Twenty-nine child homicides:

Lessons still to be learnt on domestic violence and child protection

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women's aid
until women & children are safe

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Executive summary

Women's Aid Federation of England (Women's Aid) is the national domestic violence charity which co-ordinates and supports a network of over 500 refuges, advocacy and support services for women and children experiencing domestic violence.

Women's Aid believes that all children have a right to enjoy regular contact with both parents after separation, provided it is safe for all those involved, adequate measures for protection are in place, and that it is of sufficient quality to meet the parenting needs of the child.

There is a clear overlap between the experience of domestic violence and child abuse, so it is vital that professionals working in the family justice system and in statutory agencies recognise contact with a violent parent as a serious child protection issue.

Women's Aid has compiled details of **29 children** in 13 families who were killed between 1994 and 2004 as a result of contact (and in one case residence) arrangements in England and Wales. Ten of these children were killed in the last two years. The Government has acknowledged that with regard to five of these families contact was ordered by the court.

Aim and content of the report

This report emphasises the lessons that Women's Aid believes should have been learnt from these 29 child homicides, and seeks answers to the following questions:

1. Did the court knowingly grant unsupervised contact or residence to a violent parent – and if so, has anyone been held accountable?
2. Was domestic violence recognised as a serious child protection issue?
3. Did professionals understand the dynamics of domestic violence?
4. Were children listened to and taken seriously?
5. Did frontline staff recognise significant risk indicators?
6. Was Government guidance followed?
7. Why was no Serious Case Review carried out with regard to seven of the children?

The report is largely based on the executive summaries of Serious Case Reviews, carried out after the children were killed. As we have no wish to cause further distress to relatives, we have not named any of the children.

Findings

- In three cases it is clear that not only did the court grant orders for unsupervised contact or residence to very violent fathers but that these decision were made against professional advice, without waiting for professional advice or without requesting professional advice. There was nothing to indicate that any court professionals have been held accountable.

- It is clear that domestic violence was involved in 11 out of the 13 families. In one of the two remaining cases the mother has spoken of her ex-partner's obsessively controlling behaviour (a characteristic feature of domestic violence) and in the other case there were concerns about the child's safety.

- Several of the homicides occurred during overnight stays.

- Mental health issues (including depression and suicide threats or attempts) are mentioned with regard to 9 of the 13 fathers who killed their children.

- In several cases where statutory agencies knew that the mother was experiencing domestic violence, the children were not viewed as being at risk of 'significant harm', even when she was facing potentially lethal violence.

- In five cases it is clear that the father killed the children in order to take revenge on his ex-partner for leaving him.

- Some professionals clearly did not have any understanding of the power and control dynamics of domestic violence, and did not recognise the increased risks following separation or the mother's starting a new relationship.

- In several cases professionals did not talk to the children and this meant that, in effect, there was no assessment of their needs. Sometimes this was because the perpetrator prevented any meaningful contact with the child.

- With regard to the five homicide cases where contact was ordered by the court, we can only assume that the court did not follow the recommendation in the Good Practice Guidelines about ensuring the safety of the child and the resident parent before during and after contact. The guidance in *Working Together to Safeguard Children* about supporting the non-violent parent also appears to have been largely ignored.

- No explanation was given for the failure to carry out Serious Case Reviews with regard to seven of the children who were killed

Women's Aid recommendations

- Serious Case Reviews should always be carried out when children are killed in circumstances which suggest previous information about violence or abuse within the family, and family court professionals should be required to take part whenever this is relevant.

- Mechanisms are required for holding family court professionals accountable for decisions that result in children being killed or seriously harmed. If found to be responsible, professionals (judges, magistrates, barristers, solicitors, expert witness or family court adviser) should lose their right to adjudicate, represent parties, provide evidence or report to the court in family proceedings.

- All statutory workers with child protection responsibilities should receive training to enable them to understand the dynamics of domestic violence and its links with child protection, and to recognise significant risk indicators.

- Legislation should require the courts to assess risk and to prioritise the safety of the child in all cases involving allegations of abuse, because there is always likely to be risk in contact disputes involving domestic violence.

