also Robinson et al. (2018) Making connections: A multi-disciplinary analysis of domestic homicide, mental health homicide and adult practice reviews. Journal of Adult Protection.

[3] Firmin C (2017) Contextualising case reviews: a methodology for developing systemic safeguarding practices, Child and Family Social Work 23 (1) 45-52

[4] Fish S, Munro E, Bairstow S (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews. London: Social Care Institute for Excellence.

List of acronyms

ACEs	Adverse Childhood Experiences
ACN	Adult Come to Notice
DASH RIC	Risk assessment checklist used in domestic abuse
CAMHS	Child and Adolescent Mental Health Services
CEOP	Child Exploitation and Online Protection Centre
CCN	Child Come to Notice
CPS	Crown Prosecution Service
CRIS	Crime Reporting Information System
DHRs	Domestic Homicide Reviews
DV	Domestic Violence
DVPP	Domestic Violence Perpetrator Programme
GBH	Grievous Bodily Harm
IAPT	Improving Access to Psychological Therapies
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent domestic violence advisors
IIRs	Independent Investigation Reports, formerly known as Mental Health Homicide Reviews
IMR	Individual Management Review
IPV	Intimate Partner Violence
LAC	Looked after children, Care experienced children
MAPPA	Multi-agency public protection arrangements
MARAC	Multi-Agency Risk Assessment Conferences
MASE	Multi-Agency Sexual Exploitation
MPS	Metropolitan Police Service
PLEs	Practitioner Learning Events
SABs	Safeguarding Adults Boards
SARs	Safeguarding Adult Reviews
SCRs	Serious Case Reviews, now known as child safeguarding practice reviews
TAF	Team around the family

VAWG	Violence Against Women and Girls
VRU	Violence Reduction Unit
YOT	Youth Offending Team

Appendix 1: Methods

Aims

The aim of this work was to analyse information in publicly available statutory reviews of homicides and violent incidents to establish:

- Patterns in characteristics of victims and perpetrators, the incidents and escalation towards them and associated contexts
- Patterns in professional involvement, including opportunities for improvement in professional responses.

Statutory reviews undertake detailed investigation of the circumstances surrounding certain kinds of violent incidents, often with a view to learning about how professional responses could be improved, to inform service development. They therefore provide a publicly available source of rich and detailed descriptions of the incidents, those involved, and how services worked with them.

Data sources

The sources of data for this research were reviews undertaken via four statutory processes:

- Domestic Homicide Reviews (DHRs)
- Independent Investigation Reports (IIRs, formerly known as Mental Health Homicide Reviews)
- Serious Case Reviews (SCRs) now known as child safeguarding practice reviews)[5]
- Safeguarding Adult Reviews (SARs).

The first three sources had been identified by a VRU scoping group in January 2019 as a potentially useful source of learning about violent incidents, and Safeguarding Adult Reviews were added at the suggestion of the research team.

We have included reviews published in London since January 2016. We used publication date rather than incident date as the criteria for inclusion. This was in order to capture as much data as possible, accounting for significant time lags between the incident and publication.[6]

The type of cases covered, and information provided, in each of the reviews is strongly linked to its scope and purpose. These are outlined in Table 1.

---

[5] Statutory guidance in relation to what were formerly known as Serious Case Reviews – now child safeguarding practice reviews - was changed with the publication of new Working Together guidance in July 2018. However, all of the cases reviewed had been carried out under the previous guidance. Therefore, we have used the terminology ‘Serious Case Review’ in this report.

[6] For example, some of the incidents reviewed may have occurred as far back as 2012 but were not published until post 2016. This is often due to the amount of time required to undertake the detailed work required by the review, as well as waiting for any criminal processes to be concluded before publication.

Table 1. Scope and purpose of included reviews

Review type	Legislation	Oversight	Scope and purpose
Domestic Homicide Review	Section 9(3) of the Domestic Violence, Crime and Victims Act 2004[7]	**Overseen by:** Home Office **Commissioned by:** Local Community Safety Partnerships and conducted by independent author(s)	**Scope and purpose:** '… 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 household as himself, held with a view to identifying the lessons to be learnt from the death.'[8]
Independent Investigation Review	Article 2 of the European Convention on Human Rights and with guidance in the NHS Serious Incident Framework[9]	**Overseen by:** NHS England working via Regional Investigation Teams **Commissioned by:** NHS England and conducted by independent author(s)	**Scope and purpose:** Commissioned '…when a homicide has been committed by a person who is, or has been, subject to a care programme approach, or is under the care of specialist mental health services, in the past six months prior to the event. Investigations carried out under this framework are conducted for the purposes of learning to prevent recurrence. They are not enquiries into how a person died as this is a matter for coroners. Neither are they conducted to hold any individual or organisation to account.'[10]
Serious Case Review now known as Child Safeguarding	Previously the Local Safeguarding Children Boards Regulations 2006[12]	**Overseen by:** Department for Education **Commissioned by:** Local Safeguarding Children Boards and	**Scope and purpose:** Undertaken where: (a) abuse or neglect of a child is known or suspected; and (b) either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the

[7] Domestic Violence, Crime and Victims Act 2004, c.9:3. Available at: **www.legislation.gov.uk/ukpga/2004/28/contents**
[8] Domestic Violence, Crime and Victims Act 2004, c.9:3. Available at: **www.legislation.gov.uk/ukpga/2004/28/contents**
[9] NHS (2015) Serious incident framework: Supporting learning to prevent recurrence. London: NHS England.
[10] NHS (2015) Serious incident framework: Supporting learning to prevent recurrence. London: NHS England.
[12] Local Safeguarding Children Boards Regulations (2006) Available at: **www.legislation.gov.uk/uksi/2006/90/introduction/made**

Practice Reviews[11]	Working together to safeguard children 2018[13]	conducted by independent author(s)	authority, their board partners or other relevant persons have worked together to safeguard the child.[14]
Safeguarding Adult Review	**Legislation:** Care Act 2014, Section 44[15]	**Overseen by:** Department of Health and Social Care **Commissioned by:** Local Safeguarding Adult Boards and conducted by independent author(s)	**Scope and purpose:** Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.[16]

[11] Statutory guidance on Serious Case Reviews changed in July 2018. However, all of the included reviews had been carried out under the framework provided in Working Together 2015 or 2013 which is described below.
[13] Department for Education (2018) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. London: HMSO. p. 81
[14] Department for Education (2015) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. London: HMSO. p. 75
[15] Care Act (2014) Available at: **www.legislation.gov.uk/ukpga/2014/23/contents/enacted**
[16] Care Act (2014) statutory guidance for safeguarding. London: Department of Health and Social Care. Available from: **www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1**

Definition of serious violence – inclusion and exclusion criteria

Definition of violence

This review has broadly adopted the World Health Organization definition of violence:

> *'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.'*[17]

In line with this definition, the review has included non-fatal as well as fatal incidents where this information was available.[18]

Due to the differing scope and purpose of each of the types of review, we anticipated that not all reviews would meet this definition of violence. For example, Serious Case Reviews may be commissioned in cases which are related to, but not directly caused by maltreatment[19], such as when children drown or ingest poisonous substances as a result of poor supervision. Similarly, many Safeguarding Adult Reviews relate to accidental deaths resulting from poor supervision or self-neglect, such as house fires. We therefore developed a set of inclusion criteria to determine which reviews would be included in the data set.

Inclusion criteria

We used the categorisation schemes developed by Sidebotham and colleagues[20] and Sharps-Jeffs and Kelly[21] to develop the below list of inclusion and exclusion criteria. These were agreed with the VRU.

---

[17] World Health Organization. Definition and typology of violence. [online] Available at: **www.who.int/violenceprevention/approach/definition/en/**

[18] Both SCRs and SARs include non-fatal incidents, whereas DHRs and IIRs are triggered by a death or homicide.

[19] Sidebotham P et al. (2016). Pathways to harm, pathways to protection: a triennial analysis of Serious Case Reviews 2011-2014. London: Department for Education.

[20] Sidebotham P et al. (2011) Serious and fatal child maltreatment: Setting serious case review data in context with other data on violent and maltreatment-related deaths in 2009-10. London: Department for Education.

[21] Sharps-Jeffs N and Kelly L (2016) Domestic Homicide Review case analysis. London: Standing Together Against Domestic Violence.

Table 2. Inclusion and exclusion criteria

	Fatalities	Non-fatal incidents
Included	Fatal abuse Deliberate homicide (infanticide, intimate partner homicide, adult family homicide, peer homicide) Suicide where there is a bullying or peer violence element	Physical assault (including serious peer violence) Sexual abuse Suicide or suicide attempt where there is a bullying or peer violence element Intra-familial sexual abuse Extra-familial sexual abuse
Not included	Suicide where there is no bullying or peer violence element Extreme neglect/deprivation abuse (for example starvation, failure to respond to medical needs) Deaths related to but not directly caused by maltreatment (for example drowning due to poor supervision) Deaths due to self-neglect Deaths due to poor management of care or health needs	Neglect Risk-taking (for example suicide attempt) where there is no bullying or peer violence element Self-neglect (for example. by an older person) Poor management of care or health needs

Scoping

We conducted 23 scoping interviews with senior stakeholders in relevant services, policy roles and academia (see appendix 10) in order to: test and refine the approach to this research and the accompanying strategic needs assessment by the Behavioural Insights Team, and understand what would make the final outputs useful to the sector. With respect to this piece of work specifically, stakeholders highlighted:

- The lack of cross-review analyses that already existed – some types of reviews are already routinely collated and synthesised, for example DHRs and SCRs, but there are few or no pieces of research which synthesise across review types
- The importance of understanding patterns of behaviour in escalation towards violent incidents as well as underlying characteristics and risk factors
- Identification of related pieces of research including local thematic reviews undertaken in Camden, Croydon, Hackney and Tower Hamlets. As well as, some national work including the forthcoming triennial review of SCRs, and a national review commissioned by the Child Safeguarding Practice Review Panel on adolescents at risk of criminal exploitation.

We also reviewed the methods used in a number of existing reviews of statutory reviews including the biennial and triennial reviews of Serious Case Reviews and a recent review of Domestic Homicide Reviews.

Searching and screening

We gathered the statutory review reports from a range of sources including borough web pages, national resources databases such as the NHS England list of IIRs, the NSPCC database of SCRs and the SCIE SAR library. Where possible, the documents obtained were compared to lists requested from government departments or national bodies with oversight for that review process. This led to the addition of a small number of additional reviews that had not been identified in initial search processes.

Types of cases identified

We found 151 reports in total within our date range (January 2016 onwards). All reports were uploaded in to EPPI-Reviewer 4 systematic reviewing software and screened against the above criteria.

Following screening, 64 cases were included. These have been grouped in to the following six categories based on the relationship between victim and perpetrator and the nature of the incident:

- Youth peer violence amongst 10–25-year olds (including bullying-related suicide) *(*eight cases)
- Adult peer violence (violence between two adults over 26 who are not related or in a relationship) (nine cases)
- Intimate partner violence (17 cases)
- Adult family violence (nine cases)
- Within-family violence towards children under 18 (18 cases)
- Child sexual abuse (three cases).

The table below shows how many of each of the four types of statutory review were placed in each category.

Table 3. Included reports by category

Category	DHR	IIR	SCR	SAR	Total
Youth peer violence	0	1	7	0	8
Adult peer violence	0	7	0	2	9
Intimate partner violence	14	3	0	0	17
Adult family violence	7	2	0	0	9
Within-family violence towards children under 18	0	1	17	0	18
Child sexual abuse	0	0	3	0	3
Totals	21	14	27	2	64

It was notable that there were relatively few reviews of peer violence incidents involving young people under 25, despite homicides amongst this age group making up a significant proportion of fatal incidents in London, and over 120 homicides having taken place in this age group since 2016.[22] This may be partly because the duty to undertake a Serious Case Review ends at age 18.

Due to the small number of statutory reviews, we also identified and reviewed the following non-statutory reviews relating to youth peer violence:

- Camden Youth Safety Task Force Report[23]
- Croydon Vulnerable Adolescents Thematic Review[24]
- Southwark Extended Learning Review[25]
- Tower Hamlets: Troubled Lives, Tragic Consequences.[26]

Comparing our sample to violent incidents more generally

This research was not intended to provide a representative sample of homicides and violent incidents in London. Rather, it is a convenience sample based on the availability of publicly available statutory review data relating to particular types of cases.

It is difficult to compare the numbers of cases we have found here with the frequency of incidents overall, due to the way that data are gathered and reported. For example, the age categories we have used reflect the remit of the statutory reviews (for example, Serious Case Reviews apply to children under 18, whereas national statistics divide homicides in to under and over 16). It is also difficult in national and London statistics to combine analyses of age and perpetrator. For example, we know that 35 per cent of victims of homicide in London in 2018 were aged 16 to 25. However, we do not know how many of those were killed by peers of the same age compared to older adults.

The following comparison is indicative of some of the ways that some types of incident are over- and under-represented in our data. Where available we have used data from London, otherwise data has been taken from the Home Office Homicide Index. This comparison is indicative only, and does not represent a detailed statistical analysis.

---

22 Metropolitan Police Service Data, accessed September 2019. Although this time period does not exactly match the time period in which the reviewed incidents occurred, it does illustrate the significant mismatch between the number of incidents that are likely to have occurred, and the number of statutory reviews currently available.

23 Camden Youth Safety Taskforce (2019) Camden Youth Safety Taskforce report. Available at: **www.camden.gov.uk/documents/20142/0/download+%288%29.pdf/3b1a64e6-31db-01cc-c7c9-4d04b5450bc6**

24 Croydon Safeguarding Children's Board (2019) Vulnerable adolescents thematic review. London: Croydon LSCB. Available at: **https://croydonlcsb.org.uk/wp-content/uploads/2019/02/CSCB-Vulnerable-Adolescent-Thematic-Review-PUBLISHED-Feb-2019.pdf**

25 Southwark Safeguarding Children's Board (2019) Extended Learning Review. London: Southwalk. Available at: **http://moderngov.southwark.gov.uk/documents/s82118/Southwark Extended Learning Review.pdf**

26 London Borough of Tower Hamlets Safeguarding Board (2015) Troubled Lives, Tragic Consequences. London: Tower Hamlets LSCB Available at: **www.childrenandfamiliestrust.co.uk/wp-content/uploads/2015/12/Troubled-Lives-Summary-Report-Final1.pdf**

Table 4. Comparing reviews to overall numbers of homicides

Category	Our sample…	Compared to…	Suggests…
Youth peer violence	…includes 4 homicides[27] of young people aged 16–24 (6% of our sample).	35% of homicides in London in 2018[28] involved this age group.	Under-represented in our data
Adult peer violence	… includes 13 cases in which the homicide was by a friend/acquaintance or stranger (20% of our sample).	55% of homicides in England and Wales in 2018.[29]	Under-represented in our data
Intimate partner violence	…includes 17 cases of intimate partner homicides (26% of our sample).	20% of homicides in London in 2018.[30]	Over-represented in our data
Adult family violence	…includes 9 cases of homicides of people over 16 by a family member (14% of our sample).	5% of homicides of people over 16 in England and Wales in 2018.[31]	Over-represented in our data
Within-family violence towards children	…includes 14 cases of fatal incidents[32] of children aged under 16 by a family member (22% of our sample).	7% of homicides in London in 2018 were of children under 16.[33]	Over-represented in our data

Data extraction and analysis

Data extraction and analysis of the included reviews was undertaken in two stages.

- **Stage 1:** Identifying case and context characteristics across the sample
- **Stage 2:** A more in-depth stage on a smaller sample of cases looking at systemic strengths and weaknesses in agency responses.

Stage 1 – Characteristics and contexts

The aim of this stage was to identify characteristics of the individuals, their contexts and the incidents, and analyse any patterns or commonalities. The approach to this stage of the work was based in particular on Contextual Case Review©.[34] The contextual case

[27] One young person was under 16
[28] Metropolitan Police data, accessed September 2019.
[29] Office for National Statistics (2019) Homicide in England and Wales: year ending March 2018.
[30] Metropolitan Police data, accessed September 2019.
[31] Office for National Statistics (2019) Op. cit.
[32] Note, not all of these would be categorised as homicide.
[33] Metropolitan Police data, accessed September 2019.
[34] Firmin, C. (2017) Contextualizing case reviews: A methodology for developing systemic safeguarding practices. *Child and Family Social Work* 23(1): 45-52.

review approach was developed to explore and understand peer-on-peer abuse between young people. It recognises that 'an individual's behaviour is informed by, and informs, the contexts in which they spend their time'.[35] This is explored through the contextual case review process by looking at:

- the incident and people involved
- the associated contexts
- professional responses – the engagement of services with the people and contexts associated with the case.

In consultation with the author, we adapted the contextual case review template to apply to incidents involving adults as well as young people. Our methods at this stage have also drawn on methods used in reviews of domestic homicide reviews[36] and in the biennial and triennial reviews of Serious Case Reviews.[37]

[35] Firmin, C. (2017) Ibid.
[36] Sharps-Jeffs N and Kelly L (2016) Domestic Homicide Review case analysis. London: Standing Together Against Domestic Violence.
[37] Sidebotham P et al. (2016). Pathways to harm, pathways to protection: a triennial analysis of Serious Case Reviews 2011-2014. London: Department for Education.

Key questions

Stage 1 of the work sought to answer the following key questions:

Individuals

1. What are the patterns in characteristics and behaviours of victims of violent incidents?

2. What are the patterns in characteristics and behaviours of perpetrators of violent incidents?

3. What (if any) are the overlaps between the above?

Contexts and peer groups

4. What are the patterns in characteristics and contexts of victims of violent incidents relating to:

   a. Home
   b. Family
   c. Peers
   d. School (if applicable)
   e. Neighbourhood

5. What are the patterns in characteristics and contexts of perpetrators of violent incidents relating to:

   a. Home
   b. Family
   c. Peers
   d. School (if applicable)
   e. Employment (if applicable)
   f. Neighbourhood

Incident

6. What are the patterns in characteristics of incidents of violence?

7. What are the patterns in the sequence of escalation towards a violent incident?

Professional involvement

8. What agencies are commonly involved with victims and perpetrators:

   a. Prior to an incident
   b. Following an incident (if applicable)

9. To what extent does the focus of professional response match the sources of risk and protective factors?

Level of information in review reports

10. To what extent is information available in the reports about sources of risk and protective factors (individual, home, family, peer, school, neighbourhood)

A data extraction template was developed and exported to EPPI-Reviewer 4. The full data extraction template for stage 1 is provided in Appendix 8.

Each of the included reviews was then data extracted. Many of the reviews have several reports associated with them, for example a main overview report, a briefer

executive summary and an action plan. For each of the cases, we extracted data using the most comprehensive report – usually the 'overview report'. We did not seek information about the cases from other sources such as original case files, or any media coverage. The data extraction was then aggregated and analysed by category.

Where cases had been reviewed using more than one statutory process, we used the most recent of the statutory reports.

Stage 2 – Systemic strengths and weaknesses in agency responses

The purpose of this stage was to identify common underlying weaknesses in professional practice in relation to the various types of violence, with a view to understanding how practice might be strengthened. Whilst there was also good practice reported in most reviews, we have focused on areas for improvement in order to inform what aspects of practice the VRU may want to influence through its work.

Methodology

The methodology for this stage was based on the Learning Together approach to case reviews and case review synthesis.[38] Learning Together is based on a systems approach, which acknowledges that professional practice is connected to features of people's tasks, tools and operating environment.

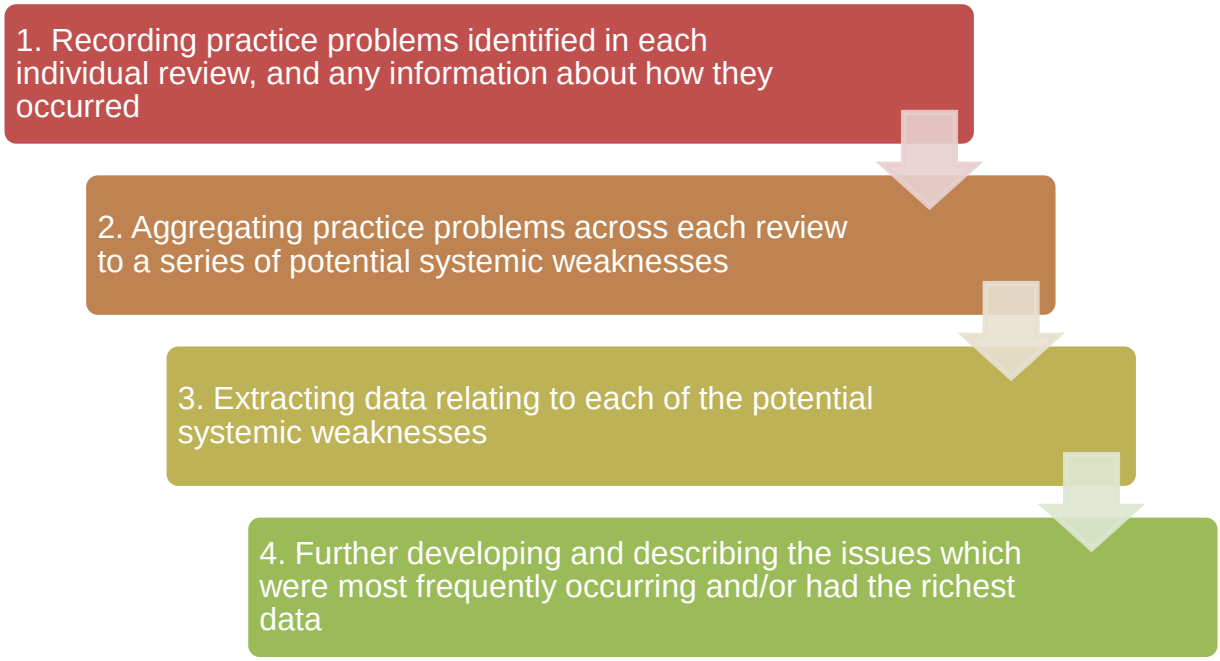
The Learning Together approach distinguishes between:

- 'Case findings/practice problems' – judgements about an individual case, and identification of poor practice within that case
- 'Systems findings' – explanations for *why* the poor practice has occurred which are more widely generalisable to a range of cases.[39]

We have used this distinction to identify key themes from the reviews using the process shown in Figure 1. We have focused on identifying a small number (three to six) of recurring themes, analysed in detail, for each category of case rather than a long list of practice problems identified across the reviews.

[38] Fish S, Munro E, Bairstow S (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews. London: Social Care Institute for Excellence.
[39] See SCIE Safeguarding Adults Reviews Library
www.scie.org.uk/safeguarding/adults/reviews/library/apply

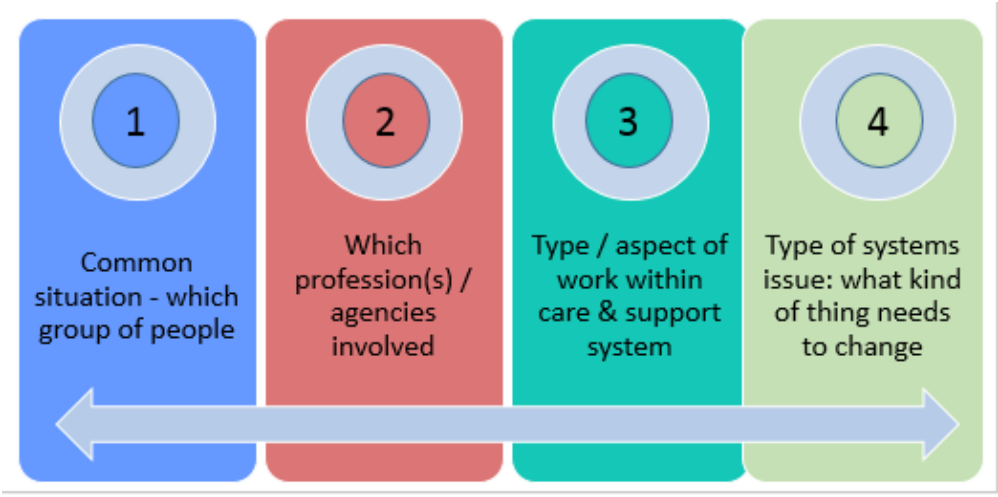
Figure 1. Stage 2 data extraction process, based on Learning Together[40]



In undertaking this process, we only recorded 'practice problems' that were identified as such within the review. That is, the research team did not re-analyse the practice described in the case. We were therefore dependent on the analysis made by the review authors at the time.