- The Government should require professionals working in statutory agencies and within the family justice system to prioritise supporting non-violent parents in making safe choices for themselves and their children.

- A person who is awaiting trial for a violent offence against a family member should not be allowed to have unsupervised contact with a child.

- In cases where there are allegations of abuse but insufficient evidence to prove this, children should be assessed in a child-friendly environment using appropriate techniques over several weeks to establish the child's perspective and whether the child is at risk, and to make appropriate recommendations for the child's welfare, because children are very unlikely to disclose abuse during a one-off interview with a person, whom they do not know and trust.

- Independent domestic violence advocacy services and supervised contact facilities should be available in every local area as part of a co-ordinated community response to domestic violence.

- The Government should commission research to identify significant risk indicators for children in cases of domestic violence where there are contact or residence proceedings or arrangements.

- Evidence from information sharing databases of domestic violence and its adverse affects on children should be made available to the family justice system, including CAFCASS. Safeguards must also be provided to ensure that the basic details contained on the databases cannot be used by domestic violence perpetrators to track down their victims.

Introduction

Women's Aid Federation of England (Women's Aid) is the national domestic violence charity which co-ordinates and supports a network of over 500 refuges, advocacy and support services for women and children experiencing domestic violence. Women's Aid's work is built on 30 years of working in partnership with national and local government, health authorities, the justice system and voluntary organisations to promote the need for an integrated approach to prevent domestic violence and to protect abused women and children.

Women's Aid defines domestic violence as physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour. Crime statistics and research both show that domestic violence is gendered – usually perpetrators of a pattern of violence are male, and it is women that experience the most serious physical and repeat assaults[1].

There is a clear overlap between the experience of domestic violence and child abuse. In 2003 the Department of Health stated***: "At least 750,000 children a year witness domestic violence. Nearly three quarters of children on the 'at risk' register live in households where domestic violence occurs."***[2]

Domestic violence is a major indicator of risk to children, and perpetrators who are violent to their female partners are also frequently violent to their children.[3] These children also tend to have the worst outcomes in child protection cases.[4] In a recent analysis of Serious Case Reviews of child deaths, one of the commonly recurring features was the existence of domestic violence.[5]

Home Office statistics show that 116 women were killed by current or former male partners in 2001/02,[6] and homicide reviews have found that post-separation contact between children and a violent parent poses a significant risk.[7] Despite this, although domestic violence features in about **16,000** cases a year where court welfare reports are ordered[8], contact was refused in only **601** cases in 2003 (less than 1% of cases).[9]

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[1] Walby S and Allen J (2004) *Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey*, Home Office Research Study 276.
[2] Department of Health (2003) *Into the Mainstream – Strategic Development of Mental Health Care for Women, (*p.16)
[3] Hester, M., Pearson, C. & Harwin, N. (1999) *Making an Impact.* London, Jessica Kingsley.
[4] Farmer & Owen (1995) *Child Protection Practice: Private Risks & Public Remedies.* HMSO.
[5] Websdale (1999) *Understanding Domestic Homicide*
[6] Home Office (2003) *Crime in England & Wales 2001/2002: Supplementary Volume.*
[7] Richards L (2003) *Domestic Violence Murder Review Analysis of Findings*, Metropolitan Police Service.
[8] Association of Chief Officers of Probation (1999) *Response to the consultation on Contact between Children and Violent Parents.*
[9] Department for Constitutional Affairs (2004) *Judicial Statistics, Annual Report 2003.*

Women's Aid has compiled a list of **29 children** in 13 families who were killed as a result of contact (or in one case residence) arrangements in England and Wales between 1994 and 2004. Ten of these children were killed during the last two years. As the Government has not collected statistics on child contact homicides, the actual number could be higher. **With regard to five of these families contact was ordered by the court.**[10]

In five of these child homicide cases the Serious Case Review ordered by the Area Child Protection Committee[11] states that there was no way in which the tragedy could have been predicted or prevented. Women's Aid does not accept this view.