In describing the systems issues we aimed to cover the following issues as recommended by a Learning Together approach to categorising and synthesising review data (see Figure 2).

Figure 2. Categorising systems issues



[40] Fish S, Munro E, Bairstow S (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews. London: Social Care Institute for Excellence.

Sampling

This stage of analysis focused on detailed analysis of the cases relating to youth peer violence, intimate partner violence and adult family violence. This was on the grounds that these were likely to be the highest priority areas for the VRU in the short-to-medium-term. The biennial and triennial reviews of SCRs have also already undertaken extensive analysis of professional practice in relation to within-family violence towards children under 18.

Limitations

Key limitations of this study are as follows:

Coverage and representativeness of types of violence

This research was not intended to provide a representative sample of homicides and violent incidents in London. Rather, it is a convenient sample based on the availability of publicly available statutory review data relating to certain types of cases. The strength of this research is in being able to use this data source to explore in detail the narratives and contexts of these cases – providing a 'deep dive' in to particular types of cases.

The purpose of the included reviews means that they focus on incidents involving:

- people who are related or in intimate partner relationships, or in the same household (DHRs)
- people who have committed a homicide and have used mental health services within the prior six months (IIRs)
- adults who die or are seriously harmed as a result of abuse or neglect, and there are concerns about how services have safeguarded them (SARs)
- children and young people who have died or been seriously harmed, and there are concerns about how services have safeguarded them (SCRs).

Clearly, these four categories do not cover a range of circumstances in which violence or homicide may take place, including violence and homicide between adults who are not vulnerable or in receipt of social care or mental health services.

As demonstrated in Table 4, this means that this research features a substantial underrepresentation of youth and adult peer homicide, a slight overrepresentation of intimate partner homicide, and a substantial overrepresentation of adult family homicide and within-family filicide compared to the frequency of these events more generally. It will therefore be important for these findings to be viewed in the context of the strategic needs assessment which is being carried out alongside this piece of research. The relatively small number of reviews being carried out following serious youth violence is also a significant finding in itself, which is explored further in the Summary report.

Quality of information in the reviews

This research has used only the information that is presented in the review reports. Whilst many of these are very comprehensive, there are often gaps in the reporting of:

- even basic demographic information about the non-reference individual where the identity of this person is known
- information about ethnicity (as has been noted elsewhere[41])
- information about age.

We have aimed to use an adapted version of a Contextual Case Review© approach to understand the contexts affecting the person, in terms of their home, family, peer group, school/employment and neighbourhood. In many of the reviews there was relatively little information about contextual factors, particularly at a wider community and neighbourhood level.

The review reports themselves are typically based on reviews of case files and interviews with staff and managers who were involved with the case, and sometimes the individuals involved and their families. The information available in reviews therefore to some extent represents patterns and biases in practice. For example, few services were taking a contextual approach to safeguarding at the time, and therefore were unlikely to record contextual information. This may change over time.

Terminology

We have used the following terminology throughout this report:

Victim and perpetrator

We have used the terms ‘victim’ and ‘perpetrator’ to refer to the person who was killed or harmed, and the person who harmed them. We recognise that these terms can be problematic, particularly where there may have been mutual aggression between a victim and perpetrator, or the person who perpetrated the incident had been victimised in the escalation towards the incident (as may be the case for serious youth violence). However, overall, we felt that this categorisation helps to elucidate potential differences in characteristics and patterns of service use.

Names of individuals

The names of victims and perpetrators[42] we use in the report are the names used in the published review reports – all of which are in the public domain.

Reference individual

We have used the term ‘reference individual’ to refer to the person who is the main focus of the review. Reviews differ as to whether their focus is on the victim, perpetrator or both. Often this is linked to the review scope and purpose – for example, the purpose of IIRs is to investigate the care and treatment provided to the person who has committed the crime.

---

[41] Bernard, C and Harris, P. (2018) Serious Case Reviews: The lived experience of Black children. Family Social Work 24(2). Available at: **https://onlinelibrary.wiley.com/doi/abs/10.1111/cfs.12610?af=R&**

[42] Often aliases or pseudonyms. In a few instances, the victim’s family have given permission for the Review to use the person’s name

Appendix 2: Youth peer violence

This section sets out our analysis of eight case reviews (seven SCRs, one IIR) involving youth peer violence.

These comprised five homicides and three young people who killed themselves where peer violence or bullying had been present in the time before they took their own life. We chose to group these cases together in order to highlight the similarities in the characteristics of the victims and the social contexts within which they were being exposed to risk and abuse.

It is notable that we found just five reviews of youth homicides published in London since January 2016. This is in the context of over 120 homicides of young people aged 16–24 during this time.[43]

Characteristics and contexts

We analysed the eight reviews in terms of the characteristics of victims and perpetrator, their relationships, contextual factors, and characteristics of the incident and escalation towards it.

[43] Metropolitan Police Service data, accessed September 2019. Although this time period does not exactly match the time period in which the reviewed incidents occurred, it does illustrate the significant mismatch between the number of incidents that are likely to have occurred, and the number of statutory reviews currently available.

Overview

Table 5. Reviews of peer violence between young people aged 10–25

Date of incident	Date of report	Brief description	Reference individual	Information provided about non-reference individual?
Homicide cases				
2014	2018	Young woman killed by a male friend	Victim	Some
2013	2016	Young man killed in an altercation with three youths. It is unclear if they were known to him	Victim	None
2017	2018	Young man killed in drive-by shooting. It is unclear if perpetrator was known to him	Victim	None[44]
2015	2016	Young man killed in a knife attack. It is unclear if the perpetrator was known to him	Victim	None[45]
2014	2019	Young man killed in knife attack by friend	Perpetrator	None
Suicide cases				
2015	2016	A young woman kills herself who had experienced bullying and cyberbullying	Victim	–
2013	2016	A young woman kills herself who had experienced bullying	Victim	–
Not reported	2017	A young person (gender not disclosed) kills themselves who had experienced suspected gang violence and sexual assault	Victim	–

[44] Murder investigation ongoing at time of writing SCR and no arrests had yet been made.
[45] Police investigation was ongoing at time of writing of SCR.

Case example 1: Peer violence between young people aged 10–25 – Child AX

Child AX was a young man of African Caribbean heritage who was killed at the age of 17 in an altercation with three other young men. The police investigation suggested that AX had been the initial aggressor and had been killed by the youths in self-defence. It is unclear whether they were known to him before this, although there was an indication that they may have had a gang affiliation, due to sustaining a further superficial wound which could have been inflicted as a signifier of a gang-related attack.

In the run-up to the incident, AX had been involved in increasingly frequent and serious criminality including being wanted for attempted murder and on bail for a sexual assault. He had also decided to leave his family home and was housed by the local authority, but then had been evicted from his independent accommodation, and had since been living at multiple addresses. At the time of his death he had left his current address and was staying at a friend's accommodation, thereby missing from care. The review proposes that this may have been in order to avoid the police.

Child AX was brought up by his mother who was also caring for her disabled younger brother after the death of child AX's grandmother. Child AX's mother suffered from depression and 'exhaustion' as a result of her caring responsibilities, as well as financially supporting her family. She worked six days a week at one point. The review suggested that child AX suffered physical and emotional neglect as a child. AX's uncle was violent towards his mother, and occasionally abusive to child AX, which resulted in the family moving to a domestic abuse refuge and child AX changing schools. The review found that child AX was offered interventions from child and adolescent mental health services (CAMHS) and attended two sessions. However, child AX's mother stopped taking AX.

The review describes how child AX's teacher said as a young child he was very able and engaged but was someone who 'struggled to contain his emotions and appeared overwhelmed by distress about his family circumstances'. This would manifest in emotional or angry outbursts. As he grew older this escalated to persistent non-attendance at school, low level offending such as graffiti, followed by much more serious offences including robbery, sexual assault, serious assault and suspected attempted murder. AX was known to use cannabis and became well known as someone who sold cannabis at his school. He is suspected to have been affiliated with a gang, and was on the London Gangs Matrix.

Case example 2: Peer violence between young people aged 10–25 – Mr H

Mr H was of mixed White British and African Caribbean heritage. At age 25, Mr H killed another 25-year-old young man who was believed to be a former friend of his. The review does not report any antagonism or incidents between the victim and perpetrator prior to the homicide. However, it may have been that this had occurred but was not known to services.

Mr H's childhood is described in the review as 'deprived and chaotic'. His parents separated when he was six and his father returned to Jamaica. Mr H reported that he had at least 26 paternal half-siblings and three maternal half-sisters. His mother travelled to Jamaica at times, leaving him either with his grandmother, who had cancer, his teenage sisters or in the care of the local authority. Mr H attended three different primary schools due to exclusions for behavioural difficulties including fighting. He stated that he used cannabis regularly from the age of 10. He reported first robbing a person at age ten. Mr H was convicted of a series of crimes before his 18th birthday including:

- six convictions for robbery between the ages of 13–18, three of which resulted in custodial sentences, the last of which was three years in a Young Offender Institution (YOI)
- convictions for breach of supervision orders and failure to surrender age 16
- conviction for harassment of a family who lived nearby.

After being released from the YOI, Mr H committed two further offences of robbery and received a custodial sentence at HMP Feltham in 2011. In prison he started to show what the review describes as 'bizarre' behaviour and received psychiatric assessment. In 2012, he seriously assaulted a prison officer.

Mr H was admitted from prison to the secure unit of the South West London and St George's mental health trust. Mr H was discharged from inpatient provision after his sentence had expired and went to a residential rehabilitation service. His mental health was stable, and he did not commit any offences during this time. He was then moved to a step-down unit, which is an 'independent living facility with minimal supervision and monitoring'. He was concerned about bumping in to former associates and was keen to move out of the area, but this was not achieved prior to the homicide.

Case example 3: Suicide in which bullying, or violence was a factor Child KA

KA was attacked by an unknown peer in 2011 on the way to school. The incident is described as a robbery with sexual overtones. Around the same time, KA also reported a physical assault by some children of similar age. Neither case resulted in the identification of a perpetrator. In 2012, KA moved to another school, remaining there until 2015.

At the age of 13, in 2012, KA was a victim of a serious sexual assault by a perpetrator of a similar age at a youth centre. The day after this, KA was reported missing and was then found and taken to a police station for a safe and well check, but did not report the sexual assault. A couple of days after the incident, KA and KA's mother informed a GP of the assault and suggested that it was a gang related offence, and that KA did not want to report the incident formally due to fear of retribution. However, following this, details were revealed to a social worker who visited as a result of the incident. This could have enabled further checks to be conducted regarding the perpetrator of the incident.

KA received pastoral support from her school for emotional difficulties such as low self-esteem, peer relationship problems, bullying and anxiety. KA suffered a panic attack when detained by police as result of a theft allegation.

In 2015, there was a gang related incident where KA was spat at and reported taking seven painkillers in a self-harm attempt. In late 2015, KA attended hospital with a cut to the arm and reported feeling low about life. She referenced the sexual abuse incident and reported feeling suicidal as a result. However, she absconded before anything could be done. She had provided a false name at the hospital. When her correct details were found, the police attended KA's home to follow up a safe and well check as KA had been 'missing'.

Six months later, KA killed herself.

Characteristics of the individuals

Victims

Homicide cases

For the homicide cases, there were five victims in total, with four male victims and one female. Most victims were aged 16–18, with one victim aged 25.

There were three male victims who had experienced adversity in early life including abuse or neglect in the family home, a parent with a mental health problem, family member in prison and parental separation with little contact with fathers. All had difficulties at school; in two cases this was due to learning disability and in one case the young person had a good level of ability but very sporadic attendance. They had also all gone on to be involved in offending behaviour, often starting with relatively low-level crimes before progressing to more serious offences such as sexual assault and suspected attempted murder. All had suspected gang affiliations. For one of the male victims, very little information was given in the review about his characteristics or background.

It was notable that some of the behaviours of the young male victims could be interpreted as aiming to create safety for themselves. For example, towards the ends of their lives, all three for whom we have information went missing regularly or frequently moved to different addresses. The reviews suggest this may have been to avoid people they were afraid of, or the police. Some of the victims (n=2) were also known to have

purchased and carried weapons. In one case the young person had indicated this was for protection.

The female victim, who was killed by a male friend of a similar age, had a different profile. She was engaged in mental health services from her teenage years as she had been missing from education, and was misusing alcohol and other substances. The review also concludes that she was being sexually exploited, although this was not recognised by services at the time. Her mother was concerned and attempted to intervene multiple times. The review describes her vulnerabilities as making her more susceptible to sexual exploitation and grooming. In the months prior to her death, the victim had been engaging in mental health provision and college, as well as ceasing her substance misuse.

Suicide cases

For the suicide cases, all victims were aged 12–18. The gender of the victims was female (n=2) or not reported (n=1). The ethnicity of the victims was not reported in any of the cases. Mental health problems featured in all three cases, with young people having longstanding mental health difficulties. All had experienced adverse childhood experiences including abuse and neglect, parental abandonment and exposure to violence.

All the young people had experienced bullying in the run-up to taking their own lives. For one young person some of the victimisation they experienced appeared to be gang-related. Whereas one victim had experienced bullying and cyberbullying at school, and one victim had experienced victimisation at the hands of someone who was her maternal uncle, but was of a similar age to them, so this has been classified as a peer.

Table 6. Victim demographic characteristics for peer violence between young people aged 10–25

Victim demographic characteristics	n
Gender	
Male	4
Female	3
Gender not reported	1
Age	
12–13	1
14–15	2
16–18	4
25–34	1
Ethnicity	
Black/Black British African	1
Black/Black British Caribbean	2
Not reported	5

Table 7. Other victim characteristics for peer violence between young people aged 10-25[46]

Other victim characteristics	n
Absent parent(s)	5
Abuse or neglect (as a child)	5
Domestic abuse	5
Mental health problems – past	4
Substance misuse	4
Educational exclusion	4
Mental health problems – current	4
Parental abandonment through separation or divorce	4
Sexualised behaviour	4
Witnessing violence (for example street violence, exposure to domestic abuse)	4
Bullying (past experience)	3
Child in Need/Child Protection Plan	3
Domestic violence – experienced as a child	3
Gang affiliation	3
History of/current self-harm	3
Missing episodes	3
Offending	3
Victim of crime	3
Parent with mental health problems	3
Member of the household being in prison	2
Substance misuse dealing/county lines	2
Victim of grooming	2
History of violence	2
Special education needs and disability	2
Carrying weapons	2
Acute illness	1
Alcohol misuse	1
Disability	1
Growing up in a household in which there are adults experiencing alcohol and substance misuse	1
Experience of being looked after by the local authority	1
LGBTQIA+	1
Missing episodes	1

Perpetrators

Information was only available about one of the perpetrators, who was male, aged 25, and of mixed White British and Black Caribbean heritage.

Relationship between victim and perpetrator

In three of the homicide cases, the relationship between victim and perpetrator is unclear as the identity of the perpetrators was not known at the time the SCRs were written. There was an indication in one case that the killing may have been gang-related due to marks made on the body during the homicide.

[46] Data available for eight cases

In two cases, the victim and perpetrator were friends. Neither review is able to suggest the reasons for the homicide, although in one case the perpetrator had a history of violent offending and drug dealing in his local area.

Characteristics of relationship

Very little was known about the characteristics of the relationships between the victim and perpetrator in any of the homicides, and whether there had been any prior violence or abuse in any of the relationships.

Contexts and peer groups

Victims

Living arrangements: Most victims (n=6) were living in the family home at the time of the incident, and one was missing from care. There was no information about one of the victims.

Risk factors: It was notable that the young people were exposed to risk factors in various aspects of their lives, including:

- **At home.** Most had experienced different forms of abuse (including emotional abuse, neglect, exposure to domestic abuse) and bullying by a peer within their home environment. There was frequently a lack of parental capacity to safeguard, in some cases this was linked to the breakdown of parent-child relationships and the young person having to move out of home, which increased their risk of exposure to dangerous environments. In another case, the young person's sibling was suspected to be involved in gang activity and had spent time in prison. Some of the parents in the cases reviewed faced challenges which made it difficult to keep their child safe. In one case, the review identifies that a parent (who was otherwise supportive and concerned) worked evening shifts which made it difficult for her to provide adequate supervision.
- **In the wider family.** There were some instances of abuse and neglect in the wider network. For example, one of the young people who killed themselves had experienced long-term sexual abuse by a family member. There was often a lack of support networks. For young people at risk of peer violence who went to live with other family members, these family members were often them unable to safeguard them (for example, an elderly grandparent).
- **In their peer group.** Several of the young people were in peer groups that were involved in offending behaviour or with suspected gang affiliations. For one of the young people who killed themselves, they were the victim of bullying and sexual assault which was thought to be gang-related.
- **At school.** Some young people were further exposed to gang-affiliated young people at school, and one young person had handled a gun at school. A young person was exposed to violence and conflict between peer groups at their school. Many of the young people had experienced school exclusion which was a further source of vulnerability. Although many schools also provided protective

factors, including support and mentoring, some did not provide adequate safeguarding in terms of making referrals to children's social care at the appropriate point.

- **In their local neighbourhood.** It was reported in some cases that there was gang activity in the wider neighbourhood, and for one young person this was how he had started associating with older, criminal peers. Lack of safety in their neighbourhood on occasion affected young people's ability to engage with services. For example, one young person felt sufficiently unsafe that they had to get a taxi to their youth offending team (YOT) appointments. Another young person frequently went missing from their home address as they feared violence from peers if they remained at home.

Protective factors: There were a number of protective factors in the young people's lives. These protective factors were often not sufficiently utilised by services working with the young person.

Parents often tried to create safety for the young people, for example by moving them to another area or another country for a time (for example, one child's mother relocated him to Sierra Leone). In all cases, this did not appear to be picked up on by professionals as a signal of concern.

Schools were often a protective factor in terms of providing support and onward referrals. In several of the cases, the young people had received better support in their primary schooling but struggled on entering secondary education. The protective influence of school was also restricted by temporary and permanent exclusions and frequent absences in several cases.

Table 8. Victim risk and protective factors across their contexts for peer violence between young people aged 10–25[47]

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**5** Emotional and physical abuse/ neglect (4), Exposure to domestic abuse (2), Victimisation by similar aged member of extended family (1)	**1** Sexual abuse by extended family	**3** Bullying (2), Sexual assault (1), Cyberbullying (1)	**1** Physical violence at school		**2** Victim of crime with suspected sexual motive in neighbour-hood (1), Racially motivated harassment by neighbours (1)
Criminality	**1** Sibling had suspected gang involvement		**4** Gang involvement or gang related victimisation (4), Peer group involved in criminal behaviour (2)	**2** Exposure to young people involved in gangs (1), Young person handled a firearm at school (1), Young person involved in selling substance misuse at school (1)		**4** Gang activity in local area (4), Spending time away from own address as feared attack (1), Victim of crime with suspected sexual motive in neighbourhood (1)

[47] The number in bold refers to the total number of reviews in which the category of risk or protective factors were present (e.g. abusive behaviours). The numbers in brackets refer to the specific type of risk of protective factor (e.g. emotional abuse), where stated in the review. As not all reviews stated the specific type of factor, and some reviews stated multiple types within a category, the numbers in brackets do not always sum to the total number.

Harmful gender norms			**1** Involved in a group suspected of sexual assault on a young woman			
Lack of capacity to safeguard	**2** Breakdown of relationship with parent (1) Parent working shift work – difficult to supervise young person (1)	**1** Wider family not able to safeguard		**2** School did not make safe-guarding referrals		
Other	**2** Registered sex offender living in family home (1), Parent not engaging with services (1)		**1** Social isolation			**1** Young person felt unsafe and moved away for a time
Protective factors						
Were any protective factors present?	**6** Parent tried to move young person to a different area for their safety (3), Parent support to engage with services (2), Good relationship with grandmother (1)	**1** Young person provided accommodation by extended family		**4** Good support in school (3), School attempted to resolve bullying (1)		

Perpetrators

Information was only available for one perpetrator in this category. The review suggested this perpetrator had:

- Risk factors in relation to criminality within his wider family, and
- Risk factors in his neighbourhood – he had been involved in violent crime and gang activity before going to prison. On his release he was unable to access services or travel to some areas of the borough in which he lived for fear of meeting former associates.

Incident

Of the five homicide incidents, in three the weapon used was a knife, one was a gun and for one incident the method of killing was not reported. Most of the incidents (n=3) took place on the street/in a public place, one was at the perpetrator's home, and for one the location was not reported.

Of the three suicides reviewed, two were by hanging: one in a local wood and one at the young person's school. The method of one young person taking their life is not reported in a case.

Escalation towards incident

For the cases of homicide, it should be noted that the nature of the information provided in the reviews means that this is focused on escalation from the point of view of what was happening in the victims' lives at the time – there is very little information about whether there was any increasing hostility between victim and perpetrator, or between rival gangs where applicable.

Common themes in the escalation towards the incident for this category were:

- Pattern of **escalating frequency and/or seriousness of offending** by the victim, for example from robbery to sexual assault and attempted murder (perhaps showing that they were moving in increasingly dangerous circles)
- **Leaving family home, missing from care, and 'sofa surfing' or frequently going missing** – One review suggested that this was the young person's attempt to keep themselves safe – by spending time in a different area of London.
- **Purchasing or carrying weapons**

In one case the perpetrator had mental health problems but had stopped taking his medication prior to the incident.

For the young people who killed themselves, the common feature in escalation across cases was prior self-harm or overdose. A young person who killed themselves had also gone missing prior to taking their life.

Professional involvement

We analysed the case reviews to see which services had been involved with both victim and perpetrator.

Victim professional involvement prior to incident

Alongside schools, the most frequently involved service was the police. Not all young people, particularly those who were victims of homicide, received support from children's social care. In several cases, children's social care had been involved in earlier childhood but had not been involved during the recent difficulties that the young person had been experiencing.

Table 9. Victim involvement in services prior to incident

Services	n
Police	7
School/s	7
Child and adolescent mental health services (CAMHS)	5
Children's social care – child in need/child protection plan	5
GP	4
Youth service	4
Mental health – other	3
Acute health services	2
Early help/Team around the family (TAF)	2
Educational psychology	2
Substance misuse services	2
Youth offending	2
Children's social care – looked after services	1
Domestic abuse services (e.g. police community safety units, domestic violence (DV) team)	1
Mental health – community mental health team	1
Housing	1
Adolescent resource team	1
Mediation services	1
Sexual health services	1
Attendance centre	1

Perpetrator professional involvement prior to incident

As detailed, there was little information about the perpetrator professional involvement.

Table 10. Perpetrator involvement in services prior to incident

Services	n
School/s	2
Adult social care	1
GP	1
Housing	1
Mental health – community mental health team	1
Mental health – inpatient	1
Mental health – other	1
Probation service	1
Special education needs and disability	1
Young offenders' institution	1
Active change foundation[48]	1

Potential areas for improvement in professional responses

We analysed the case reviews to see if there were common difficulties in professional practice in dealing with these types of cases. We aimed to focus on common difficulties as a way of informing areas of practice that the VRU may wish to focus its work on. The reviews themselves also tend to focus on identifying practice problems, as a way of understanding what could be done differently with similar cases in the future, although many also identified some aspects of good practice.

We aimed to identify possible underlying systemic issues, rather than issues that were specific only to a particular case. We therefore looked for issues which recurred across cases, or where there was an indication that this was likely to occur more widely than just in this specific case.

In relation to youth peer violence, we identified the four following key issues that appeared to recur across cases:

1. Understanding of safeguarding during adolescence
2. Holistic assessment, including recognising the impact of early trauma
3. Responses to young people who go missing
4. Role of schools.

It is important to note that the practice described in the reviews can be from as far back as 2013, so practice may have already changed or improved in these areas.

Due to the small number of statutory reviews we found relating to youth peer violence, we also sought to identify publicly available non-statutory reviews of cases that had been conducted in London. These will be discussed at the end of the section.

[48] Active Change Foundation Ltd is a charity aiming to protect young people and communities from extremism and violence in all its forms by raising public awareness, challenging conflict through dialogue and developing resilience through training and support services.

1. Understanding of safeguarding during adolescence

Both the homicide and suicide cases we reviewed included examples of risks faced by older children and young people not being viewed as safeguarding issues. This mirrors findings from other research which suggests that safeguarding issues faced by older children can present distinct challenges, which need a particular type of professional response.[49] This finding applied across a range of behaviours and risks, including risks arising from:

- involvement in offending and gang affiliation
- self-harm
- bullying/cyberbullying.

This led to professional responses that did not always consider risk and safety alongside other issues.

Child criminal exploitation, gang affiliation and offending behaviour

Several of the reviews highlighted that young people being involved in offending and gang activity was often viewed solely through a criminal justice lens, and did not engender an appropriate safeguarding response. In one case, a young person was involved in an increasingly serious pattern of offending behaviour. This led to involvement with police and youth offending services, but did not trigger children's social care involvement. The review states:

> *'[Young person's] emerging pattern of offending and risk-taking behaviour should have been of concern to professionals in children's social care [but] in this case, were not factored into assessments or responses from a safeguarding perspective.'*

In another case, a 13-year-old young person was accused of gang-related sexual assault on at least one young woman. The review notes that, as well as the young person not being investigated, they were also not considered as requiring a safeguarding response in their own right.

Similarly, the reviews note that there was often a lack of recognition in the cases of young people who were experiencing child criminal exploitation. In two cases, the young people were identified as having been coerced or harassed in to selling substances, but again this was not seen by professionals at the time as a safeguarding issue.

This meant that young people involved in offending and gangs frequently became involved with the criminal justice or youth offending systems, but were much less often

[49] Firmin C, Horan J, Holmes D et al. (undated) Safeguarding during adolescence – the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding. Research in Practice.

provided with a service by children's social care in response to the risks they were facing.

It could be argued that a children's social care response is unnecessary when a young person is already being supported by youth offending services, which aim to take a holistic approach to support the young person's welfare as well as address their offending. However, these cases support the argument that has been made elsewhere: a welfare approach within an overall youth justice framing is not the same as involvement from a service whose primary purpose is to safeguard your welfare and consider and reduce risks to safety.[50] The types of intervention offered by the youth offending services in these cases, whilst addressing relevant issues (for example, weapons awareness, support with peer influence/peer association), missed a vital piece of the puzzle – an explicit consideration of the young person's risk of significant harm and the reduction of risk to the young person. As stated in one review:

> *'…information [about young person living back in their home borough and accessing weapons] should absolutely have been shared with children's social care in order to trigger an Initial Child Protection Conference and ensure a robust multiagency risk management plan with regular review.'*

Self-harm

In two of the suicide cases we reviewed, it was noted that, similarly, professionals did not always recognise self-harm as requiring a safeguarding response. In both cases, school were aware that the young person was self-harming, but did not make onward referrals to either early help, children's social care or CAMHS.

In both cases, this was due to the young person having good relationships with school staff and school therefore aiming to manage the issue internally. However, it meant that the risks to the young person, and how they interrelated with other sources of risk in their lives, were not well understood. Again, a referral to children's social care may have helped to put the overall response to the young person within a child protection framework, with a more explicit focus on identifying and reducing the risks to them.

Bullying and cyberbullying

In one of the cases of suicide we reviewed, bullying and cyberbullying had been a factor in the young person's self-harm and, apparently, when she killed herself. The review author notes that, understood alongside other risk factors, the cyberbullying (involvement in an abusive group chat) should have been grounds for a referral to children's social care. However, staff did not appear to be equipped to respond

[50] Firmin, C (2018) Contextual risk, individualised responses: An assessment of safeguarding responses to nine cases of peer-on-peer abuse. *Child Abuse Review,* 27:52-57.

effectively to cyberbullying, including the fact that cyberbullying was not in the school's bullying policy.

Underlying systemic factors

The cases we reviewed all provided examples of where safeguarding issues more prevalent in adolescents were not well handled by the professionals working with the young people. The evidence base suggests that this is part of a wider pattern of agencies struggling to respond to safeguarding issues as they manifest in older children, and particularly where the risk is from outside the family[51].

There is little information in the reviews themselves about the reasons why 'the system' struggles to deal with adolescent safeguarding issues. However, there is some indication through the variety of recommendations made in the reviews that there may be multiple systemic reasons why services struggle to respond to adolescent safeguarding. Across different reviews, recommendations are made about changes to overall service configurations and the implementation of a contextual safeguarding model, changes to assessment practices, and amendments to policy (including bullying and cyberbullying policies). One review also highlights that assessment tools used within some agencies, such as the ASSETplus assessment tool[52] used in youth offending, may not support consideration of wider wellbeing and safeguarding issues.

It has been noted elsewhere that another key underlying issue is the fact that the statutory framework for child protection is not configured to deal with intrafamilial abuse, and are not well equipped to deal with risks that are posed to young people either from themselves or outside the family, and which undermine parental capacity to safeguard.

2. Holistic assessment, including recognising the impact of early trauma

Several of the reviews note that professionals' assessments of young people were frequently impeded by having an incomplete picture of the young person's experiences and vulnerabilities, particularly in relation to traumatic experiences from early childhood. This often led to professionals underestimating the level of risks that young people were experiencing.

[51] Firmin, C. (2017) Contextualising case reviews: A methodology for developing systemic safeguarding practices. *Child and Family Social Work,* 23(1):45–52.

[52] Youth Justice Board. (2014) AssetPlus: assessment and planning in the youth justice system. London: Youth Justice Board. Available at: **https://www.gov.uk/government/publications/assetplus-assessment-and-planning-in-the-youth-justice-system**

In some cases, incomplete assessments were due to a lack of information about early life experiences that were relevant to the young person's current behaviour. For example:

- A young person, who was involved in violence and offending, had come to this country as a child from Sierra Leone. Little was known about his experiences while living there. However, the possibility of early trauma from experiencing conflict there was not taken in to account by professionals in terms of informing interventions with that young person.
- Information about another young person's history of serious sexual and emotional abuse was lost in her move between boroughs and between schools. This meant that when she began presenting with distress and deliberate self-harm, the significance of this was not fully understood.

In other cases, the information was known but was not treated as being relevant to the risky behaviours that the young person was showing in adolescence. For example, another young person was known to have a history of emotional abuse and neglect, but this was not reflected in responses to their later offending behaviour.

This led to an incomplete understanding of the levels of risk faced by young people, and some of their reasons and motivations behind the behaviour they were showing.

Underlying systemic factors

One review in particular explored some of the reasons underlying this practice problem. The authors highlight that:

- Current events are often more immediately concerning to agencies, and a clear presenting incident may be more likely to get a response than an ongoing, chronic situation.
- Chronologies can be a useful tool in understanding patterns of behaviour. However, these are not consistently created. This means that professionals who are new to a case do not have ready access to the history of that young person. Time pressures make it difficult for most professionals to go back through the young person's case file to understand historic concerns.

Linking this to the finding above, there is also likely to be an issue of inter-agency communication in that any information that *is* known about early trauma is likely to be held by children's social care services. As noted in the above finding, this agency appears to be less likely to be involved in certain types of adolescent safeguarding, for example in relation to offending behaviour and child criminal exploitation. This may further explain why connections are not made between these types of behaviour and earlier trauma and adverse experiences.

3. Responses to young people who go missing

Young people going missing was part of the escalation towards the serious incident in a number of both homicide and suicide cases. Several of the reviews identified mishandling of the young people's return including:

- Independent return interviews not being conducted, as is specified in national guidance[53]
- 'Safe and well' interviews not adequately exploring the reasons for going missing – for example in one case the missing episode was linked to a gang-related sexual assault – even when there was prior intelligence about the reason for the young person going missing which should have informed the questions in the interview.

This meant that opportunities to explore the significance of the young person's missing episode were missed. In a case, this was linked to a significant delay in a sexual assault being recorded as a crime. In other cases, it was not clear what the impact of this had been. However, given that several reviews conclude that the young person was going missing out of fears for their own safety if they stayed in their current address, it would appear that an important opportunity to acknowledge and address risk may have been missed.

Underlying systemic factors

Little information is given in the reviews as to why practice following missing episodes was not as it should have been. There was some indication that there may have been confusion between the status of police safe and well checks and independent return interviews. In some cases, this meant that if a safe and well check had been done, it was not considered necessary for an independent interview to be conducted also.

There also appeared to be a gap in provision in one local area for children who went missing but were not an open case to children's social care. It is unclear to what extent this is a widespread issue.

4. Role of schools

In a number of the cases we reviewed, schools could be both a protective factor, but also in some cases were a source of risk. Many of the reviews highlighted excellent practice by schools, particularly primary schools, in terms of providing behavioural support, emotional support and mentoring. Many schools showed good knowledge of safeguarding procedures, and appropriately made onward referrals to children's social care as necessary.

---

[53] Department for Education (2014) Statutory guidance on children who run away or go missing from home or care. London: Department for Education. Available at: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf**

However, schools could also be a source of risk in terms of:

- Providing a context in which young people met others who were involved in criminality and gang-related behaviour. This was particularly highlighted in one case in relation to a Pupil Referral Unit attended by the young person who was eventually the victim of a homicide. This young person was also reported to have seen and handled a gun at school.
- Safeguarding knowledge and practice within school was not uniformly good, particularly in relation to issues regarding mental health problems and self-harm, and there were two cases in which school attempted to manage young people's mental health problems within the school for longer than the review authors considered appropriate.
- When young people were excluded from school, the protective benefits of school were lost. Within the cases we looked at, five young people were excluded from secondary school and two were also excluded from primary school.

Several of the reviews found that young people had been coping adequately within primary school, but showed worsening behaviours on their transition to secondary school.

Underlying systemic factors

Again, there was relatively little information in the reviews to explain underlying reasons for some of the practice described in the reviews. In a review, school staff had told the review team that they felt ill-equipped to deal with the significant rise in both admissions of young people with special educational needs and disabilities, and also the increasing risks from gang-related exploitation and offending.

With regard to exclusions, national data has shown a rise in exclusions in both primary and secondary school[54]. The Timpson Review of exclusions[55] identifies possible drivers for this, including differences in school leadership and culture, schools not being equipped to deal with disruptive behaviour, and a system that does not incentivise inclusion.

Comparing these findings to other reviews

Due to the small number of statutory reviews we found relating to youth peer violence, we also sought to identify publicly available non-statutory reviews of cases that had been conducted in London. We identified four potential sources:

---

[54] Department for Education (2018) Permanent and fixed-period exclusions in England: 2016 to 2017. London: Department for Education. Available at: www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2016-to-2017

[55] Secretary of State for Education (2019) Timpson Review of School Exclusion. London: Houses of Parliament. Available at: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/807862/Timpson_review.pdf**

1. Croydon Vulnerable Adolescents Thematic Review[56]
2. Tower Hamlets – Troubled Lives, Tragic Consequences[57]
3. Camden Youth Safety Taskforce[58]
4. Southwark Extended Learning Review[59]

Reports one and two were more closely matched in in terms of methods to the statutory reviews we have analysed, as these were based on analysis of individual cases of young people. We considered the findings of report three – however this was not based on case review but did include primary research with young people. Report four was based on interviews with senior leaders, so was not considered analogous to our other data sources.

[56] Croydon Safeguarding Children's Board (2019) Vulnerable adolescents thematic review. London: Croydon LSCB. Available at: **https://croydonlcsb.org.uk/wp-content/uploads/2019/02/CSCB-Vulnerable-Adolescent-Thematic-Review-PUBLISHED-Feb-2019.pdf**

[57] London Borough of Tower Hamlets Safeguarding Board (2015) Troubled Lives, Tragic Consequences. London: Tower Hamlets LSCB Available at: **www.childrenandfamiliestrust.co.uk/wp-content/uploads/2015/12/Troubled-Lives-Summary-Report-Final1.pdf**

[58] Camden Youth Safety Taskforce (2019) Camden Youth Safety Taskforce report. Available at: www.camden.gov.uk/documents/20142/0/download+%288%29.pdf/3b1a64e6-31db-01cc-c7c9-4d04b5450bc6

[59] Southwark Safeguarding Children's Board (2019) Extended Learning Review. London: Southwalk. Available at: **http://moderngov.southwark.gov.uk/documents/s82118/Southwark Extended Learning Review.pdf**

Table 11. Overview of non-statutory reviews of cases that had been conducted in London

Review	Purpose	Methods	Inclusion criteria for individuals	Key findings
Croydon Safeguarding Children Board - Vulnerable Adolescents Thematic Review (2019)	To determine whether there were any patterns in the children's experiences, which could inform and improve future planning. Terms of reference: - To gain an understanding of the factors that might be present in a child's life that would make them vulnerable to such life-changing or life-ending results - To gain an understanding of what services or provision has been made to these children and their families in order to inform what might work for others in the future to prevent the same outcomes - To influence commissioning of timely and appropriate services to address these latest issues.	- Analysis of the two SCRs on individual children - Agencies examined their records for each of the 60 children and summarised their findings - Gathering views of family members and children - One-day practitioner learning events (PLEs) held across four workshops - Meeting with Croydon BME forum - In-depth case analysis of 15 children's social care case files	Adolescents who died in 2017 (n=5) Adolescents identified as having poor outcomes or of considerable concern by police, youth offending, children's social care or Multi-Agency Sexual Exploitation (MASE) (n=55)	**Of the adolescents who died:** All male, aged 15–17. Three young people were Black Caribbean, one was White British, and one was Mixed White and Black Caribbean. **Group identified as having poor outcomes:** - A total of 37 male and 23 females - Some 71.67% of children classed as being from non-white backgrounds. The two largest groups in the sample were: Black Caribbean males and White British females. - Majority of children lived in the most densely populated areas of Croydon. - Over half were known to children's services by age of five years, and nearly three quarters by age of 12. - A number of the young people showed aggressive and disruptive behaviour in primary school, and 19 received fixed-term exclusions in primary school. - Young people's behaviour deteriorated throughout secondary education, with over half of children being made subject to fixed-term exclusions, managed moves or

				placements in pupil referral units or alternative educational provision. - Young people became involved in offending, were victims of child sexual exploitation or child criminal exploitation. Over half were thought to be in, or affiliated to, gangs. Involvement in county lines substance misuse activity and victims and perpetrators of knife crime. - Over 75% of the young people were reported missing at some point.
Tower Hamlets - Troubled Lives, Tragic Consequences (2015)	Thematic review of incidents which took place in 2013/2014 when several older children committed grave offences.	- Examination of chronologies from a range of agencies, and assessments and plans from children's social care and youth offending service. Also, education and mental health records. - Reflective conversations with a range of individuals and groups.	Five individuals who committed serious offences resulting in death or serious injury, and one victim. All aged over 14.	**Of the adolescents who committed offences:** All male, aged over 14. **Group identified as having poor outcomes:** - Going missing - Substance misuse - Gang or delinquent street group involvement - Victims of youth violence or exploitation - Early onset of behaviour difficulties - Attendance issues - School exclusion - Attendance at special educational provision - Violence, threats or aggressive behaviour to staff. **For the five children who committed violence, following factors were present:** - Abuse and neglect

				- Attachment issues to one or more of their parents - Fractured family relationships - Loss of a parent figure - Violence from them to their family - Causing damage to their home - All boys who committed offences had contact with CAMHS from a young age and displayed behavioural difficulties. Several started displaying behavioural difficulties in primary school. - At secondary school started demonstrating challenging behaviour and truancy. - All subject to exclusions. All attended special educational provision. - For several children, the transitions from primary to secondary was when behaviours started to change.
Camden Youth Safety Task Force (2018)	To answer three broad questions: - Why do some young people carry knives? - What are the main causes of youth violence? - What can be done to address the problem of youth violence in Camden?	- Four secondary schools' visits, speaking with a hundred students - Four youth centre visits speaking with seventy young people - Online survey completed by 169 people - Small and individual focus groups including with 12 young people open to Camden's Youth	N/A	**Why do some young people carry knives?** - Fear and protection were highly rated by respondents (33%) to online survey said they felt unsafe in Camden. Reference was made to 'postcode wars' – in which young people defend certain areas which are affiliated with them.

		Offending Service - Two parents' groups and three community conversations involving parents and local residents involving c100 people - Open drop-in session - Professional focus groups with youth workers, family support workers, community safety officers, headteachers and Borough Commander of Metropolitan Police - One-to-one meeting with policy experts and voluntary groups		**What are the main causes of youth violence?** - Lack of 'things to do' – lack of youth services, youth centres and after school activities. Young people unaware of activities on offer - School exclusions – young people felt more could have been done to keep them in school - Gangs, grooming and substance misuse trade - most common answers to online survey question about causes of violent crime - Lack of opportunities for training and employment – linked to gangs, young people getting involved in gangs and illegal substance misuse as a way to make money - Trauma and adverse childhood experiences - Social media, identity and negative role models

Appendix 3: Adult peer violence

This category comprises nine cases, of which seven are IIRs and two are SARs. The seven IIRs and one of the SARs relate to homicides, and the remaining SAR relates to a young woman with learning disabilities who was assaulted on multiple occasions by another resident in the residential accommodation in which she lived.

This section includes cases involving violence between adults aged 26 and over who do not fall in to the category of either intimate partner violence/homicide or adult family violence/homicide.[60] It therefore includes violence between people who are friends or acquaintances, or stranger violence.

These cases have been grouped together as, even in some of the cases in which there was a form of acquaintanceship between the victim and perpetrator (for example neighbours), it is often unclear to what extent there was any prior interaction or relationship between them. The nature of the data sources meant that all the reference individuals involved were vulnerable, either due to mental health problems or having care and support needs.

[60] The perpetrator in one of the cases was under the age of the 26. However, as his victim was over 26 this has been included in this category rather than youth peer violence.

Table 12. Reviews of extrafamilial violence between adults aged 26 and above

Date of incident	Date of publication	Brief description	Reference individual	Information provided about non-reference individual?
2014	2017	A man killed by his friend, a male mental health service user.	Perpetrator	No
2011	2016	A woman killed by a female mental health service user. They were not known to each other.	Perpetrator	None
2013	Undated	A man killed by his neighbour, a male mental health service user.	Perpetrator	Some
2014	2018	A man killed by his neighbour, a male mental health service user.	Perpetrator	Some
2012	2018	A man killed by his housemate, a male mental health service user.	Perpetrator	Very little
2015	2018	A woman killed by her male housemate in their supported accommodation.	Both	–
2014	2017	A man killed by a male stranger.	Perpetrator	None
2013	2017	A man killed by a fellow male resident at his homeless hostel.	Both	–
2015	2016	Young woman with learning disabilities who was assaulted on multiple occasions by another resident in her residential accommodation.	Victim	Yes

Case example 4: Extrafamilial violence between adults aged 26 and above – Mr EF (Perpetrator)

Mr EF was born in Uganda and moved to the UK when he was four years old. The records show that Mr EF's father had alcohol misuse problems and was violent to Mr EF. His parents separated during his childhood, and he had no contact with his father. For periods of time he had lived with his mother and her partner. He reports that this was mostly to keep away from his father.

Mr EF was first identified as displaying signs of mental health problems from approximately 20 years of age, in 2004. He was also noted to be have been using cannabis for several years previously. He was diagnosed with paranoid schizophrenia, with possible substance misuse-induced psychosis.

On 14 April 2014, Mr EF absconded from the mental health inpatient ward where he was being treated. He was visited by a trainee GP the next day and a plan was made to review him in the community.

Mr EF and Mr BC had been 'drinking friends' for some time. On 8 May 2014, Mr EF was at Mr BC's house and had taken a knife for protection. He became convinced that Mr BC was going to kill him and subjected him to a 'frenzied attack' with a knife. He returned a week later and set fire to Mr BC's flat.

Case example 5: Extrafamilial violence between adults aged 26 and above – Ms A (Perpetrator)

In 2011, Ms A fatally stabbed a woman in a park after attempting to stab another stranger on the street. Neither woman had previously been known to her. In the run-up to the incident, Ms A had stopped taking her mental health medication as she thought she was pregnant. Ms A had several years previously been convicted of the manslaughter of her mother.

Ms A experienced adversity from a young age: her parents separated when she was five years old, and her father moved abroad. During Ms A's teenage years, her behaviour had become difficult (truanting from school, bullying and violent outbursts), and she spent a brief period in the care of the local authority for allegations against her mother.

At aged 15, Ms A was cautioned by police for an assault on her mother. She subsequently went missing from home. In the following years, Ms A suffered from serious mental health problems, was involved in offending, was sexually exploited and was subject to domestic abuse from at least one partner.

Characteristics of the individuals

Victims

A number of the victims of violence by an acquaintance, neighbour or housemate had significant vulnerabilities, and several were living in supported or residential accommodation. Several were individuals with vulnerabilities such as substance misuse, homelessness, and involvement in street begging. Other characteristics of this group included:

- chronic illness
- disability
- unemployment.

There was very little information provided about the two victims of stranger homicide. There is no suggestion in the reports that these individuals were vulnerable or marginalised.

Table 13. Victim demographic characteristics for extrafamilial violence between adults aged 26 and above

Victim demographic characteristics	n
Gender	
Male	6
Female	3
Age	
25–34	1
35–44	1
45–54	2
65–74	1
Adult – exact age not known	4
Ethnicity	
White English/Welsh/Scottish/Northern Irish	1
Ethnicity not reported	8

Table 14. Other victim demographic characteristics for extrafamilial violence between adults aged 26 and above[61]

Other victim characteristics	n
Chronic illness or long-term condition	3
Disability	2
Unemployment	2
Substance dealing/county lines	1
Substance misuse	1
English as a second or additional language	1
Financial issues	1
History of/current self-harm	1
History of violence	1
Learning disability	1
Low income/financial difficulties	1
Mental health problems - current	1
Migration status	1
Social isolation	1
Homeless	1
Street begging	1
Unsuitable housing	1
Chaotic lifestyle	
Self-neglect	1

[61] Data available for 6 cases. No information available for three cases'

Perpetrators

As would be expected from the four IIR reports, all perpetrators had mental health problems and were in the care of mental health services during or within the six months prior to the incident. A perpetrator reported in the SARs also had mental health problems.

Some perpetrators had a history of violence, although often not of sufficient severity to have predicted the behaviour displayed in the incident.

Table 15. Perpetrator demographic characteristics for extrafamilial violence between adults aged 26 and above

Perpetrator demographic characteristics	n
Gender	
Male	8
Female	1
Age	
18-24	1
25-34	3
35-44	1
Adult – exact age not known	4
Ethnicity	
Black/black British African	4
Not reported	5

Table 16. Other perpetrator characteristics for extrafamilial violence between adults aged 26 and above[62]

Other perpetrator characteristics	n
Mental health problems – current	8
History of violence	7
Substance misuse	5
Unemployment	5
Alcohol misuse	4
Medication (for example failure to comply)	4
Migration status	4
Offending	4
Sexualised behaviour	4
Financial issues	3
Victim of crime	3
Mental health problems – past	3
Absent parent(s)	2
Chronic illness or long-term condition	2
History of/current self-harm	2
Learning disability	2
Abuse or neglect (as a child)	1
Bullying (past experience)	1
Criminal exploitation	1
Domestic abuse	1
Educational exclusion	1

[62] Data available for nine cases

Growing up in a household in which there are adults experiencing alcohol and substance misuse	1
Care experienced child	1
Low income/financial difficulties	1
Missing episodes	1
Parental abandonment through separation or divorce	1
Carrying weapons	1
Witnessing violence (for example street violence, exposure to domestic abuse)	1
Non-engagement with services	1
Trauma	1
Frequent moves	1
Homeless	1
Gambling addiction	1
Communication difficulties	1

Relationship between victim and perpetrator

Most homicides occurred between known peers (n=6) who were living together, neighbours or friends, whereas two victims were not known to the perpetrator. When the perpetrator and victim had an existing relationship, in two of the cases, the reviews report abusive behaviours happening before the reference incident. In one case, the victim and perpetrator had an ongoing conflict, including locking each other out of the property they shared and accusing each other of stealing money. In the second case, the incidents were an ongoing pattern of physical abuse by another resident.

Table 17. Relationship types for extrafamilial violence between adults aged 26 and above

Relationship types	n
Friend/acquaintance	1
Housemate	4
Neighbour	2
Stranger	2

Table 18. Relationship characteristics for extrafamilial violence between adults aged 26 and above

Relationship characteristics	n
Emotional abuse	1
Financial abuse	1
Physical abuse	1
Conflict over a debt	1
Unknown	6

Contexts and peer groups

Victims

Living arrangements: Of the five victims for whom information was available, one was living alone, one in shared private accommodation, one in supported accommodation, one in residential provision for people with learning disabilities and one in temporary accommodation (a hostel) as the victim was homeless.

Risk factors: A number of the victims of homicide were killed by an acquaintance, neighbour or housemate, and experienced a number of risk factors which were related to general vulnerability and, in many cases, poverty. Three victims experienced antisocial behaviour, physical and emotional abuse within their home. Some risks were posed within hostels and residential accommodation, including substance misuse, risks from other residents and inadequate security.

Several of the victims also had little family contact or support.

Protective factors: Conversely, some of the residential accommodation was a protective factor, for example in a case the staff within the accommodation were trained in behavioural management techniques.

Table 19. Victim risk and protective factors across their contexts extrafamilial violence between adults aged 26 and above

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**3** Antisocial behaviour (1), Physical abuse (1)			N/A		
Criminality	**1** Substance misuse within temporary accommodation			N/A		
Lack of capacity to safeguard				N/A		
Other	**3** Transitory residents (1), Risk presented by other residents (1), Inadequate security within accommodation (1)	**2** Little contact with family (1), Family not able to support (vulnerable in their own right) (1)		N/A		**1** Overall transient population
Protective factors						
	5 Staff in accommodation trained in behaviour management techniques and safeguarding (4), Friends within accommodation (1)	1 Positive relationship with family		N/A		

Perpetrators

Living arrangements: At the time of the incident, three were living alone in private/housing association accommodation, two were in supported accommodation, two in residential accommodation, one in shared private accommodation, and one with their family.

Risk factors: Like the victims, some of the perpetrators experienced risks associated with their housing situation. For example, a culture of substance misuse within a homeless hostel, risks from other residents and, in the case of a perpetrator with learning disabilities, inadequate security which meant he was able to attack a fellow resident. Several of the perpetrators were in unstable housing situations, or had previously experienced homelessness.

Protective factors: The perpetrator accommodation could also be a protective factor where care coordinators and other staff were able to provide support and behaviour management.

Table 20. Perpetrator risk and protective factors across their contexts extrafamilial violence between adults aged 26 and above

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**4** Violence towards other residents of shared accommodation (2) Emotional abuse (1)	**2** Domestic violence by perpetrator (1), Threats to kill family members and damage to property (1)	**1** Financial abuse by a friend	N/A		
Criminality	**3** Substance misuse (1), within homeless hostel (1)			N/A		
Harmful gender norms				N/A		
Lack of capacity to safeguard				N/A		
Other	**5** Unstable housing (1), Homelessness (2), Poor quality housing exacerbating relationship problems (1), Risk presented by other residents (1), Inadequate security within accommodation (1), Not wishing to live alone (1)	**2** Little or no contact with family		N/A		
Protective factors						
	3 Staff in accommodation trained in behaviour management techniques, safeguarding and care coordination (2) Good relationship with mother (1)	**4** Family supported care and treatment	**1** Support from friend by providing accommodation			

Incident

Of the nine incidents in this category, eight were homicides and one was a non-fatal series of physical assaults.

Of the eight homicides, seven perpetrators used a knife. There was one instance where the method of the homicide was not reported.

Four homicides and one non-fatal injury were in the victim's home. In three cases this was also where the perpetrator lived (for example, in temporary accommodation in a hostel). There were two homicides in public places and two were not reported.

Escalation towards the incident

Common features in the escalation towards the incident include:

- stopping mental health medication (either of own accord, or on advice of doctor)
- recently discharged or absconding from inpatient unit
- violent attacks on other individuals.

Professional involvement

Victim involvement prior to incident

There was relatively little information provided about victim service use prior to the incident.

Table 21. Victim involvement in services prior to incident in extrafamilial violence between adults aged 26 and above

Services	n
GP	3
Probation service	1
Acute health services	1
Adult social care	1
Housing	1
Mental health – community mental health team	1
Mental health – inpatient	1
Police	1
Substance misuse services	1
Homeless medical centre	1
Community learning disability team	1
Local authority safeguarding team	1

Perpetrator involvement prior to incident

There was relatively little information provided about perpetrator service use prior to the incident. All perpetrators were in receipt of mental health services prior to the incident, and all had spent time in mental health inpatient units. Some (n=3) perpetrators were recorded as having prior involvement from the police.

Table 22. Perpetrator involvement in services prior to incident in extrafamilial violence between adults aged 26 and above

Services	n
Mental health – community mental health team	7
Mental health – inpatient	7
GP	4
Mental health – other	4
Acute health services	3
Mental health – Improving Access to Psychological Therapies (IAPT)/early intervention	3
Police	3
Housing	2
Other	2
Children's social care – child in need/child protection plan	1
Children's social care – looked after services	1
Counselling services	1
School/s	1
Youth offending	1

Appendix 4: Intimate partner violence

This section comprises 17 cases (14 DHRs, three IIRs) involving intimate partner homicide. Several of the cases had been reviewed under more than one process – in each instance the most recent of the two reports was used. A brief summary of each of the cases is shown below.

Table 23. Reviews of intimate partner violence

Date of incident	Date of report	Brief description	Reference individual	Information provided about non-reference individual?
2017	2018	Woman is killed on the street with a knife by a male (ex-partner).	Both	–
2016	2018	Woman is killed by a male (ex-partner) in their family home.	Perpetrator	Some
2016	2017	Man is killed by his partner (female) with a knife. There is evidence to suggest mutual aggression.	Perpetrator	None
2015	2017	Woman is killed by partner (male) with a knife.	Both	–
2015	2016	Woman is killed by partner (male) with a knife.	Victim	Little
2015	2017	Woman is killed by partner (male) with a knife.	Both	–
2015	2017	Father and child are killed by partner (female) with a knife.	Both	–
2015	2017	Woman is killed by partner (male).	Both	-
2015	2018	Man kills partner (female) then kills himself.	Perpetrator	Little
2014	2016	Woman is killed by her partner (male) with a shotgun.	Both	–
2014	2016	Woman is killed by ex-partner (male) in their family home.	Both	–
2013	2018	Woman is killed by her ex-partner (male).	Both	–
2013	2016	Woman is killed by her husband.	Both	–
2013	2016	Woman is killed by her husband with a knife.	Both	–
2012	2018	Woman is killed by ex-partner (male), who then attempts to kill himself.	Perpetrator	Some
2012	2018	Woman is killed by partner (male).	Perpetrator	Little
2011	2017	Woman is killed by partner (male).	Both	–

Case example 6: Intimate partner violence – Nargiza

Nargiza aged 29, was originally born and raised in a Central Asian Republic. She was a graduate who had trained as a healthcare professional and worked as a Catering Assistant on her arrival in the UK. She had an arranged marriage to Marat shortly after finishing her degree. Marat, 35, also from a Central Asian Republic was a graduate and worked as a chef whilst in the UK. They both lived together in a family home in Bexley and had three children together, a baby age one who lived in the UK with them, and two children who lived with family members in Central Asian Republic. It is unclear why they lived away from the family in the UK.

Nargiza and Marat's immigration status was subject to change, and Nargiza had to apply for extensions and had no recourse to public funds, which increased her vulnerability. In June 2014, Nargiza disclosed to her manager that she was experiencing domestic abuse from Marat. Nargiza was subsequently referred to a domestic abuse service and the police. This is the first record where Nargiza attempted to leave Marat and went to stay in a domestic abuse refuge. Nargiza experienced a range of types of abuse within her marriage, including physical abuse, coercive control, financial abuse, emotional abuse and isolation, sexual violence and using her children to control her behaviour. Nargiza tried to secure Indefinite Leave to Remain from the Home Office. Marat used her immigration status to control her, for example threatening to cancel her visa so she wouldn't be able to return to the UK. Marat used 'abuse of process[63]' as another way to control Nargiza - using his knowledge of the immigration system and her dependence on him as a means of control.

Marat had alcohol misuse problems. There are several accounts of him being drunk and abusing Nargiza. In more than one instance, an ambulance was called because Marat experienced chest pains. Health professionals suspected that Marat had anxiety, and on one occasion displayed symptoms of depression and paranoia.

By the end of June 2014, Nargiza returned to Marat where incidents of domestic abuse continued. However, contact with professionals was limited. In August 2016, Nargiza travelled back to her country of origin. She stayed longer than planned because her father was ill. The review states: 'This period appears to have been the trigger for a dispute between Nargiza and Marat' (who was still in London). Marat spoke to Nargiza's father saying that he wanted a divorce. The family attended a 'reuniting commission[64]' in the Central Asian Republic, which Marat participated in via internet.

When Nargiza returned to London on 4 November 2016, she stayed with a friend. Marat began turning up at her place of work. During this period, Marat had several police and ambulance call-outs for chest pains, drinking and depression. On 19 November, Nargiza returned to her country of origin and remarried Marat (while he was still in the UK) and returned to UK on 22 November 2016 to be with Marat.

On 11 December Nargiza spoke to her father and said that everything was fine. On 12 December Nargiza was found dead at Nargiza and Marat's family home. Marat, the alleged perpetrator, was arrested and charged with murder and subsequently remanded to prison. He took his own life while in prison. There has therefore been no criminal trial in this case.

---

[63] Defined as 'as perpetrators using their right to access legal proceedings in order to emotionally abuse their victims and continue unwanted contact with them'. Waxman C. and Fletcher H. (2016) *Abuse of process: A report by Voice4Victims CIC.* Available at: **http://www.voice4victims.co.uk/wp-content/uploads/2016/11/Abuse-of-Process-28th-November-report-FINAL-1.-pdf.pdf**

[64] No clear definition. From the review, the family attended a 'reuniting commission' with representatives from both victim and perpetrator family, as well as some local civic leaders.

Case example 7: Intimate partner violence – Lottie

Lottie was aged 25 at the time of the incident. She was a white British single parent who gave birth to her daughter Betty just before her 18th birthday. Lottie's parents were the primary carers for Betty after it was determined that Lottie was unable to care for her daughter. Lottie had a personality disorder, suffered from depression and had a long history of alcohol, substance misuse and self-harm. Lottie's own relationship with her mother was volatile, and she had professional involvement from a young age due to domestic abuse in the family home growing up.

Lottie moved repeatedly between different addresses both within and, on occasions, outside the borough. Sometimes this was to flee the domestic abuse she was experiencing and sometimes she was moved because of reports of antisocial behaviour. In the past, she had a problem with some travellers and also received threats from neighbours. Lottie's grandmother described how Lottie sometimes mixed with the wrong people. She often reported feeling threatened and harassed by them. At times her relationship with her family appeared strained. Lottie was unemployed, had never worked, and was in receipt of benefits.

Bert was a 23-year-old white British male at the time of the homicide. He has a younger brother, Fred, and one older half-brother called Reg who has a record for violent and other crimes, and had been in a relationship with Lottie some years earlier. There were reports of domestic abuse in Lottie's relationship with Reg.

Bert had a propensity to violence and had previously received a lengthy prison sentence for an unprovoked attack on a motorist. Around the age of 13, Bert's behaviour began to deteriorate and there were incidents of violence between him and his brother, Fred. Bert's mother reported that he also started to self-harm and, after being sacked from an apprenticeship for threatening behaviour at the age of 17 he was detained in hospital for several weeks. The assault on the motorist followed shortly after. When his mother and brother could no longer cope with his behaviour, he rented a room privately, stayed with friends and latterly stayed with Lottie. He would spend the occasional night with his mother. He sometimes worked as a gardener, builder and with a security agency.

Bert was very well known to some statutory agencies, particularly health, police and probation. He was known to mental health services from the age of 17. He was diagnosed with dissocial personality disorder although a diagnosis of psychosis had also been considered previously. He also had a history of substance and alcohol misuse. Bert presented to mental health services for help when he was in a crisis, and often following involvement with the police when he was on bail, but he was generally unable to sustain engagement or remain compliant with medication. Bert was in contact with mental health services at the time of the homicide. However, in the three months prior to Lottie's death, there were no recorded incidents of violence. Mental health staff had noted the positive relationship dynamics between Bert and Lottie, and no alcohol or substance misuse concerns.

In March 2015, Bert called his mother and told her that he had stabbed Lottie. Bert's mother arrived at Lottie's flat and then alerted the emergency services. Lottie was found in bed with a wound to her neck. She was taken to hospital and pronounced dead later that morning. Bert was arrested and a homicide investigation was started. Bert was convicted of her murder in May 2016 and sentenced to life imprisonment, to serve a minimum of 15 years in prison.

Characteristics of the individuals

Victims

Fifteen of the victims were female and two were male. Nine victims were aged 25–34, five victims aged 35-44 and one victim aged 18–24. Women from backgrounds other than white British were disproportionately represented amongst these cases (10 of 19 cases; ethnicity not reported for six cases).

Most victims had experienced domestic abuse before the homicide from the perpetrator, in some instances, victims had experienced domestic abuse from family members and previous partners either as a child or an adult. Where victims were from non-white British communities, this increased vulnerability occurred because English was a second or additional language, as well as have an insecure migration status. This left three victims subject to potential criminal exploitation, for example in two reviews the victims were suspected to be sexually exploited. In one case, the victim had an insecure immigration status after moving to the UK in an arranged marriage.

Some victims had alcohol and substance misuse, in addition to increased mental health problems. A small number of cases had financial issues and homelessness, however a large majority of victims were in employment

Table 24. Victim demographic characteristics for intimate partner violence

Victim demographic characteristics	n
Gender	
Male	2
Female	15
Age	
18–24	1
25–34	9
35–44	5
Adult (18 or over) – exact age not known	2
Ethnicity	
White English/Welsh/Scottish/Northern Irish	3
White Irish	1
White Other *Russian; Romanian*	2
Asian/Asian British Indian	1
Asian/Asian British Other *South Asian; Central South Asia*	2
Black/Black British African	1
Black/Black British Caribbean	1
Mixed White and Asian	1
Other *Turkish/Eastern European*	1
Ethnicity not reported	4

Table 25. Other Victim characteristics for extrafamilial violence in intimate partner relationships[65]

Other victim characteristics	n
Domestic abuse	12
Alcohol misuse	5
Domestic abuse during pregnancy	4
Substance misuse	4
English as a second or additional language	4
Migration status	4
Abuse or neglect (as a child)	3
Abuse or neglect (as an adult)	3
Criminal exploitation	3
Domestic violence - experienced as a child	3
Low income/financial difficulties	3
Mental health problems – current	3
Social isolation	3
Child in need/child protection	2
Financial issues	2
Mental health problems – past	2
Sexualised behaviour	2
Victim of crime	2
Absent parent(s)	1
Caring responsibilities	1
Growing up in a household in which there are adults experiencing alcohol and substance misuse	1
History of/current self-harm	1
History of violence	1
Care experienced child	1
Missing episodes	1
Offending	1
Witnessing violence (e.g. street violence, exposure to domestic abuse)	1
Family home unkept	1
The family minimising or refuting concerns	1
Lack of regular school attendance	1

Perpetrator characteristics

The majority of perpetrators were men (n=15 vs n=2), and most (n=7) were under the age of 44 at the time of the incident. The majority (n=12) were of black or minority ethnic origin. In five incidents, either the victim or perpetrator's migration status was a factor in domestic abuse. In one incident where the female was the perpetrator, the review suggests that there was potential mutual aggression between victim and perpetrator.

The majority (n=9) of the perpetrators had alcohol misuse problems and six had substance misuse problems, which in a number of cases appeared to be a direct contributor to the incident. In some instances, perpetrators had previous convictions for offences relating to their substance abuse where they had either stolen or attacked

[65] Data available for 17 cases

people. A large proportion of perpetrators had a long history of mental health problems, in some instances self-harm and suicide attempts (n=3).

Several of the perpetrators experienced unemployment, financial difficulties and social isolation (n=5), often linked to their mental health problems.

A few of the perpetrators had experienced difficulties in childhood, such as bullying or absence of a parent (father).

Table 26. Perpetrator demographic characteristics for intimate partner violence

Perpetrator demographic characteristics	n
Gender	
Male	15
Female	2
Age	
18–24	1
25–34	6
35–44	6
Adult (18 or over) – exact age not known	4
Ethnicity	
White English/Welsh/Scottish/Northern Irish	1
White Irish	1
White Other *Romanian* *Russian*	2
Asian/Asian British	2
Asian/Asian British Pakistani	2
Asian/Asian British other *Central South Asia*	1
Black/Black British	1
Black/Black British African	2
Black/Black British Caribbean	1
Other *Turkey*	2
Ethnicity not reported	2

Table 27. Other perpetrator characteristics for intimate partner violence[66]

Perpetrator characteristics	n
Alcohol misuse	10
Unemployment	8
History of violence	7
Substance misuse	6
Mental health problems – past	6
Mental health problems – current	6
Domestic abuse	5
Low income/financial difficulties	5
Migration status	5
Offending	5
Abuse or neglect (as a child)	3
History of/current self-harm	3
Medication (for example failure to comply)	3
Absent parent(s)	2
Bullying (past experience)	2
English as a second or additional language	2
Financial issues	2
Carrying weapons	2
Criminality for example driving uninsured and disqualified	2
Chronic illness or long-term condition	1
Disability	1
Substance dealing/county lines	1
‘Manipulative’ of professionals	1
Caring responsibilities	1
Homelessness	1
Disengaged from services	1
Victim of crime	1

Relationship between victim and perpetrator

In most cases the relationship between the victim and perpetrator was married or partner, however there were four cases where the couple had separated. A review detailed the victim was in an arranged marriage. The longest relationship recorded was eight years, however caution should be used when interpreting this finding because reviews rarely recorded this detail this information. Some relationships were shorter, in one incident less than a year before the perpetrator killed the victim.

Table 28 shows the characteristics of the relationships. A number of the relationships were characterised by domestic abuse. This manifested in physical, emotional, sexual, and financial abuse. In six cases, coercive control was used.

In a case where the perpetrator was a female who killed her husband, there is a complicated picture, with conflicting evidence about whether the victim or perpetrator experienced domestic abuse previously. The review suggested that the homicide could

[66] Data available for 16 cases. No information available for one case.

have either occurred because the perpetrator used ‘violent resistance’ or there was bi-directional violence and that this may have been assessed as ‘situational couple violence’.

Table 28. Relationship characteristics for intimate partner violence

Relationship characteristics	n
Domestic abuse	15
Physical abuse	9
Emotional abuse	8
Coercive control	6
History of relationship strain/separation	6
Financial abuse	4
Stalking	3
Other	3
Sexual abuse	2
Unknown	1

Contexts and peer groups

Victims

Living arrangements: Most (n=10) of the victims were living in the family home, one victim was living alone, one victim was living in supportive living, and one victim in a shared private house. The majority of victims experienced risk factors within their home, mostly relating to domestic abuse by the eventual perpetrator of the incident.

Risk factors: In some cases, additional risk factors were posed by the wider family context, including the victims’ family being out of the country to identify any safeguarding concerns, and so were unable to provide support or safety. Risk factors in the wider neighbourhood, included abusive neighbours, in one incident racial abuse. Some victims were vulnerable in their area, for example in Newham where sex work is prevalent amongst Romanian women.

Protective factors: We identified protective factors in some cases relating to concerned family members, friends and employees. In one case, the victim was accessing support from the local borough’s housing team to move out of the area where she was experiencing domestic abuse.

Table 29. Victim risk and protective factors across their contexts in intimate partner violence

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**11** Domestic abuse from perpetrator (11), Mutual aggression (2)	**3** Domestic abuse from other family members	1 'Wrong crowd'			**2** Abusive neighbours
Criminality	**2** Substance misuse		**2** Sex work			**2** Experiences of racism from neighbours (2), Antisocial behaviour (2)
Harmful gender norms	**1** Partner (male) belief that he was 'the boss' and the victim should obey	**1** Gender norms in family meant female victim was dependent on older brother to manage difficult relationship with perpetrator				**1** Sex work in area is prevalent
Lack of capacity to safeguard	**3** Concerns about welfare of child/ren	**3** Family did not protect	**1** No one to turn to		**5** No escalation of safeguarding risks by colleagues and managers	**1**
Other	**4** Rent eviction (1), Spousal visa (2), financial difficulties (1), Alcohol abuse (2)	**5** No family in the country to identify safeguarding issues (3); family conflict or disowned (2), no family (1)				**1** Felt vulnerable in area
Protective factors						
Were any protective factors present?	**2** Daughter (1) Services 'housing' (1)	**4** Caring and concerned family	**5** Support from a friend		**1** Support from colleagues	**1** Agencies moved victim out of area

Perpetrators

Living arrangements: Most (n=9) of the perpetrators lived in a family home, two lived alone and one was in shared private accommodation. In one case, it is unclear where the perpetrator lived because he was evicted due to rent arrears. As noted above, the perpetrators' home environments were often places of domestic abuse and conflict, which was either instigated by the perpetrator or whereby they had a key role.

Risk factors: Generally, there was little information in the reviews about wider contextual factors that could impact on the perpetrators. Some (n=3) perpetrators appeared to be experiencing additional stress securing work, with one perpetrator sacked from his apprenticeship. Immigration status and spousal marriage arrangements was considered a contributary factor to domestic abuse. A large majority of perpetrators had a history of violence, and one perpetrator had probation service involvement as he had just been released from prison for armed robbery. The same perpetrator had kept a gun in his house which was the weapon used in the homicide.

Protective factors: There was relatively little information about possible protective factors. Some perpetrators had good support from their family members. There was little mention of friendships, relationships or peer groups in any of the reviews. A perpetrator was engaging in martial arts and dance classes to improve confidence before the incident.

Table 30. Perpetrator risk and protective factors across their contexts in intimate partner violence

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	2 Physical fights between perpetrator and victim (1), emotional abuse (1)	**2** Domestic violence in family (1), strained relationships (1)				**2** Noise complaints from concerned neighbours (1)
Criminality	**2** Gun in house (1), Previous arrests and probation service (2)		**1** Financial theft from partner		**1** Lack of trust in authorities	**1** Multiple attacks against neighbours
Harmful gender norms						
Lack of capacity to safeguard					**1** Manager did not escalate risk after threats were made about victim	
Other	**2** Immigration status of perpetrator (1), Poor family dynamics (1)	1 No family in the country to identify safeguarding issue		**1** Fired from apprentice-ship when behaviour spiralled	**2** Lack of consistent work	
Protective factors						
Were any protective factors present?	**1** Perpetrator stated victim was a protective factor	**4** Mother and family members	**1** Partner engaged in care			1 Engaging in martial arts and dance classes to improve confidence

Incident

All of the incidents in this category were homicides.

Information about weapons used were given in 12 of the reviews. Most (n=9) of the homicides were committed with knives, one was committed with multiple weapons including a knife and an iron, one with a sawn-off shotgun, and in another incident the victim was thrown from her 30-storey flat. Almost all (n=14) of the incidents occurred in the victim's home, which was mostly shared with the perpetrator. Two incidents occurred in an attack on the street, with one incident outside the victim's child's school.

Table 31. Weapons involved in incident in intimate partner violence[67]

Types of weapons	n
Knife	9
Gun	1
Iron	1
Pushed out of building	1
Strangled	1
Unknown	5

Table 32. Location of incident in intimate partner violence

Location of incident	n
Victim or perpetrator home	14
Street	2
Unknown	1

Escalation towards incident

Commonalities in the escalation towards the homicides included:

- **Perpetrator experienced adverse life event** shortly before homicide, for example, relationship breakdown or job loss
- **Victim and perpetrator have argument** and perpetrator claims self-defence
- **Alcohol or substance misuse** immediately prior to incident
- The perpetrator and victim arguing, and concerned neighbour or family member **calls the police and ambulance service**
- **The perpetrator being released from police custody or prison** prior to the incident

[67] Total figure does not reflect the total number of cases as one victim was killed with two weapons – an iron and knife.

- **The perpetrator being discharged from or ceasing to engage with mental health services** prior to the incident

Professional involvement

Victim involvement prior

Most of the victims had multiple professional involvement with services before the incident. This includes in particular with police and domestic abuse services, health services such hospitals and GPs and children's social care.

Table 33. Victim involvement in services prior to incident in intimate partner homicide

Services	n
Police	11
Domestic abuse services (for example police community safety units, DV team)	11
GP	10
Acute health services	9
Children's social care – child in need/child protection plan	5
Housing	4
School/s	4
Health visitor	2
Ambulance service	2
Mental health – IAPT/early intervention	2
Voluntary sector	2
Adult social care	1
CAMHS	1
Substance misuse services	1
Primary care	1
Witness care unit	1
Immigration services	1
Citizens advice bureau	1
Solicitors	1
Not reported	4

Perpetrator involvement prior

The majority of perpetrators had police involvement where offences ranged from grievous bodily harm (GBH), to armed robbery, to substance misuse/drink driving. There were multiple accounts of damage to property, and in one instance the perpetrator kidnapped the victim. Most perpetrators had previous offending history and had served time in prison. Some were accessing probation services and had to meet regularly with their probation officer.

The majority of perpetrators accessed their local GP, in some instances for routine check-ups, whereas other perpetrators were getting access to mental health services.

Table 34. Perpetrator involvement in services prior to incident in intimate partner homicide

Services	n
Police	14
GP	11
Acute health services	9
Probation service	7
Children's social care – child in need/child protection plan	4
Housing	4
Domestic abuse services (for example police community safety units, DV team)	3
Mental health – community mental health team	3
Mental health – inpatient	3
Substance misuse services	3
Counselling services	2
Mental health – IAPT/early intervention	2
Mental health - other	2
School/s	2
Voluntary sector	2
Prison service	2
UK border agency	2
Immigration services	1
Health visitor	1
Welfare benefits advisor	1
CAMHS	1

Perpetrator involvement after the incident

The majority of perpetrators were arrested and prosecuted for the murder of their partners. In a case, the perpetrator was transferred to mental health inpatient facility for diminished responsibility. In two cases, the perpetrator killed himself before the case went to trial, and in another instance, the perpetrator tried to take his own life.

Potential areas for improvement in professional responses

We undertook detailed analysis of professional practice in 18 cases of intimate partner violence. The purpose of this was to identify possible areas where there may be predictable weaknesses in professional practice. Whilst there was also good practice reported in most reviews, we have focused on areas for improvement in order to inform what aspects of practice that the VRU may want to influence through its work.

The below findings therefore focus on issues which were observed across a number of different cases and are presented in order of the most frequently recurring themes:

1. Not arresting for domestic violence and poor risk management of perpetrators' offending behaviour
2. Weaknesses in Multi-Agency Risk Assessment Conferences (MARACs)
3. Understanding the influence of ethnicity, nationality and gender
4. Weaknesses in addressing risk to children impacted by domestic violence

It is important to note that, due to the inevitable time lag between incidents occurring and reports being published, some of the practice described in the reviews may have changed since publication. These issues are therefore presented as 'lines of enquiry' that VRU may wish to consider as part of their role in preventing and addressing violence.

1. **Not arresting for domestic violence and poor risk management of perpetrators' offending behaviour**

A large proportion of the intimate partner violence cases we reviewed included examples of professional responses to domestic abuse that were not in line with best practice. In particular, we found:

- The police not did not always arrest perpetrators of domestic abuse offences, even when there was ground to do so.
- Agencies having overall poor risk management of perpetrators offending behaviour.

These patterns were linked to occasions where professionals were unable to safeguard the victim and/or children, and missed opportunities to manage the offending behaviour of the perpetrator. This issue largely affected the police and probation services. However, in a review children's social care was considered responsible for not providing enough support to the perpetrator.

Police not arresting for domestic violence

We found a number of examples where the police did not arrest the perpetrator for incidents of domestic abuse, even though the review authors felt that this would have been appropriate. There were multiple reasons why this occurred:

- Victim did not want to press charges
- Victim withdrew their statement
- Not enough evidence gathered that is police not wearing body worn cameras
- Not considering alternative prosecution options.

For example, in a case the victim did not want to press charges, and alternative prosecution options were not explored. The review states:

> '*After incident on car, police had captured evidence to refer to Crown Prosecution Service [CPS] – however when the victim did not want to prosecute the perpetrator – police did not pursue: The fact that [the victim] would not be willing to support a prosecution was not in fact a limitation on prosecution because the officers had seized the weapon and had evidence of the damage together with [victim] and [perpetrator] first accounts at the scene captured on video. With this evidence, a "victimless" prosecution was certainly feasible but it was not considered. It is, of course, not known if the [CPS] would have taken a decision to prosecute or, as is also possible, to recommend disposal by way of conditional caution.'*

This lack of follow-up in these cases created a situation whereby the behaviour of the perpetrator was not appropriately responded to, and in some cases left the perpetrator free to commit further acts of violence.

Poor risk management of perpetrators' offending behaviour

The reviews mentioned a number of examples of a poor risk management of perpetrators' offending behaviour, particularly relating to the probation service and children's social care. There were instances where:

- Perpetrators missed their appointments and this was not followed up by probation officer to seek another one or reason for missing the appointment.
- Probation officer did not check the validity of perpetrators claims. There was one example where the perpetrator said to his probation officer he left the country but actually had not. This was not followed up.
- Not providing adequate support after the perpetrator was released from custody including appropriate medication, as reported: *'One of the unforeseen consequences of recalling [perpetrator] to custody was that he was then released at the end of his sentence without any planning by a statutory agency or indeed any notification to other agencies'.*
- The length of time perpetrators waited to attend a perpetrator programme – and never accessing one.

Some reviews highlighted an inadequate support for perpetrators to attend a programme. A review articulated the challenge:

> '*Probation notes that risk assessments were predominantly based on the information and version of events presented by the perpetrator and that more robust partnership work and information sharing should have been undertaken. Moreover, more effort should have been made to secure a place on the [Integrated Domestic Abuse Programme] IDAP[68] [the perpetrator] before his order expired.'*

In another case, the social worker from children's social care did not ask about the extent to which domestic violence and abuse, and therefore did not offer appropriate support and signposting. The review notes:

> '*[Perpetrator] was not asked about his domestic violence and abuse by the social worker. This is despite the fact that the allegations in June 2016 could be seen as an example of abuse of process[69], and there were missed opportunities to explore his behaviour as part of the assessment undertaken by children's social care.'*

[68] Integrated Domestic Abuse Programme (IDAP) is a nationally-accredited community-based groupwork programme designed to reduce re-offending by adult male domestic violence offenders.

[69] Defined as 'as perpetrators using their right to access legal proceedings in order to emotionally abuse their victims and continue unwanted contact with them'. Waxman C. and Fletcher H. (2016) *Abuse of*

The mother of a perpetrator reported her son's mental health problems and medication was not adequately supported:

> '*When [perpetrator] came out of prison there was nothing set up for him. I contacted the mental health team, he had no meds. He had someone who helped with housing but no-one else helped. I did all of the chasing – where is the meeting, who is looking after him, who is he seeing?'*

In another case, probation services did not take appropriate action in relation to the perpetrator's substance misuse and alcoholism:

> '*…[perpetrator's] probation officers failed to implement the specific decision of the [MAPPA[70]] meeting that he be referred to alcohol services. There is evidence that in the months and weeks prior to the killing, he was drinking and subsequent interviews show that he was also using cocaine. It was unavoidable that the supervision of [perpetrator] by the national probation service was undertaken by a succession of different officers but it is clear that at various times information was available to his supervisors that he was drinking and yet there is no indication that any effort was made to address the issue.'*

It should be noted there were good examples of practice for example positive, open communication between probation officer and perpetrator; resources for perpetrator to attend courses (IDAP, anger management); acting in client's best interest, challenges positively, good communication between agencies (for example probation and children's social care).

Underlying systemic issues

There is some indication in the reviews why perpetrators were not arrested or subsequently offending behaviour managed.

Why did police not arrest for domestic abuse at time of incident?

The reviews suggested a number of reasons why perpetrators of domestic abuse were not always arrested when it would have been appropriate. Some reviews identified that it appeared that identifying, prioritising and pursuing offenders with outstanding charges relating to violent and domestic violent offences did not appear to be given sufficient priority by the police. This may also explain why, when victims declined to press charges, alternatives such as evidence-based prosecution were not explored.

---

process: A report by Voice4Victims CIC. Available at: **www.voice4victims.co.uk/wp-content/uploads/2016/11/Abuse-of-Process-28th-November-report-FINAL-1.-pdf.pdf**

[70] Multi-agency public protection arrangements

A review identified that police did not follow Home Office rules for recording crime and did not transfer the case between police services.

Why was there poor risk management of perpetrators offending behaviour?

It was not always clear why there was poor risk management of perpetrators' offending behaviour. In a review, it is documented that there had been changes to probation:

> '*During 2014, the National Probation Service was subject to a major reorganisation. For a period of time the workforce was unsettled and there was a reduction in the level of staff available.'*

It was also reported that changes of worker could lead to required support not being put in place. As the review noted:

> '*This case illustrates the fact that the inevitable changes in supervising officer are critical moments in the overall period of supervision – they are potentially opportunities for a new officer to "take a fresh look" at a client but also a moment at which key issues may "fall between the cracks.'*

There was also evidence that perpetrators may not always be eligible for support. One review noted that programmes were available but the local authority commissioners need *'to improve the resources for perpetrators of domestic violence, in particular when the threshold for ongoing involvement of children's social care is not met'*.

Ensuring access to the Domestic Violence Perpetrator Programme (DVPP) is a key part of a coordinated community response as it can help ensure perpetrators are held accountable and supported to change their behaviour. This also chimes with the increasing focus nationally on the identification of those who use violence and abuse, with Strategy to End Violence Against Women and Girls (VAWG)[71] aiming to have an 'embedded robust approach to tackling perpetrators through greater scrutiny of their motives and behaviour with a reduction in re-offending' (p109).

2. Weaknesses in Multi-Agency Risk Assessment Conferences (MARAC)

A (Multi-Agency Risk Assessment Conference) MARAC is a victim-focused information sharing and risk management meeting attended by all key agencies (police, independent domestic violence advisors, children's social care, health, housing, probation and education etc), where high-risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up-to-date risk information with a timely assessment of a victim's needs and

[71] Home Office (2016) Strategy to End Violence Against Women and Girls: 2016–2020. Available at: **www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020** [Accessed: 6 May 2018].

links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator.[72]

Some of the intimate partner violence cases we reviewed included examples of professionals' use of MARAC for safeguarding high-risk victims and their children. A number of reviews identified problems with how MARAC supported the recognition and response to victims and their children. These practice issues highlighted:

- delays or no referral made to MARAC.
- issues with how MARAC meetings were run and recorded (for example quality of notes, absence of important representatives).
- in MARAC meetings, professionals did not adequately assess and manage risk to the victim, children or perpetrator.

Delays or no referral made to MARAC in sharing information to increase the safety, health and wellbeing of victims – adults and their children

We found multiple instances where high-risk victims were not appropriately referred to MARAC, or there were serious delays when there should have been more efficient action. This manifested in different ways. In one instance, a MARAC referral was not made for three months from a substance misuse service to the MARAC mechanism despite the severity and escalation of perpetrator risk to the victim.

In the same case, the review reports that the police treated domestic violence incidents in isolation, which in turn meant the risk was considered too low for a MARAC referral. The review states:

> *'Although coming to the attention of the police for numerous incidents [a total of 14 reports] [perpetrator attacks victim], each one was often treated in isolation and there was a failure to see the "big picture"… no MARAC referrals were ever made and the necessity to obtain an in-depth secondary risk assessment was not triggered as this is only done when the risk level is either "medium" or "high". The child protection and looked after process did not challenge the lack of support for [the victim].'*

One review recorded multiple missed opportunities for professionals to safeguard the victim through referring to MARAC; an example included the victim's daughter being a witness to domestic violence on at least two known occasions which in accordance with local protocol, should have triggered a MARAC referral. As stated:

> *'There was also evidence of an escalation in the severity of violence, so a higher risk level was indicated and a MARAC referral should have been made on repeat*

[72] Reducing the risk of domestic abuse (2019) [webpage]. Available at: **www.reducingtherisk.org.uk/cms/content/Marac**

and professional opinion criteria. This was a clear missed opportunity to increase Lottie's [victim] safety through a coordinated, multi-agency action plan and arresting Bert [perpetrator].'

Issues at the MARAC meeting

Issues with the way that MARAC meetings were run and recorded were identified in a number of reviews. These examples included:

- poor quality of minutes
- lack of actions arising from case discussion
- absence of key professionals (for example, Substance Misuse Service, London Ambulance Service)
- limited information sharing from other agencies aside from independent domestic violence advisor (IDVA)[73], police and children's social care)
- a possible assumption that the IDVA had responsibility for the case and therefore other agencies need not take any action
- lack of governance from the MARAC process, Terms of Reference, or clear process
- no recording of the need for all MARAC agencies to 'flag' their databases to indicate high-risk MARAC case
- action from MARAC being to 'flag and tag'. This does not give a clear route to intervene
- lack of knowledge as to where the MARAC Steering Group reports into in relation to performance, issues and practice, and this should be addressed.

In MARAC meetings, professionals did not adequately assess and manage risk to the victim, children or perpetrator

We found several examples whereby the MARAC was not successful in managing risk in regard to the victim, child and perpetrator. Practice examples included:

- cases being removed from the MARAC process without a clear risk assessment
- MARAC meetings being used to share information, but not to develop a clear joint approach to managing risks in the case and agreeing actions. This could give the appearance of managing risk, whilst not actually safeguarding victims
- not managing perpetrator patterns of offending behaviour when the MARAC is designed to enable better risk management

[73] Definition from **SafeLives** states the 'main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans'.

- not continuously monitoring and reviewing cases for changes and escalation in risk.

Underlying systemic issues

There was some information in the reviews to suggest reasons why the MARAC was at times ineffective in increasing the safety of victims and their children, and managing overall risk and threat from perpetrator. One review highlighted that changes are being made across the sector:

> '*It should be noted that much of the period under review also coincided with much activity within the domestic violence sector, with many agencies introducing domestic violence policies and procedures for the first time and practices that are now embedded such as MARAC [meetings] and risk assessments being introduced. Nevertheless, even taking this into account, there remain many examples of agencies falling below the expected standards.'*

It was clear from a review that these changes were taking effect through the introduction of the Multi-Agency Safeguarding Hub becoming operational in April 2015. In some instances, there was a limited awareness of thresholds for MARAC (health services); awareness and understanding of civil orders in domestic abuse cases and the police service role (police); and importance of completing necessary risk assessment (for example, the DASH risk assessment checklist[74]) and agreed toolkit for social work practitioners (children's social care). In one review, existing MARAC arrangements were thought to lack governance, as stated:

> '*The discussion around the MARAC highlighted a lack of governance, including the fact that both the MARAC itself, and the MARAC Steering Group, are chaired by the police, which could lead to a lack of proper scrutiny.'*

3. Understanding the influence of ethnicity, nationality and gender

A number of the intimate partner violence cases had practice examples where the impact of victims' nationality and ethnicity, and how this interacted with gender, were not appropriately explored by professionals. We saw a number of cases in which professionals made assumptions which had an impact on the victim's safety, and that of their children, and where there were missed opportunities to safeguard. This was particularly reported to affect police, children's social care and hospital staff, however there could be other agencies the reviews did not capture.

There were several examples where a person's nationality/ethnicity led to unhelpful assumptions being made about their situation. In an example, the professionals

[74] Definition from **SafeLives** states the 'purpose of the Dash risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a Marac meeting in order to manage their risk'.

appeared to interpret both the perpetrator and victim's behaviours based on assumptions about 'cultural norms' with their country of origin (Zimbabwe). For example, the review states that recordings from children's social care state that:

> '*[Perpetrator] is said to be revengeful and comes from a background where the man is the boss and women have to obey. He has said that if mother [victim] leaves him he won't lose anything by killing her and the children anyway.'*

Elsewhere the review notes that the police recordings of another incident state that:

> '*[Perpetrator] was noted to be argumentative with [victim] and the officers attending. Officers noted "cultural issues" in their report in relation to the way [the perpetrator] spoke to [the victim] but this was not expanded upon, or followed up on.'*

It appears that 'cultural issues' are used as an explanation of the perpetrator's behaviour towards the victim, and potentially to normalising or underestimating the level of risk she was experiencing.

In another review, the victim was from an African Caribbean background, which the review author thought may have affected professional responses to her, which tended to underestimate the level of risk she was facing. The review notes:

> '*Afro-Caribbean women are often perceived – or assumed – to be capable and independent, and that this stereotype may have been part of agencies' responses to [victim], particularly as she was clearly educated and in work.'*

In another review, the victim was of Romanian origin. Evidence from *Open Doors*[75] suggests that Romanian women have high engagement in prostitution in the borough in which she lived, furthermore, that there is a strong organised crime connection, including by trafficking and modern slavery activities, within the neighbouring borough. The review suggested that professionals had limited understanding of this issue, and the impact it may have had on the victim. This issue also occurred in two other DHRs in the same borough. The review notes that the victim:

> '*… [had limited] … capacity to build a support network of their own, or to develop a high level of trust with professionals and services outside of their community. There is also the impact of shame attached to being exposed as involved in prostitution, fear of not being believed, fear of being arrested, fear of being deported, fear of retaliation and negative experiences of authorities.'*

The review suggests that practitioners could do more to work with this community as a whole, and to make them aware of their rights.

[75] NHS funded outreach service for with women involved in sex work

Immigration status

We found several examples of immigration status being used by the perpetrator as a method of control. In one case the victim was originally from outside the UK, as was the perpetrator who had a permanent residency and Leave to Remain. The victim's immigration status was more insecure, and she also had no recourse to public funds. This made it much more difficult for her to seek help. The review notes that the perpetrator used his knowledge of the immigration system, and the victim's dependence on him for her immigration status, as a means of control. This did not appear to be recognised by professionals as a risk factor.

Underlying systemic issues

There was little information in the reviews exploring why professionals could be making assumptions about victim and perpetrator based on their protected characteristics. It could be argued that in some of the cases, professionals held stereotypes, or did not have enough knowledge or training about protected characteristics (such as ethnicity and immigration status) and accessing support for victims with no recourse to public funds.

4. Weaknesses in addressing risk to children impacted by domestic violence

A number of the intimate partner violence cases included examples of the professionals not recognising the vulnerability of children who were impacted by domestic violence in the family home – this was particularly the case in children's social care and the police. However, it could be argued that other agencies do not always recognise the impact of domestic abuse on children which was not reported in the reviews. We identified two key issues:

- Ineffective use of Merlin[76] by police
- Over-optimistic assumptions by children's social care about parental ability to safeguard children from domestic abuse.

Ineffective use of Merlin

When a child is at the scene of a domestic abuse incident, police must create a Child Come to Notice (CCN) report on the Merlin system. The Merlin report is then shared with children's social care and may drive further information sharing and case conference discussion.

There were instances in the reviews where children were not safeguarded because Merlin was not used appropriately. In some cases, it appeared that the police created a Merlin report, but then it was then not shared with all relevant agencies. In other cases, police did not create a Merlin report at all, and no further action was taken.

[76] Merlin is a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason.

Police not creating a Merlin

There were multiple instances in which the police did not create a Merlin report despite there being safeguarding concerns about children being present at time of a domestic incident. In one case, no Merlin report was created for seven incidents of domestic abuse that occurred with a child in the household. In another incident in the same case, children's social care was only made aware of a domestic incident that occurred by the disclosure of the victim's child to their school teacher.

Similarly, in another review the victim disclosed to her solicitor in a sworn statement supplied to police about her fears for her children. However, this was not documented on the MPS Crime Reporting Information System (CRIS) record and no record was made in the Merlin report. This meant no referral was made to children's social care. The review states:

> '*If this information was passed to children's social care and health services, it would have provided the evidence to support concerns on [victim's daughter] emotional wellbeing and would have provided grounds to consider the protection of all of her children.'*

In the same case, a domestic violence incident was reported to police by neighbours, which provided a further opportunity to accurately assess risk and consider the welfare of the victim's children. The original call referred to the victim being at a neighbour's house with her children. However, there was no Merlin report completed and the actions of the officers attending the victim's home were not supervised to ensure this was done. The secondary investigation was hampered by the incorrect recording of the victim's surname on the CRIS report.

> '*If an intelligence check had been made on the home address it would have revealed the rape investigation. This was another occasion where links could have been made with children's social care, had a Merlin entry been made.'*

An insight into a different mechanism was detailed when the review highlighted that the police officers completed a Book 124D Domestic Violence Report Form. This made no mention of the victim's three children. Consequently, there were no CCN or relevant Merlin forms completed to alert children's social care and no referral to an IDVA.

Police creating Merlin, but it was then not shared

Some of the reviews highlighted that police responded to domestic violence in the family home by generating a Merlin reports. When Merlin records were created by the police (for example, following the Safeguarding Toolkit) and then shared appropriately, it demonstrated effective practice and information sharing, allowing children's social care to act in recognition of the children's situation. The Merlin reports also meant that information could be shared with health services for example the health visitor. However, there were many instances where Merlin reports were created but not shared, as detailed below.

In a review, when the perpetrator threatened to kill both the victim and the children, a Merlin report was generated. However, there was no recorded action by the police or any other agency. The reason for this is not expanded upon in the review.

> '*The Individual Management Review (IMR) does not detail any concerns by the police, or action, in relation to the fact that the children were included in the threat to kill, although a Merlin was created.'*

In some instances, Merlin reports were not shared with children's social care, health services or the children's school. This meant professionals were unaware of previous domestic violent incidents. As one review details:

> '*[The failure to share previous Merlin's] means that children's social care were unaware of both incidents, and so when they received the Merlin for the later incident in November 2013, as far as they were concerned that was the first incident since January 2012, rather than the fourth.'*

Health services and schools noted in that review that they did not routinely receive Merlin reports so are often unaware of domestic abuse within families known to the police and other agencies. This has since been rectified within that borough.

Children's social care assuming the victim could safeguard and perpetrator would not harm their children

In a small number of cases, children's social care appeared to make over-optimistic assumptions about victims' ability to safeguard children and that the perpetrator would not harm their child. In one instance, the review highlighted that children's social care wrongly assumed that the victim could safeguard both herself and the children from the abuser. It was clear that the professionals did not recognise that the perpetrator made threats to kill both the victim and her children.

> '*While the Service [children's social care] appropriately recognised that [victim's] relationship with the children was a mitigating factor in the impact of the abuse on them, they wrongly assumed that [victim] as a domestic violence/abuse victim could safeguard herself and the children from the abuser.'* (p83)

Conversely, in one review when risk was minimised or denied by the parent of the child, this impacted on social workers from children's social care's ability to manage risk to children:

> '*Children's social care reflect that the above three aspects form what agencies refer to as the "toxic trio" or "multiple risk" [maternal depression, alcohol use of the parents and domestic abuse] as they have been identified as common features in households where harm comes to children…when reviewing the chronology, each theme was not always a factor in each contact with this household and there were many strengths evident in relation to the parenting and attachments observed. The risks were often denied or minimised by [the perpetrator].'*

Underlying systemic issues

Merlin

There was little information in the reviews to suggest why the Merlin was not effective, either through police creating Merlin records but not sharing with agencies, or not making Merlin reports at all, despite the risk to children present at the incident. In two instances, the review highlighted that it was not routine to send Merlin reports to health services and schools.

It is not clear why police missed opportunities to generate a Merlin report. This could be due to responding to the violent incident rather than assessing the whole situation and recognising the impact of domestic violence on children.

Children's social care assumptions

There is little information on why children's social care assumed the victim could safeguard, or perpetrator would not harm their children. In one review, the parental domestic abuse issues did not appear to meet thresholds for children's social care, or a subsequent referral to MARAC.

Appendix 5. Adult family violence

This section comprises nine cases (seven DHRs, two IIRs) involving 'adult family violence' - violence between adult (over 18) family members who are not in an intimate partner relationship with each other, for example parents and their adult children.

Separating out this category of domestic abuse from domestic abuse involving intimate partner violence is in line with the approach taken by Standing Together Against Domestic Violence[77] noting that the Home Office definition conflates these two forms of abuse, which has the potential to obscure a few differences between the two.

Several of the cases had been reviewed under more than one process – in each instance the most recent of the two reports were used. A brief summary of each of the cases is shown below.

Table 35. Reviews of adult family violence

Date of incident	Date of report	Brief description	Reference individual	Information provided about non-reference individual?
2015	2018	Disabled man killed by his daughter.	Both	–
2014	2017	Woman killed by her son who was a mental health service user.	Perpetrator	Some
2012	2017	Woman killed by her son, who had longstanding mental health problems.	Both	–
2015	2016	Woman killed by her son who had autistic spectrum disorder and mental health problems.	Both	–
2013	2016	Man killed by his son who had mental health problems.	Perpetrator	Some
2012	2019	Mental health service user who killed his mother.	Perpetrator	Very little
2014	2016	Woman killed by her brother.	Victim	Some
2015	1018	Man killed by his son, who was experiencing mental health problems.	Both	–
2015	2018	Man killed by his brother, who was experiencing mental health problems.	Both	–

[77] Sharps-Jeffs N and Kelly L (2016) *Domestic homicide review: Case analysis.* London: Standing Together Against Domestic Violence, London Metropolitan University.

Case example 8: Adult family violence – Delphine

Delphine was 81 years old at the time of the incident and of Mauritian heritage. She had multiple age-related health conditions. She was the main carer for Julien who had an autism spectrum disorder, with support from her other children. She had not received a carer's assessment or been identified as a vulnerable adult. She lived alone. Julien had not been violent to her before the incident, but had destroyed her property on occasions, which meets the definition of domestic abuse.

Julien received a diagnosis of autistic spectrum condition in 2010/11 (he was in his late 30s at the time). He worked in a national chain store and lived alone. He had type 2 diabetes which was not always well managed. He was socially isolated and was reported as only having one friend, who shared his interest in collecting rare vinyl records. His friend died in 2010 which was linked to his first psychotic episode.

In February 2015 Julien was visited by his GP at Delphine's house because his physical health had significantly deteriorated as he was not taking his medication for diabetes and high blood pressure. He was lying in bed and refusing to move. An AMHP visited and Julien was detained until the Mental Health Act 1983 Section 2. Julien later said the deterioration in his condition was due to stress at work. His family also noted ongoing depression following the death of his friend. After this he was detained at an adult mental health inpatient unit.

From April 2015 he began to eat, drink and take his physical health medication. He started to take unescorted leave from the ward. The plan was for him to take extended leave at home with his family when they were ready. Julien had gone on unescorted leave to Delphine's house the night before the incident to pick up his key but was not able to take it. The following day he left the ward again. The ward received a call from Delphine expressing her concern about the plan for Julien to have extended leave. The phone call was cut off abruptly, and the next contact was from the police about the incident.

Characteristics of the individuals

Victims

There were approximately equal numbers of female compared to male victims (n=5 vs. n=4). In this data set the majority (n=6) of victims were aged over 65, with three aged over 75. This is a substantially older age profile than for the other categories of incident. A high number of the cases (n=7) also involved victims of black or minority ethnicity.

Perhaps unsurprisingly, given the older age of the victims, a number had vulnerabilities relating to chronic health conditions. In one case particularly, the victim had severe health problems and was disabled with limited mobility. Despite this, many had caring responsibilities, mostly towards the perpetrators of the incidents. None of the victims had received formal carers' assessments or support.

Several victims (n=4) had experienced domestic abuse before the homicide, mainly at the hands of the perpetrators. Although in one case, the victim had experienced domestic violence from her husband, before being killed by her son. Previous domestic abuse by perpetrators in these cases was more commonly in the form of emotional abuse, such as threats; destruction of property, or financial abuse rather than prior physical harm.

Table 36. Victim demographic characteristics in adult family violence

Victim demographic characteristics	n
Gender	
Male	4
Female	5
Age	
35–44	2
55–64	1
65–74	3
75–84	2
85+	1
Ethnicity	
White English/Welsh/Scottish/Northern Irish	1
White Irish	1
White Other *Russian*	1
Asian/Asian British Bangladeshi	2
Asian/Asian British Other	1
Black/Black British African	1
Black/Black British Other *Mauritian*	1
Ethnicity not reported	1

Table 37. Other victim characteristics in adult family violence[78]

Other victim characteristics	n
Caring responsibilities	6
Chronic illness or long-term condition	6
Domestic abuse	4
English as a second or additional language	4
Abuse or neglect (as an adult)	3
Substance misuse	2
Financial issues	2
Mental health problems - current	2
Absent parent(s)	1
Alcohol misuse	1
Disability	1
Mental health problems - past	1
Migration status	1
Offending	1
Social isolation	1
Sexualised behaviour	1
Unemployment	1
Witnessing violence (for example street violence, exposure to domestic abuse)	1

[78] Data available for nine cases.

Perpetrator characteristics

The majority of perpetrators were men (n=9 vs n=1), and most (n=7) were under the age of 44 at the time of the incident. The majority (n=5) were of black or minority ethnic origin (see table below for further detail).

The majority of perpetrators (n=8) had mental health problems, which in a number of cases appeared to be a direct contributor to the incident. In the majority of cases, the mental health problems were known and diagnosed, though often had worsened without the knowledge of services in the time prior to the incident. Non-compliance with medication for mental health problems was a feature in a number of cases (n=5). Some perpetrators (n=3) also had chronic health conditions, which in two cases related to type 2 diabetes, poor self-management of which interacted with and at times exacerbated mental health problems.

Several of the perpetrators experienced unemployment (n=3), financial difficulties and social isolation, often linked to their mental health problems.

Some of the perpetrators were known to misuse substances (n=6) and alcohol (n=4). Again, this was a feature in the escalation towards the incident in several cases.

Several perpetrators had experienced difficulties in childhood, such as bullying or absence of a parent (father).

Table 38. Perpetrator demographic characteristics in adult family violence

Perpetrator demographic characteristics	n
Gender	
Male	8
Female	1
Age	
25–34	5
35–44	2
45–54	2
Ethnicity	
White English/Welsh/Scottish/Northern Irish	1
White Irish	1
White Other	2
Asian/Asian British Bangladeshi	2
Asian/Asian British Other	1
Black/Black British African	1
Black/Black British Other *Mauritian*	1

Table 39. Other perpetrator characteristics in adult family violence[79]

Other perpetrator characteristics	n
Mental health problems - past	8
Mental health problems - current	8
Caring responsibilities	5
Substance misuse	5
Medication (for example, failure to comply)	5
Alcohol misuse	4
Social isolation	4
Bullying (past experience)	3
Chronic illness or long-term condition	3
History of violence	3
Offending	3
Unemployment	3
Absent parent(s)	2
Financial issues	2
Low income/financial difficulties	2
Abuse or neglect (as a child)	1
A parent with a mental health problem	1
Acute illness	1
Domestic abuse	1
Domestic violence – experienced as a child	1
English as a second or additional language	1
Growing up in a household in which there are adults experiencing alcohol and substance misuse problems	1
Learning disability	1
LGBTQI	1
Migration status	1
Missing episodes	1
Parental abandonment through separation or divorce	1
Sexualised behaviour	1
Carrying weapons	1
Witnessing violence (for example street violence, exposure to domestic abuse)	1
Difficulties in self-care, hoarding	1
Homelessness	1
Alleged racially motivated bullying at work	1
Trauma due to war experience	1

Relationship between victim and perpetrator

In most cases, the relationship between the victim and perpetrator was that of parent-child. Two were fathers who were killed by their sons, one was a father killed by a daughter, and four were mothers killed by their sons. The remaining two cases were of siblings.

[79] Data available for nine cases.

The table below shows the characteristics of the relationships. A number of the relationships were characterised by caring responsibilities. In some cases, this was of parents caring for their adult child (for example, where there were mental health problems or chronic illness). In some cases, there was mutual caring, for example in a case in which the perpetrator's elderly mother cared for and to some extent financially supported him. However, he also cared for his mother when she became ill.

Some of the relationships had pre-existing abuse by the victim from the perpetrator, including emotional and financial abuse. It is interesting to note that just a single victim had experienced known prior physical abuse at the hands of the perpetrator. In one case, the perpetrator appeared to have experienced emotional abuse from the victim, who believed that the perpetrator was possessed by the devil and had encouraged him to undergo exorcism. In another review, the relationship between the victim and perpetrator is characterised as 'enmeshed and unhealthy'.

Table 40. Relationship characteristics in adult family violence

Relationship characteristics	n
Carer (not including parents caring for children under 18)	6
Domestic abuse	3
Emotional abuse	2
Financial abuse	2
History of relationship strain/separation	2
Coercive control	1
Neglect	1
Physical abuse	1
Unknown	2

Contexts and peer groups

Victims

Living arrangements: Some of the victims (n=4) were living in family home, and five were living alone. The majority of victims experienced risk factors within their home, mostly relating to domestic abuse by the eventual perpetrator of the incident. A victim had additional risk factors at home related to his disability, and his daughter's inability to provide adequate care and safety.

Risk factors: In a small number of cases additional risk factors were posed by the wider family context. This included the perpetrator threatening other family members, and gender norms meaning that victims felt unable to take action in the face of threats and conflict. A risk was identified in one case where the wider family were not in the UK, and so were unable to provide support or safety.

Protective factors: We identified protective factors in a small number of cases. In two cases, the victim had good support from their wider family, including in one case for their role as a carer. However, it is interesting to note that this was rarely capitalised on or recognised by services.

Table 41. Victim risk and protective factors across their contexts in adult family violence

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**5** Non-physical domestic abuse from perpetrator (4), Physical abuse by perpetrator (1), Adult neglect (disabled person) (1)	1 Threats made by perpetrator to other family members				
Criminality	1					
Harmful gender norms		**1** Gender norms in family meant female victim was dependent on older brother to manage difficult relationship with perpetrator				
Lack of capacity to safeguard	**2** Cared for by adult child unable to meet needs					
Other		**1** No family in the country to identify safeguarding issues				
Protective factors						
Were any protective factors present?		**2** Support in caring role for perpetrator from other family members ‘Close knit’ family	**2** Strong links in local community and involvement in Church Friends		**1** Support from colleagues, who raised alarm after victim was killed	

Perpetrators

Living arrangements: Most (n=5) of the perpetrators lived with their family, two lived alone and two were homeless at the time of the incident. As noted above, the perpetrators' home environments were often characterised by domestic abuse and conflict, which was either instigated by the perpetrator or in which they had a key role.

Risk factors: Generally, there was little information in the reviews about wider contextual factors that could impact on the perpetrators. A small number of (n=2) perpetrators appeared to be experiencing additional stress in the workplace, in one case in relation to alleged racially motivated bullying.

Protective factors: There was relatively little information about possible protective factors. Some perpetrators had good support from their family members. There was little mention of friendships, relationships or peer groups in any of the reviews.

Table 42. Perpetrator risk and protective factors across their contexts in adult family violence

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**4** Physical fights between perpetrator and victim (brothers) (1), Arguments and threats (2), Possible emotional abuse (2)					**1**
Criminality						**1**
Harmful gender norms		1 Difficult to manage conflict between sister and brother as sister relied on another brother to mediate				
Lack of capacity to safeguard						
Other	**2** Homelessness		1 Peer group using alcohol		2 Some indication that stress at work exacerbated mental health symptoms Workplace bullying	
Protective factors						
Were any protective factors present?	**2** Perpetrator mental health problems managed with support from victim	1 Mother and family members involved in mental health care				**1** Engaging in martial arts and dance classes to improve confidence

Incident

All of the incidents in this category were homicides. In one case, although the perpetrator was convicted of murder, she said that she had helped her father to die because he was in pain.

Information about weapons used were given in six of the reviews, four of the homicides were committed with knives, one with an axe, and one via asphyxiation with a plastic bag. All of the incidents occurred in the victim's home, which was, in some cases, shared with the perpetrator.

Escalation towards incident

Commonalities in the escalation towards the homicides included:

- **Threats, conflict or violent behaviours other than physical violence** (for example, destruction of property) by the perpetrator towards the victim
- The perpetrator **stopping taking or reducing medication for a mental health problem** and experiencing an associated increase in symptoms
- The perpetrator being **discharged from or ceasing to engage with mental health services** prior to the incident
- The perpetrator **not disclosing extent of mental health symptoms** due to fear of stigma
- The perpetrator **going on leave from an inpatient mental health ward**
- **Perpetrator experienced adverse life event** shortly before homicide, for example, relationship breakdown
- **Alcohol or substance misuse** immediately prior to incident.

Professional involvement

Victim involvement prior

Most of the victims had had relatively little involvement with services prior to the incident, and in four cases no information on involvement was provided at all.

It was notable, given that the majority of victims were identified in the reviews as being carers for the perpetrator, none had received a formal carers' assessment or support in that role.

Table 43. Victim involvement in services prior to the incident in adult family violence

Services	n
GP	5
Acute health services	4
Police	4
Housing	3
Adult social care	2
Counselling services	1
Jobcentre plus	1
Mental health - IAPT/early intervention	1
Mental health – other	1
Other	1
Not reported	4

Perpetrator involvement prior

All of the perpetrators had received input from a community mental health team in relation to their mental health problems, and several had had previous admissions as mental health inpatients. A number had had prior police involvement

Again, despite a number of the perpetrators having caring roles, none had received a formal carer's assessment or support in this role.

Table 44. Perpetrator involvement in services prior to the incident in adult family violence

Services	n
Mental health – community mental health team	8
GP	6
Police	6
Mental health – other	5
Housing	4
Mental health – inpatient	4
Acute health services	1
Ambulance service	1
Counselling services	1
Food bank	1
Jobcentre plus	1
Mental health – IAPT/early intervention	1
Voluntary sector	1
Other	1

Potential areas for improvement in professional responses

We undertook detailed analysis of professional practice in nine cases of adult family violence. The purpose of this was to identify possible areas where there may be predictable weaknesses in professional practice. Whilst there was also good practice reported in most reviews, we have focused on areas for improvement in order to inform what aspects of practice that the VRU may want to influence through its work.

The below findings therefore focus on issues which were observed across a number of different cases and are presented in order of the most frequently recurring themes:

1. Lack of support for people in caring roles
2. Lack of recognition of domestic abuse between adult family members
3. Challenges in working with dual diagnosis.

It is important to note that, due to the inevitable time lag between incidents occurring and reports being published, some of the practice described in the reviews may have changed since publication. These issues are therefore presented as 'lines of enquiry' that the VRU may wish to consider as part of its role in preventing and addressing violence.

1. Lack of support for people in caring roles

Of the nine cases of adult family violence which we reviewed, six featured a caring role within the relationship between victim and perpetrator. In five cases the victim was the main carer for the perpetrator, and in a case the perpetrator was the carer for the victim. There was an additional case in which victim and perpetrator were siblings who were both carers for their seriously ill and bedbound mother.

The reviews highlighted the significant strain that caring placed on individuals and relationships, and the lack of support for carers observed in many of the cases. This manifested in three interlinked ways across the cases:

- A lack of consideration for the carer's ability to care
- A lack of formal carer's assessment, and resulting absence of support
- A tendency not to consider risks to carers and put adequate safeguards in place.

Lack of consideration of the person's ability to care

In a number of cases, there should have been reasons to think that it may not be appropriate for the carer to be in this role. This included people in caring roles who were:

- Older and suffering from health problems
- Vulnerable in ways that made it difficult for them to care, including having substance misuse problems or possible mental health problems and difficulty coping.

Often these individuals were not formally identified as carers, but even when they were, professionals seem to have given little consideration to the risks presented to both parties in the caring relationship. This often led to significant strain on the individuals involved as their needs were increasingly not met.

Lack of formal carer's assessments

Under the Care Act 2014, adults over the age of 18 are entitled to a carer's assessment if they care caring for another adult over the age of 18 who is ill, elderly or disabled. The

purpose of the assessment is to explore the impact that caring has on the carer's life, and to identify what support may be needed.

In many of the reviews we considered, those in caring roles had never been offered a formal carer's assessment, despite meeting the definition of a carer, and being treated as the main carer in other ways (for example, attending care review meetings). In some cases, the person had been offered an assessment 'by proxy' via the person they cared for or had been offered but had declined and this had not been appropriately followed up. Again, this resulted in a lack of support for carers and the care recipient, meaning that neither their needs nor the care recipient's needs were adequately met.

Inappropriate safeguards in place for carers

In many of the cases under review, the reviews concluded that the homicide which occurred could not have been predicted or prevented. However, there were some cases in which there were clear risks to the victim (who was also the person's carer) which were poorly managed.

For example, in one case it was known that there was a pattern in which alcohol use by the perpetrator was linked to a relapse in his psychotic symptoms, and threatening behaviour towards his mother (his carer). Despite this, the perpetrator was allowed to return home to live with his mother after a period of alcohol use, and a worsening of his mental health problems, because there were no inpatient beds available at the time. The review concludes that there was insufficient consideration of the risks to his mother.

Two reviews comment on risk assessment practices within mental health services. One review noted that GP risk assessments for someone whose mental health problems were being managed in primary care were focused primarily on the person's risk of harm to themselves, rather than their risk of harm to others. In one case, the review notes that the perpetrator's risk assessment was raised from green to amber on the day before the incident, but it was unclear whether the risk related to the perpetrator's risk of harm to themselves, or to others.

The impact of all of these issues was that inappropriate caring relationships continued for long periods of time, without appropriate support or respite for the carer. In some cases, this may have contributed to the carer themselves becoming a perpetrator of homicide. In others, it left the carer vulnerable to becoming a victim.

Underlying systemic factors

There was little information in the reviews about possible systemic factors underlying the poor support for carers, although other research[80] has also highlighted this is an issue in cases of adult family violence.

[80] Sharps-Jeffs and Kelly (2016) Domestic homicide review: Case analysis. London: Standing Together Against Domestic Violence

One review highlighted poor communication between mental health services and adult social care services, which were responsible for providing a carer's assessment. This appeared to have been exacerbated by social workers no longer being integrated in to community mental health services.

Another review highlighted a possible misinterpretation that someone could only be designated a carer if they were co-habiting with the person they were caring for. This is a misunderstanding of the legislation and guidance. It is unclear how widespread this may be.

2. **Lack of recognition of domestic abuse between adult family members**

A number of reviews noted that, although behaviours meeting the definition of domestic abuse were present in the cases, these were not identified by professionals working with the families concerned.

For example, one review noted that the perpetrator had destroyed the victim's property in the escalation towards the incident. The review notes that:

> *'Julien had destroyed Delphine's property on a number of occasions and this is evidence of domestic abuse within the Government definition (2013). This behaviour was not named as such by any agency in contact with the family, nor by the family of Delphine and Julien.'*

In another of the cases reviewed, there were clear indications of financial abuse but this was also not picked up on by professionals working with the victim and his daughter, the eventual perpetrator.

In a third case, the police had been called out to the family multiple times for verbal and physical aggression between the eventual homicide victim and perpetrator, as well as between other siblings. It appeared that no support from domestic abuse services was offered to any of the family members.

Underlying systemic factors

The reviews suggest a number of issues which may underlie the lack of recognition of domestic abuse in these cases:

- **Tendency to more readily recognise some forms than others.** Whereas physical abuse may be readily recognised as domestic abuse, behaviours such as destruction of property may not fit professional conceptualisations of domestic abuse
- **Less well-developed responses to family violence compared to intimate partner violence.** One review reported that a 'whole family' approach may have been helpful in exploring and addressing the issues of conflict and abuse within the network of family relationships, but that this did not seem to be an obvious course of action to professionals at the time.

- **A reluctance to 'think the unthinkable', particularly in the context of carer relationships**. One review reflected that professionals may be reluctant to suspect family members of abusive behaviours, particularly where they were in a caring role. The review notes that 'Practitioners need to suspend their disbelief that someone who outwardly appears to care for a close relative, such as a parent, can cause them harm and that mental illness is an added risk factor.'

3. Challenges in working with dual diagnosis

Four of the cases reviewed included perpetrators who had both mental health problems, and difficulties with drug and/or alcohol misuse. The reviews highlight that this often led to additional challenges for professionals in providing effective support. This included:

- One man being discharged after showing psychotic symptoms because it was assumed these were the result of cannabis use. The review notes that insufficient consideration was given to whether he was using cannabis to self-medicate pre-existing symptoms.
- A lack of recognition of one perpetrator's ongoing alcohol and drug misuse, alongside a diagnosis of schizophrenia, and therefore no referral made to substance misuse services.
- A lack of understanding of the role that alcohol misuse played in one perpetrator's relapse of mental health problems.

Underlying systemic factors

The reviews highlighted a number of issues underlying difficulties in adequately supporting individuals with dual diagnosis.

Practitioner knowledge and training was a key issue highlighted. For example, one review notes in relation to cannabis use:

> *'The panel were concerned about the possibility that the factor of cannabis consumption may have altered the way in which the presentation of Abdul was viewed, adversely affecting treatment planning and risk management and leading to premature discharge. Many service users with diagnoses of severe and enduring mental illness are also cannabis users and this should be seen as an extra risk factor rather than a reason to under assess and treat.'*

Another review highlights that care coordinators interviewed as part of the review said that they did not feel equipped to work with dual diagnosis.

A third review highlights that risk management processes may not adequately support consideration of the interplay of mental health problems and substance misuse difficulties.

Appendix 6. Within-family violence towards children under 18

This section comprises 18 cases (17 SCRs; 1 IIR) involving violence within the family towards children aged 18 or under. We have taken a broad definition of 'family' to include parents, step-parents, parents' partners, grandparents and the wider family network. These cases included 23 child victims (five incidents included two child victims). In two of the incidents, an adult was also killed within the same incident and three also involved the perpetrator killing themselves. The cases we reviewed varied in type of incident: 14 of the cases were homicides, with three of those being filicide, and three cases were non-fatal injury and one fatal injury. In the cases we looked at, most children who had been killed or seriously harmed were under the age of five – this pattern has also been seen at a national level.[81]

We took a wide definition of 'family', to include step-parents, partners, grandparents and so on. Within this definition, the perpetrator or suspected perpetrator in 17 cases was the child's biological parent or parents. In one case the perpetrator was the partner of the child's mother.

Several of the cases had been reviewed under more than one process – in each instance the most recent of the two reports was used. A brief summary of each of the cases is shown below.

[81] Brandon M, Bailey S., Belderson P et al. (2009) *Understanding Serious Case Reviews and their Impact. A Biennial Analysis of Serious Case Reviews 2005-07.* London: DCSF

Table 45. Reviews for parental violence towards children

Date of incident	Date of report	Brief description	Type of incidents	Reference individual	Information provided about non-reference individual
2016	2018	Baby (3 months old) killed by parents.	Homicide	Both	–
2016	2019	Child (5 years old) killed by mother's partner (male).	Homicide	Perpetrator	Some
2012	2018	Mother kills herself and her baby.	Homicide / suicide	Perpetrator	–
2016	2019	Baby (2 weeks old) died in suspicious circumstances whilst in care of mother.	Fatal	Both	–
2017	2018	Two children (nine and three years old) killed by their mother prior to taking her own life.	Homicide/suicide	Both	–
2014	2016	Child (22 months old) and mother killed by husband.	Homicide	Both	–
2017	2018	Twin babies (16 months old) sustain serious injuries by father, one subsequently dies.	Homicide	Both	–
2016	2018	Baby (13 months old) sustained serious injuries.	Non-fatal injury	Both	–
2015	2016	Baby (6 months old) died of traumatic brain injury.	Homicide	Both	–
2015	2016	Mother and young person kill themselves.	Homicide/suicide	Victim	None
2015	2017	Baby has serious fractures that were non-accidental and non-fatal.	Non-fatal	Both	–
2013	2019	Two children (nine and four years old) killed by their mother.	Homicide	Both	–
2015	2016	Mother killed husband and child (4 years old), whilst injuring her other child (18 months old).	Homicide	Both	–
2013	2016	Child (3 years old) is killed by father.	Homicide	Both	–
2015	2017	Child (age 16) is seriously assaulted by mother.	Non-fatal	Both	–
2013	2016	Child (6 years old) died of head injury, father charged with murder	Homicide	Both	–
2016	2019	Baby (13 weeks old) suffered non-accidental, cardiac arrest and had visible burns to his legs.	Homicide	Both	–
2015	2016	Baby (3 months old) killed by mother.	Homicide	Both	–

Case study 9: Family violence towards children under 18 – Child M

Child M was a 13-month-old black British child of African-Caribbean ethnic origin who was taken to hospital by mother. The toddler was found to have bruising to the face and transverse fractures to both femurs (broken thighbone). Prior to this incident, Child M presented at hospital with two other non-accidental injuries. Child M and an elder sibling were subject to child protection plans.

After the incident, both parents were arrested, and subsequently charged with child cruelty. Both parents had been known to police and children's social care having had prior criminal convictions for various offences from a young age. The father was still on licence from a prison sentence for offences of possession and intent to supply heroin and cocaine. Previously he was sentenced to eight years of imprisonment for conspiracy to rob. The mother's criminal conviction was for theft (over five years ago) and an incident where she had held a knife to the throat of her victim and inflicted a cut.

The family had professional involvement due to police and probation services involvement for father, as well as reported domestic incidents where the mother had received significant injures which required hospital treatment after an altercation with Child M's father. Health services and children's social care were actively involved in the management of Child M and an elder sibling's child protection plan.

Subsequent proceedings resulted in the court directing the return of the children to their mother's care. At the criminal trial, father was found not guilty of GBH, although both parents were found to be guilty of child cruelty and sentenced in February 2018.

Case study 10: Family violence towards children under 18 – Family W

Ms W, 28, was a white British woman and had lived in south-east London all her life; she had attended local schools and went on to attend college. Ms W appeared to come from a close-knit family who were supportive to one another. Ms W had been in a relationship with the father of both children from the age of 14 years until October 2015 when at the age of 25, she asked him to leave the family home. There had been some volatility, which had been referred in 2010 to both the police and children's services. Professionals involved formed the view at the time that Ms W tended to minimise the marital difficulties, and did not want to take matters further. Ms W had two children, AW and BW, aged 9 and 3, who were attending school and considered to be healthy and happy.

Ms W was experiencing a range of stress factors in the months leading up to the incident including homelessness, financial issues, a breakdown of a key friendship from her support network and suffering a miscarriage. These were combined with an underlying 'depression' which seems to have continued following the birth of the second child; she reported having post-natal depression with both children to family, but not to professionals. There was minimal professional involvement, for example, when Ms W was homeless, children's social care sent a letter to her to contact them for support. On two occasions, in the 15 months up to the deaths, Ms W had expressed 'feeling suicidal'. The first was over the phone to the Department for Work and Pensions (DWP) in October 2015 when she was querying why her benefits had been stopped and she said that 'she owes so much money there was no point in going on for her or her children'.

Ms W and her two children were found dead by the police in their temporary house, empty packets of over-the-counter sleeping tablets and painkillers were found alongside a two-thirds empty bottle of methadone. A series of messages were written on the wall with reference to betrayal and loss and personal letters to family members explaining her actions were found within the property. She had not been prescribed methadone or had known substance misuse problems.

Characteristics of the individuals

Victims

There were roughly equal numbers of female compared to male victims (n=9 vs. n=10). It should be noted that in six cases, the gender of the victim was not known. As has been shown in other research on child deaths and SCRs,[82,83] children aged 5 and under (n=16) were most likely to be killed or seriously harmed, and therefore subject to SCRs. Unlike other similar research, our data does not show the expected spike in deaths in older children. This is because seven of the SCRs relating to older children have been discussed under youth peer violence. A high number of the cases (n=13) also involved victims of black or minority ethnicity.

[82] Brandon M, Bailey S, Belderson P et al. (2009) *Understanding Serious Case Reviews and their impact.* London: DCSF.

[83] Sidebotham P, Brandon M, Bailey S et al. (2016) *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014.*

Some victims were in a household with domestic abuse (n=9), and there were eight instances recorded where the victim had experienced abuse or neglect prior to the homicide from the perpetrator. Only a small number were on a child protection plan or child in need plan (n=5). Again, this is similar to the findings of other research.[84]

Many of the victims were living with parents who had mental health problems (n=8), substance misuse and alcohol misuse problems (n=7).

Table 46. Victim demographic characteristics in parental violence towards children

Victim demographic characteristics	n
Gender	
Male	9
Female	10
Not known	6
Age	
0–1	4
1–2	6
3–5	6
6–7	1
8–9	2
16–18	1
45–54	1[85]
Child (under 18) – exact age unknown	2
Adult over 18 – exact age unknown	1
Ethnicity	
Mixed White and Black Caribbean	1
Mixed White and Black African	1
Mixed White and Asian	2
Mixed other	3
Asian/Asian British Bangladeshi	1
Black/Black British African	1
Black/Black British Caribbean	5
Ethnicity not reported	11

[84] Brandon M, Belderson, P, Warren C et al. (2008) *Analysing child deaths and serious injury through abuse and neglect: What can we learn? Biennial analysis of Serious Case Reviews 2003–2005.* London: DCSF.

[85] Note – parent (mother) was also killed which is why the analysis has a victim aged between 45–54 years old

Table 47. Other victim characteristics in parental violence towards children[86]

Other victim characteristics	n
Domestic violence – experienced as a child	9
Abuse or neglect (as a child)	8
Parent with mental health problems	8
Growing up in a household in which there are adults experiencing alcohol and drug use problems	7
Child in need/child protection	5
Growing up in a household where there are alcohol and drug problems	5
Witnessing violence (for example street violence, exposure to domestic abuse)	5
Absent parent(s)	3
Low income/financial difficulties	2
Member of the household being in prison	2
Alcohol misuse	2
English as a second or additional language	2
History of/current self-harm	2
Parental abandonment through separation or divorce	2
History of violence	1
Care experienced children	1
Mental health problems – past	1
Migration status	1
Victim of crime	1
Others – flee civil war (Somalia)	1

Perpetrator characteristics

There were 23 perpetrators in total – in five of the cases both mother and father were judged to be responsible for the incident. There were roughly equal numbers of female compared to male perpetrators (n=12 vs. n=11), and most were aged 25-34 (n=8). The majority (n=7) were of black or minority ethnic origin, however it should be noted that ethnicity was not reported in 14 of the reviews.

Most perpetrators (n=10) had mental health problems, which in some cases appeared to be a direct contributor to the incident. In the majority of cases, the mental health problems were known and diagnosed, though often had worsened without the knowledge of services in the time prior to the incident. In several instances, parental mental ill health appeared to be a direct causal factor, for example there were a number of cases in which the parent took a child's life at the same time as their own, and one case in which a parent had killed their child and partner whilst experiencing psychosis. In some cases, one or both parents were experiencing mental health problems including depression and anxiety. However, the extent to which this had a causal relationship with the incident is unclear.

[86] Data available for 14 cases. No information available for four cases.

A number of the perpetrators were known to abuse drugs (n=6) and alcohol (n=4), and again this was a feature in the escalation towards the incident in a number of cases (see Table 49).

Domestic abuse featured in a high proportion of the included reviews (n=9). There also appeared to be several ways that domestic abuse was linked to incidents of violence towards children. In some cases, this involved domestically, and often physically, abusive partners (often men) directing violent behaviour towards their children. In other cases, domestic abuse was one of a range of stressors and other risk factors such as substance misuse and involvement in offending behaviour, which formed the backdrop to a violent incident towards a child. A large number of perpetrators had previous offending behaviour. In some instances, parents had a long history of criminal behaviour, or police involvement due to domestic abuse.

Some perpetrators experienced unemployment (n=4) and financial difficulties (n=2). Further, housing issues occurred frequently, in terms of families living in accommodation that was inadequate, families living in temporary accommodation, experiencing frequent housing moves and homelessness. In a number of cases, this placed a strain on parents and their ability to care for their children, as well as their ability to engage with services – and for services to locate and engage with them.

The difficulties faced by people originally from outside the UK also featured in a number of cases (n=5). For some people, this meant that they had no support networks or family within this country who might have been alert to risk factors or changes in their behaviour. In some cases, difficulties in relation to obtaining secure immigration status represented another stress factor on parents.

Table 48. Perpetrator demographic characteristics in parental violence towards children

Perpetrator demographic characteristics	n
Gender	
Male	11
Female	12
Age	
25–34	8
35–44	3
45–54	2
Adult (over 18) – exact age unknown	10
Ethnicity	
White English/Welsh/Northern Irish/Scottish/British	1
White Other	1
Mixed White and Black Caribbean	1
Asian/Asian British Bangladeshi	2
Black/Black British Caribbean	2
Black/Black British Other	1
Other – Kurdish Turkish	1
Not reported	14

Table 49. Other perpetrator characteristics in parental violence towards children[87]

Other perpetrator characteristics	n
Mental health problems – current	10
Domestic abuse	9
Offending	9
Mental health problems – past	6
Drug misuse	6
Alcohol misuse	4
Migration status	5
Unemployment	4
History of violence	4
Abuse or neglect (as a child)	3
Chronic illness or long-term condition	2
Financial issues	2
Low income/financial difficulties	2
Medication (e.g. failure to comply)	2
Homelessness	1
Absent parent(s)	1
A parent with mental health problems	1
Drug dealing/county lines	1
English as a second or additional language	1
History of/current self-harm	1
Parental abandonment through separation or divorce	1
Social isolation	1
Witnessing violence (for example street violence, exposure to domestic abuse)	1
'Unhappy childhood' did not make threshold for children's social care	1
Not reported	1

Relationship between victim and perpetrator

In all but one case, the relationship between the victim and perpetrator was that of parent-child. There was one victim killed by their mother's partner. The cases we reviewed varied in type of incident: 14 of the cases were homicides, with three of those being filicide, and three cases were non-fatal injury and one fatal injury.

[87] Data available for 17 cases. No information available for one case.

Table 50 shows the characteristics of the relationships. A number of the relationships were characterised by abuse, particularly physical abuse (n=11), emotional abuse (n=5) and neglect (n=2).

Table 50. Relationship characteristics in parental violence towards children

Relationship characteristics	n
Physical abuse	11
Emotional abuse	5
Neglect	3
Domestic abuse	2
Financial abuse	2
Coercive control	1
None	1
Not known	6

Contexts and peer groups

Victims

Living arrangements: The majority (n=17) of the victims were living in family home, one was living alone, and one was homeless. The majority of victims experienced risk factors within their home, mostly relating to domestic abuse by the eventual perpetrator of the incident.

Risk factors: In a large number of cases, additional risk factors were posed, including serious parental mental health problems and substance misuse. In one case, there was opiate abuse in the home. Other risk factors included living with offenders (n=2), risk of homelessness (n=4), eviction and debt problems.

Protective factors: We identified protective factors in a small number of cases. In two cases, the victim had good support from their wider family. This includes in a case where the school alerted children's social care to absences.

Table 51. Victim risk and protective factors across their contexts in parental violence towards children

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**10** Domestic abuse within the home (4), Neglect, physical abuse, emotional abuse (6), Concerns about faith-based abuse (1)					
Criminality	**4** Drug misuse within the home (2), opiate abuse (1), Convicted offender within the home (2)					
Lack of capacity to safeguard	**6** Serious parental mental health problems (4), Being cared for by unsuitable caregivers (1), Parent gave false information to services (1)					
Other	**7** Unsuitable housing or home environment (2), Parental homelessness or at risk of homelessness (4), Eviction (1), Debt problems (1), Father had history of causing non-accidental injury to children, Alcohol misuse (1)	**1** Wider family not aware of child protection plan				
Protective factors						
Were any protective factors present?	**1** Good engagement with services	**2** Support from wider family (2)		**1** School alerted CSC to absences from school		

Perpetrators

Living arrangements: Most (n=14) of the perpetrators were living in a family home, two lived alone, two in shared accommodation and two were homeless. As noted above, the perpetrators' home environments were often characterised by domestic abuse and conflict, which was either instigated by the perpetrator or in which they had a key role.

Risk factors: There were multiple issues in the perpetrators' lives, characterised by homelessness, temporary housing, frequent moves and overall financial problems. In one review, it was highlighted that the perpetrator did not tell the full truth to services so professionals were unable to get the full picture. There was little information in the reviews about wider contextual factors that could impact on the perpetrators.

Protective factors: In a small number of cases, the wider family network provided support to perpetrators. In three cases, accommodation was offered by family members.

Table 52. Perpetrator risk and protective factors across their contexts in parental violence towards children

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**7** Domestic abuse (5), Physical and emotional abuse of child (2)					
Criminality	**4** Drug use within the home (3), Convicted offenders within home (1)					
Lack of capacity to safeguard	**4** Unable to safeguard due to mental health problems (3), Not telling the full truth to services (1)					
Other	**6** Homeless/inadequate accommodation (3), Temporary housing (1), Frequent moves (1), Alcohol abuse (1), Financial issues (2)		1 Limited support network			
Protective factors						
Were any protective factors present?	1 Family support with caring for child (from grandmother)	3 Accommodation offered by family members (1), Support from family members 2)				

Incident

Most incidents took place in the family home, with one incident occurring in a hotel and another in a park. In the majority of incidents, it is unclear if a weapon was used, most specify non-accidental injury. There were two instances where the mother killed herself and her children.

Escalation towards incident

In most of the reviews, the perpetrator faced multiple stress factors, for example mental health problems, financial difficulties including homelessness, and substance misuse/alcohol abuse experienced prior to the incident. The reviews found these to be possible factors in their child's homicide. A review commented:

> *'Ms W [perpetrator] had a number of stress factors that she was dealing with in the months leading up to the incident: a relationship with a friend's ex-partner that resulted in a pregnancy and subsequent miscarriage, homelessness, possible debt and the loss of the friendship with her 'best' friend who had previously provided a lot of support to Ms W. These were combined with an underlying 'depression' which seems to have continued following the birth of the second child.'*

Other commonalities included:

- Reasons for the homicide were unclear in a number of cases
- Perpetrator experienced adverse life event shortly before homicide, for example relationship breakdown
- There was domestic abuse in the family and the perpetrator killed the child and/or child's parent
- The perpetrator killed the victim and then killed themselves, often due to stressors such as debt and housing problems, or acute mental health problems
- Alcohol or drug use immediately prior to incident – *'drug-induced psychosis'.*

Professional involvement

Victim involvement prior

Fewer than half of the victims had been known to children's social care (n=9) prior to the incident. In a number of cases, many of the families had been known only to universal services including GP and health visiting prior the incident. This also highlights the importance of these services in safeguarding, and in being alert to known risk factors such as domestic abuse and parental mental health problems.

Table 53. Victim involvement in services prior to the incident in parental violence towards children

Services	n
Children's social care – child in need/child protection plan	9
Police	7
GP	6
Health visitor	5
School/s	5
Housing	3
Early help/Team around the family	2
Acute health services	2
Young carers service	1
Not reported	7

Victim involvement after

There was very little information about victim involvement in services after the incident.

Table 54. Victim involvement in services after the incident in parental violence towards children

Services	n
Ambulance service	5
Acute health services	3
Children's social care – child in need/child protection plan	2
Police	1
Not reported	13

Perpetrator involvement prior

Most perpetrators had police involvement (n=10) prior to the incident. Some received input from health services, particularly in relation to their mental health problems, and one had previous admissions as mental health inpatients. Four perpetrators had probation service involvement due to previous convictions ranging from GBH to domestic abuse, theft and drug abuse/intent to supply.

Table 55. Perpetrator involvement in services prior to the incident in parental violence towards children

Services	n
Police	10
GP	9
Acute health services	5
Children's social care – child in need/child protection plan	4
Housing	4
Probation service	4
Health visitor	3
Mental health problems – other	3
School/s	3
Adult social care	2
Children's social care - looked after services	2
Domestic abuse services (e.g. Police community safety units, DV team)	2
Early help/Team around the family	2
Mental health – community mental health team	2
Ambulance service	1
Family therapy team	1
Mental health – IAPT/early intervention	1
Mental health – inpatient	1
Pre-natal health care	1
Private sector (private law proceedings)	1
Not reported	4

Perpetrator involvement after

After the incident, many perpetrators were arrested and convicted for the incident. Three became mental health inpatients as they were convicted of the homicide with diminished responsibility.

Table 56. Perpetrator involvement in services after the incident in parental violence towards children

Services	n
Police	6
Mental health – inpatient	3
Children's social care – child in need/child protection plan	2
Acute health services	2
Ambulance service	1
Children's social care – looked after services	1
Probation service	1
Mental health – other	1
Not reported	13

Appendix 7. Sexual abuse

This category includes three cases of sexual abuse/assault. These represent a small subset of sexual assault cases, particularly in relation to children and young people. It would not be usual to conduct an SCR for a young person who has experienced sexual abuse, but a review will be initiated in some exceptional cases. Here the reviews were conducted either because:

- a service user was the perpetrator of sexual abuse
- the perpetrator was a foster carer
- the case offered useful learning regarding use of technology.

Table 57. Reviews for sexual abuse/assault

Date of incident	Date of report	Brief description	Reference individual	Information provided about non-reference individual?
2013[88]	2017	Girl who experienced multiple incidents of sexual abuse.	Victim	Very little
Unclear	2016	Child sexually assaulted by an older child.	Perpetrator	None
2016	2018	Girl who was found to be subject of indecent images on YouTube.	Victim	None

Case example 11: Sexual abuse/assault – Thomas (Perpetrator)

Thomas' parents divorced when he was small, and he was the younger of two children. Reports of neglect led to children's social care becoming involved with the family. There were many recorded incidents of abusive behaviour towards Thomas and extreme neglect of his physical and emotional needs. There were records of two possible non-accidental injuries when he was two, and he had a developmental delay. A close family member of Thomas has alleged sexual abuse perpetrated by one of their relatives and there is reference to a sex offender visiting the home. His mother's behaviour was recorded as aggressive and threatening toward school staff, and seriously emotionally and physically abusive to Thomas. Thomas' mother had complex emotional and physical support needs.

Thomas displayed sexualised language at a young age in school and had poor attendance. Thomas alleged at the age of about six that he had been sexually abused by a person known to the family who was in prison for assaulting children.

At the age of 10, he moved in with his aunt who provided care for him adequately, and then his mother took to London to live with her. The previous local authority stated that Thomas should remain on child protection intervention, however he was assessed as a child in need.

[88] This relates to the date that sexual abuse by her foster carer, the most recent incident, was discovered.

Thomas was sent to a special residential school in East Sussex due to his problematic behaviour where he accessed therapeutic provision, as well as accessing CAMHS when he was home during holidays. He missed the majority of appointments due to mother.

The Sussex police investigated an allegation that Thomas had sexually assaulted a peer at his school. Police did not follow this up, partly because resources were not prioritised for this incident, and partly because there was no forensic evidence to proceed with a prosecution. School staff had seen Thomas and the victim in the day prior to the incident which was thought to undermine the case.

However, Thomas was moved and was placed in a one-year placement upon finishing school at 16. Seven days after moving to the new placement, he was arrested for the sexual assault of a child of primary school age near to his placement.

Case example 12: Sexual abuse/assault – Kesandu (Victim)

Kesandu was 9 years old and lived with her mother as her parents were separated. Primary school staff had raised several concerns about Kesandu. For example, she was overweight for her age group, had the wrong size clothing and did not have underwear. Kesandu also had a wetting incident during a school activity. Kesandu's mother was employed as an unqualified worker in school part time. The school sought support and advice from Early Help during regularly arranged consultation sessions between school and Early Help. School was informed by the Early Help Coordinator, who appropriately checked available recording systems of other agencies. The family was not known to children's services and the school was advised to continue their internal early help intervention and to keep monitoring.

In 2016, Child Online Exploitation Service (CEOP) received a referral from an unknown teenage boy in relation to a young girl who was reported to appear naked on several YouTube videos, six in total. The images were assessed to be indecent and the report informed that an adult could be seen in the background of one of the videos. Following investigation, which took several months, the girl was identified as Kesandu.

Police and children's social care worked in partnership with school staff to conduct a joint home visit. During this visit, the police officer explored the family home and found the home conditions to be unsuitable for a girl of Kesandu's age to be living in. The mother was asked to consider alternative caring arrangements. However, she was unable to. Therefore, under s.46 Children's Act, the police removed Kesandu and she was placed in local authority care.

Characteristics of the individuals

Victims

In two of the cases, the victims were female – a child aged 9, and a child whose age was not reported. In the other case there were multiple victims, and details were not provided in the report as the focus of the SCR was on the perpetrator.

From the two cases where victim data is reported, there were multiple adverse childhood indicators, including abuse or neglect experienced, absent parent(s)/parental abandonment through separation and both victims experienced care. From what is known, a victim grew up in a household with substance and alcohol misuse.

In a case, the victim was subject to grooming and criminal exploitation through sharing indecent images online. It is unclear who the perpetrator is.

Table 58. Victim demographic characteristics for sexual abuse/assault

Victim demographic characteristics	n
Gender	
Female	2
Multiple victims, gender not reported	1
Age	
8–9	1
Child (under 18) exact age not known	1
Multiple victims, age not reported	1
Ethnicity	
Not reported	2
Multiple victims, ethnicity not reported	1

Table 59. Other victim characteristics for sexual abuse/assault

Other victim characteristics	n
Absent parent(s)	2
Abuse or neglect (as a child)	2
Care Experienced Child	2
Child in Need/Child Protection	1
Criminal exploitation	1
Financial issues	1
Grooming	1
Growing up in a household in which there are adults experiencing alcohol and substance misuse	1
Learning disability	1
Parental abandonment through separation or divorce	1
Victim of crime	1
Witnessing violence (e.g. street violence, exposure to domestic abuse)	1
Growing up in a household where there are alcohol and substance misuse problems	1

Perpetrators

The perpetrators (n=2) were male, and the identity of one perpetrator (involved in creating indecent images) was not known. Most perpetrators were over the age of 18,

and one perpetrator was 17. Ethnicity was not recorded. In a case, the perpetrator was a foster carer and there is little information about him.

In a case, the perpetrator had a history of children's social care involvement (see Thomas's case study) from the age of two where he sustained non-accidental injuries and become subject to a child protection plan. The perpetrator experienced severe abuse from his mother, moved to a different local authority and was made subject of a child in need plan. As the perpetrator had multiple behavioural and emotional issues, he was supported in a residential provision.

Table 60. Perpetrator demographic characteristics for sexual abuse/assault

Perpetrator demographic characteristics	n
Gender	
Male	2
Not known	1
Age	
12–17	1
Adult (over 18) exact age not known	2
Ethnicity	
Not reported	3

Table 61. Other perpetrator characteristics for sexual abuse/assault

Other perpetrator characteristics	n
Abuse or neglect (as a child)	1
Care experienced child	1
Absent parent(s)	1
Child in Need/Child Protection	1
Domestic violence – experienced as a child	1
History of violence	1
Learning disability	1
Offending	1
Parental abandonment through separation or divorce	1
Special educational needs and disability	1
Sexualised behaviour	1

Relationship between victim and perpetrator

In one case, the young person was abused on multiple occasions, but it was abuse by a foster carer that had triggered the SCR. In one case, the identity of the perpetrator was unknown. In one case, the perpetrator abused multiple individuals, including fellow residents of the accommodation where he lived. In one case, the perpetrator abused a child who appeared to be unknown to them.

The relationships did not appear to be characterised by any other harmful behaviours or forms of abuse.

Contexts and peer groups

Victims

Living arrangements: A victim was living in family home and one victim in a foster care home. There was no information about a victim as the SCR focused on the perpetrator of sexual abuse.

Risk factors: In a case, the victim was experiencing sexual abuse in the foster home by her foster parents. The victim had been placed into care after being sexually abused by a family friend aged six. It would appear that from a young age, the victim had been known to multi-agency services due to concerns about drug and alcohol misuse and domestic violence in the household. In another case, we found that there was a lack of capacity to safeguard, whereby the mother had failed to protect the victim from creating indecent images. In a case, the victim had been assaulting other children at school and the victim told teachers ‘she hurt inside’ and ‘walking with her legs splayed open’. Although the school alerted the safeguarding lead, who consulted children’s social care to express concerns, no action was taken to escalate this incident to ensure a multi-agency response.

Protective factors: We identified protective factors in a case whereby the school had offered some support and made a safeguarding referral.

Table 62. Victim risk and protective factors across their contexts in sexual abuse/assault

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours	**1** Sexual abuse	**1** Abuse within family				
Criminality						
Harmful gender norms						
Lack of capacity to safeguard	**1** Mother failed to protect from creation of indecent images	**1** Mother failed to protect from sexual abuse by a family friend		**1** School did not escalate safeguarding concerns		
Other		**1** No contact with wider family				
Protective factors						
Were any protective factors present?				**2** Some support from school School made appropriate safeguarding referral		

Contexts and peer groups

Perpetrators

Living arrangements: A perpetrator was living in a residential provision, and one perpetrator living in a family home where he fostered children including the victim. The perpetrator (who lived in the residential provision) was a victim of physical, emotional, sexual abuse and neglect from a young age. After being placed in care, there were multiple placement moves including the most recent placement breakdown prior to the incident. In one case, there is no information about the perpetrator.

Risk factors: In a case, we found an overall insufficient response to supporting and managing the risk of the perpetrator in his residential accommodation. The perpetrator had moved from London to a placement out of the borough. There was a failure to acknowledge that the move was prompted by a previous allegation of sexual assault by a different victim. This lack of capacity to safeguard and an overall insufficient understanding of the level of risk the perpetrator posed to others.

Protective factors: We identified no protective factors in the contexts of perpetrators.

Table 63. Perpetrator risk and protective factors across their contexts in sexual abuse/assault

	Home	Family	Peer group	School	Employment	Neighbourhood
Risk factors						
Abusive behaviours		**1** Mother experienced physical abuse, emotional abuse and neglect as a child				
Criminality						
Harmful gender norms						
Lack of capacity to safeguard	**2** Insufficient supervision by staff in residential accommodation Failure to acknowledge level of risk	**1** Not safeguarded from sexual abuse by family member and latterly, family friend		**1** School did not respond appropriately to level of risk		
Other						
Were any protective factors present?						

Incident

In one case, the incident took place at the victim's home, and one of the cases in which multiple incidents took place in various public places. The incident location was not known in one case.

Escalation towards incident

There was little or no information regarding escalation of the incident in any of the cases.

Professional involvement

Victims

Victim involvement prior

The two victims for whom information was available both had absent parents and multiple instances of contact with children's social care and health services:

- A child had experienced significant adversity within her birth family, including exposure to substance and alcohol misuse, domestic violence, emotional abuse and neglect and sexual abuse. She was then taken into care by her paternal grandmother who could not care for her (she was not offered support from the local authority) and then taken in to foster care where the sexual abuse she experienced initiated the SCR.

- For the other child, there had been ongoing concerns about neglect within her school where the mother and child were accessing early help provision. These were confirmed by a home visit by the police and school social worker following her identification as the subject of indecent images in a YouTube video.

Table 64. Victim involvement in services prior to incident in sexual abuse/assault

Services	n
GP	2
School/s	2
Children's social care – child in need/child protection plan	1
Children's social care – looked after services	1
Early help/team around the family	1
Police	1
Special educational needs and disability	1
School nurse	1
CEOP social worker	1

Victim involvement after

After the incident, the victims were taken into care by children's social care. Alternative care arrangements were sought. However, there were no suitable family households for the victims to reside in. Due to the nature of one incident, the police were involved.

Table 65. Victim involvement in services after the incident in sexual abuse/assault

Services	n
Children's social care – looked after services	2
GP	1
Police	1
Not reported	1

Perpetrators

Perpetrator involvement prior

For two perpetrators, professionals had been involved because they themselves experienced abuse and neglect as children and had been in care. For example, a perpetrator was living in a special residential provision out of county, prior to the incident occurring.

Table 66. Perpetrator involvement in services prior to incident in sexual abuse/assault

Services	n
GP	2
School/s	2
Children's social care – child in need/child protection plan	1
Children's social care – looked after services	1
Early help/TAF	1
Police	1
Special educational needs and disability	1
Not reported	1

Perpetrator involvement after

All perpetrators were arrested after the incident by the police.

Appendix 8. Data extraction template

Template based on the Contextual Case Review© template[89] and adapted in consultation with the author.

1. Type of report

SCR
IIR
DHR
SAR

2. Date of incident

2019
2018
2017
2016
2015
2014
2013
2012
2011
2010
Not clear

3. People – victim and perpetrator characteristics

Please note the following data is extracted for victim and perpetrator

Victim details

If more than one victim [please specify]
How many victims in incident? [please specify]
Victim age: Write exact age
Victim gender: M/F/Other [please specify]

Victim ethnicity:
• White
  ○ White English/Welsh/Scottish/Northern Irish/British
  ○ White Irish
  ○ White Gypsy or Irish Traveller
  ○ White Other
• Mixed
  ○ Mixed White and Black Caribbean
  ○ Mixed White and Black African

[89] Firmin, C. (2017) Contextualizing case reviews: A methodology for developing systemic safeguarding practices. *Child and Family Social Work* 23(1): 45–52.

- Mixed White and Asian
- Mixed Other

- Asian/Asian British
  - Asian/Asian British Indian
  - Asian/Asian British Pakistani
  - Asian/Asian British Bangladeshi
  - Asian/Asian British Chinese
  - Asian/Asian British Other
- Black/African/Caribbean/Black British
  - Black/Black British African
  - Black/Black British Caribbean
  - Black/Black British Other
- Other
  - Arab
  - Other
- Not reported

Victim characteristics

	Description	Further information
For each victim [if more than one victim, complete for each victim]:		
Qualitative summary	*Please provide a qualitative summary of victim characteristics, in order to show the interplay between different characteristics*	Please detail
Absent parents	*Was one or both of the victim's parents absent during their childhood?*	Please detail
Abuse or neglect as a child (ACE) (sub-codes) – physical, sexual, emotional, financial, coercive control	*Has the victim experienced abuse or neglect as a child, and if so which forms?*	Please detail
Abuse or neglect as an adult	*Had the victim experienced abuse or neglect as an adult, and if so which forms?*	Please detail
Acute illness	*Illness relevant in timeframe that created a vulnerability or contributed to a vulnerability*	Please detail (e.g. having an operation isn't the same as long term condition)
Alcohol misuse	*Did the victim engage in alcohol misuse?*	Please detail
Bullying (past experience)	*Did the victim have past experience of being bullied or being a bully?*	Please detail
Caring responsibilities	*Did the victim have a caring responsibility?*	Please detail
Chronic illness or long-term condition	*Did the victim have a chronic illness?*	Please detail

Child in Need/Child Protection	*Had the victim ever been categorised as a child in need, or on a Child Protection plan?*	Please detail
Criminal exploitation	*Has the victim experienced criminal exploitation, including sexual exploitation?*	Please detail
Disability	*Was the victim disabled?*	Please detail
Domestic abuse	*Had the victim experienced domestic abuse?*	
Domestic abuse during pregnancy	*Had the victim experienced domestic abuse during pregnancy?*	Please detail
Drug dealing/county lines	*Was the victim involved in selling drugs?*	Please detail
Substance misuse	*Did the victim engage in substance misuse (other than alcohol)*	Please detail
Educational exclusion	*If under 18, was the person not in, or excluded from education?*	Please detail
English as a second or additional language	*Speaks English as a second or additional language*	Please detail
Financial issues	*Was the victim experiencing financial difficulties?*	Please detail
Gang affiliation	*Was the victim known or thought to be affiliated with a gang?*	Please detail
Grooming	*Had the victim experienced grooming by the perpetrator or someone else?*	Please detail
Growing up in a household where there is alcohol or substance misuse (ACE)	*Did the victim grow up in a household where there was alcohol or substance misuse?*	Please detail
History of violence	*Did the victim have a history of perpetrating violence?*	Please detail
LAC	*Had the victim ever been a looked after children or young person?*	Please detail
Learning disability	*Did the victim have a learning disability?*	Please detail
LGBTQI	*Was the victim lesbian, gay, bisexual, trans*, queer or intersex?*	Please detail
Low income/financial difficulties	*Did the victim have low income or financial difficulties?*	Please detail
Medication (e.g. not taking prescribed medication)	*Were there any issues relating to medication? e.g. not taking prescribed medication*	Please detail
Member of the household in prison (ACE)	*Did the victim have any members of their household in prison?*	Please detail
Mental health problems – past	*Did the victim have a history of mental health problems?*	Please detail
Mental health problems – current	*Did the victim have mental health problems at the time of the incident?*	Please detail
Migration status	*Was victim originally from outside UK?*	Please detail
Missing episodes	*Had the victim ever gone missing?*	Please detail

Offending	*Did the victim have a history of offending?*	Please detail
Parent with a mental health problems (ACE)	*Did the victim have a parent with a mental health condition?*	Please detail
Parental abandonment through separation or divorce (ACE)	*Did the victim have experience of parental abandonment through separation or divorce?*	Please detail
Special educational needs and disability	*Did the victim have special educational needs*	Please detail
Social isolation	*Was the victim socially isolated (e.g. few friends, not in a relationship)*	Please detail
Sexualised behaviour	*Did the victim display inappropriate sexualised behaviour?*	Please detail
Unemployment	*Was the victim unemployed at the time of the incident?*	Please detail
Victim of crime	*Had the victim been the victim of another crime prior to the incident?*	Please detail
Witnessing violence (e.g. street violence, exposure to domestic abuse)	*Had the victim witnessed violence incidents?*	Please detail
Others?		Please detail

Perpetrator characteristics

Same list as for victims

Relationship between victim and perpetrator

Parent or caregiver (per) to child (V)	
Child (per) to parent or caregiver (V)	
Other family relationship	*Please specify*
Intimate partner violence - If IPV, marital status at time of incident - Duration of relationship - If separated, time since separation - Reason for separation	
Other extrafamilial relationship: - Known peer (e.g. friend, neighbour) - Unknown peer (e.g. gang member) - Stranger - Other	*Please specify*
Not clear	

Characteristics of relationship

Carer	*Please detail*
Coercive control	*Please detail*
Domestic abuse	*Please detail*
Emotional abuse	*Please detail*
Financial abuse	*Please detail*

History of relationship strain/separation	*Please detail*
Neglect	*Please detail*
Physical abuse	*Please detail*
Sexual abuse	*Please detail*
Other	*Please detail*

4. Contexts – victim and perpetrator

Please note the following data is extracted for victim and perpetrator

Home

What were the person's living arrangements? - Living in family home - Living in shared private accommodation - Living in supported accommodation - Foster care - Living in residential provision (residential child care, adult care home, homeless hostel) - Homeless	*Please detail*
Were any of the following risk factors present: - Abusive behaviours - Criminality - Harmful gender norms - Lack of capacity to safeguard - Other	*Please detail*
Were any protective factors present?	*Please detail*

Family (if person not living with their family – I.e. not already covered under 'home')

No information/not applicable	
Were any of the following risk factors present: - Abusive behaviours - Criminality - Harmful gender norms - Lack of capacity to safeguard - Other	*Please detail*
Were any protective factors present?	*Please detail*

Peer group

No information/not applicable	
Were any of the following risk factors present: - Abusive behaviours - Criminality - Harmful gender norms - Lack of capacity to safeguard - Other	*Please detail*
Were any protective factors present?	*Please detail*

School (if in education)

No information/not applicable	
Were any of the following risk factors present: - Abusive behaviours - Criminality - Harmful gender norms - Lack of capacity to safeguard - Other	*Please detail*
Were any protective factors present?	*Please detail*

Neighbourhood

No information/not applicable	
Were any of the following risk factors present: - Abusive behaviours - Criminality - Harmful gender norms - Lack of capacity to safeguard - Other	*Please detail*
Were any protective factors present?	*Please detail*

5. Escalation towards incident

Insert qualitative description of escalation

Characteristics of incident

Weapons used if applicable	*Please detail*
Technology featured	*Please detail*
Location/s of incident/s	*Please detail*

Abusive behaviours experienced by victim – prior to incident

Physical	*Please detail*
Sexual	*Please detail*
Emotional	*Please detail*
Financial	*Please detail*
Coercive control	*Please detail*

Abusive behaviours experienced by victim – during incident

Physical	*Please detail*
Sexual	*Please detail*
Emotional	*Please detail*
Financial	*Please detail*
Coercive control	*Please detail*

Abusive behaviours experienced by victim – following incident

Physical	*Please detail*
Sexual	*Please detail*
Emotional	*Please detail*

Financial	*Please detail*
Coercive control	*Please detail*
Not applicable	

6. Professional involvement

Please note the following data is extracted for victim and perpetrator

Which of the following services were involved with the victim prior to the incident:

Acute health services	*Please detail*
Adult social care	*Please detail*
Ambulance service	*Please detail*
CAMHS	*Please detail*
Children's social care – child in need/child protection plan	*Please detail*
Children's social care – looked after services	*Please detail*
Counselling services	*Please detail*
Domestic abuse services (e.g. Police community safety units, DV team)	*Please detail*
Early help/TAF	*Please detail*
Educational psychology	*Please detail*
Family therapy team	*Please detail*
Food bank	*Please detail*
GP	*Please detail*
Housing	*Please detail*
Jobcentre Plus	*Please detail*
Mental health – IAPT/early intervention	*Please detail*
Mental health – community mental health team	*Please detail*
Mental health – inpatient	*Please detail*
Mental health – other	*Please detail*
Police	*Please detail*
Private sector	*Please detail*
Probation Service	*Please detail*
Special educational needs and disability	*Please detail*
Substance misuse services	*Please detail*
School/s	*Please detail*
Voluntary sector	*Please detail*
Youth offending	*Please detail*
Youth service	*Please detail*
Other	*Please detail*

Which of the following services were involved with the victim after the incident:
Same list as above

Which of the following services were involved with the perpetrator prior to the incident:
Same list as above

Which of the following services were involved with the perpetrator after the incident:
Same list as above

7. Match between issues and response

Did services attempt to intervene at each of the following levels?

	Safety created	
Individual	Yes/No	*Please describe (e.g. investigation, charges, convictions, relocation (home), managed move (school), exclusion (school), Child Protection plan, looked after*
Home (code)	Yes/No	*Please describe*
Peer group (code)	Yes/No	*Please describe*
School (code)	Yes/No	*Please describe*
Neighbourhood locality (code)	Yes/No	*Please describe*

Overall, did the level of intervention match where risk was occurring? Yes/No

8. SCR level of information

	What was the level of information in the SCR at each of these levels?	*Description* *High – thorough reporting, with sufficient information for data extraction* *Medium – some information, with some gaps in data for extraction* *Low – little or no information, significant gaps in data extraction*
Individual	High Medium Low	*Any comments?*
Home	High Medium Low	*Any comments?*
Peer group	High Medium Low	*Any comments?*
School	High Medium Low	*Any comments?*
Neighbourhood locality	High Medium Low	*Any comments?*

9. Reference individual [Standard]

Victim
Perpetrator
Both

Appendix 9. About the Violence Reduction Unit

Background

The VRU was established by the Mayor of London, Sadiq Khan, in September 2018. It brings together specialists from health, police, local government, probation and community organisations to tackle violent crime and its underlying causes.

The goals of the VRU are to:

1. Stabilise and reduce violence across London
2. Find the major causes of violence and coordinate action across London to tackle them at scale, delivering a long-term reduction in crime and associated harms
3. Involve communities in the work of the VRU and build their capacity to deliver the best long-term solutions to reduce violence.

A public health approach to violence

The VRU is committed to taking a public health approach to violence, which it defines as follows:

- **Focus on a defined population, often with a health risk in common** – Connectors could be where they live, common experiences, a health condition, or demographic characteristics, like age.
- **With and for communities** – Focus on improving outcomes for communities by listening to them and jointly designing interventions with them.
- **Not constrained by organisational or professional boundaries** – People often do not neatly sit within a service user grouping. Developing partnerships with and between organisations means that we can look across the system for solutions and not be too narrow in our approach.
- **Focus on generating long-term as well as short-term solutions** – Acting on the root causes and determinants as well as controlling the immediate impact of the problem. Identifying actions to be taken now and putting solutions in place for the future.
- **Use data and intelligence to identify the burden on the population including any inequalities in levels of risk** – Analysis of the differences between the group of people we are looking at and their peers gets to their real story and the challenges they might be facing. It tells us about the impact that these challenges have in different areas of people’s lives, like school, work or family. It also tells us about underlying causes and protective and risk factors.
- **Rooted in evidence of effectiveness to tackle the problem** – Learning, where we can, from the experience of others and evaluating new approaches. This is important so interventions can be replicated if they work or revised if they don't.

A contextual violence reduction approach

As part of taking a public health approach, the VRU is also committed to looking at the context and influences that impact on individuals – termed a 'contextual violence reduction approach'. The VRU plans[90] to adopt such an approach, focusing on:

- Children and Young People – Reducing Adverse Childhood Experiences and building resilience
- Families and Home – Support and enable them to nurture and protect young people
- Peers and Friends – Support young people to be the best they can individually and together
- Community and Neighbourhoods – Enable and Empower communities to lead from within to build sustainable futures
- Institutions and Systems – Institutions providing responsible leadership; London partners having mutual accountability to invest in what works
- City and Place – Building a London that is safe, united and inclusive
- National and International context – learn from and share with the global community to build on what works and improve outcomes for all.

[90] London Violence Reduction Unit Strategy (2019) Available at: www.london.gov.uk/moderngovmb/ieListDocuments.aspx?CId=443&MId=6342&Ver=4

Appendix 10. Stakeholder engagement

We conducted 23 scoping interviews with senior stakeholders in relevant services, policy roles and academia, in part accompanied by a member of the Behavioural Insights Team.

- Greater London Authority
- Hackney CVS
- London Adults Safeguarding Board
- London Borough of Hackney
- London Safeguarding Children Board
- Marion Brandon, University of East Anglia
- Metropolitan Police
- NHS
- NHS England
- Peter Sidebotham, University of Warwick
- Probation Trust
- Victim Support
- Victims Commissioner for London
- Violence Reduction Unit
- Youth Justice Board

January 2020

Analysis of statutory reviews of homicides and violent incidents in London

Appendices to the report for the Mayor of London's Violence Reduction Unit

This report summarises findings from research commissioned by the Violence Reduction Unit (VRU) with the aim of mapping and understanding violence in London.

The VRU was established by the Mayor of London, Sadiq Khan in September 2018. It brings together specialists from health, police, local government, probation and community organisations to tackle violent crime and its underlying causes.

The aim of this piece of work is to undertake a review of statutory reviews of homicides and serious incidents of violence in London.

First published in Great Britain in January 2020 by
the Social Care Institute for Excellence

Written by Hannah Roscoe, Florence Lindsay-Walters, Lucy Brims, Sheila Fish

Social Care Institute for Excellence

54 Baker Street
London W1U 7EX
Tel 020 7766 7400
www.scie.org.uk