The aim of this report is therefore to consider the lessons that should have been learnt in relation to these 29 child homicides. In particular, we set out to answer the following questions:

1. Did the court knowingly grant unsupervised contact or residence to a violent parent – and, if so, has anyone been held accountable?
2. Was domestic violence recognised as a serious child protection issue?
3. Did professionals understand the dynamics of domestic violence?
4. Were children listened to and taken seriously?
5. Did frontline staff recognise significant risk indicators?
6. Was Government guidance followed?
7. Why was no Serious Case Review carried out with regard to seven of the children?

This report is largely based on publicly available information from the executive summaries of Serious Case Reviews, which are sometimes very brief or indeed non-existent. Some Area Child Protection Committees (ACPCs) do not comment on the case but simply provide 'learning points'. In three cases (involving the killing of seven children) there was no Serious Case Review. In another case we were informed by the local authority that a Serious Case Review had been carried out, but there was no executive summary because the children were killed before 1999 when revised guidance required ACPCs to provide executive summaries. For these reasons the information available is incomplete, and there may have been examples of good practice that were not included in the executive summaries and perhaps also good (unexplained) reasons for some of the decisions that were taken or not taken.

Women's Aid has no wish to cause extra distress to the mothers or relatives of children who have been killed. This report therefore comments on individual cases anonymously, and the main focus is on the policy and practice issues that need to be addressed, if similar tragedies are to be prevented in future.

[10] Letter (16.7.2002) to Women's Aid from Rosie Winterton MP, Parliamentary Secretary, Lord Chancellor's Department.
[11] Required by Part 8 of *Working Together to Safeguard Children.*

National context

Legislative and policy developments

The Children Act 2004 is essentially the Government's response to the abuse and killing of one child, Victoria Climbié. As the statutory services failed to protect Victoria, the Act seeks to improve child protection by establishing clear lines of accountability for children's services and requiring statutory agencies to co-operate and share information about children.

However, the Children Act 2004 does nothing to address another serious child protection issue – the frequent failure of the family justice system to ensure the safety of children involved in contact or residence proceedings with violent parents.

In New Zealand, when three children were killed by their violent father after the court had granted him residence, they held a ministerial enquiry and then amended their family law to require the courts to prioritise the safety of the child in contact or residence cases involving allegations of abuse *(see page 31).* While the Children Bill and the Domestic Violence, Crime and Victims Bill progressed through parliament, there were several attempts to introduce similar amendments here, but they were all rejected by the Government.

In the Green Paper on *Parental Separation*[12] the Government acknowledges that: ***"It is vital – particularly if we are to provide for better enforcement of contact orders – that issues of domestic violence are fully and properly dealt with by the courts. Contact arrangements which put the safety of the child or the resident parent at risk should***

[12] Department for Constitutional Affairs, Department for Education and Skills and Department for Trade & Industry (2004) *Parental Separation: Children's Needs and Parents' Responsibilities (para.46).*

not be put in place. (…) That is not to say domestic violence should automatically determine that a child should have no contact but it does mean arrangements need to be put in place which ensure that contact is safe for everyone" *(para.46).* Women's Aid shares this perspective. We believe that all children have a right to enjoy regular contact with both parents after separation, provided it is safe for all those involved, adequate measures for protection are in place, and that it is of sufficient quality to meet the parenting needs of the child.

However, the Green Paper on *Parental Separation* acknowledges that implementation of the Good Practice Guidelines on child contact and domestic violence has been "*patchy*" *(para.48).* It also reports that "*judges and others have said that there is insufficient provision of supervised contact centres*" *(para.18).* We have concerns about future legislative proposals arising from this Green Paper to enforce contact orders more rigorously. Contact must be safe before it is enforced

The Government intends to address the need for safe contact by implementing a recent amendment to the Children Act 1989 (expanding the definition of harm to include "*impairment suffered from seeing or hearing the ill-treatment of another")* and introducing new court application forms with specific questions about domestic violence. However, these safeguards proposed in the Green Paper are not sufficient to prevent children from being abused, neglected, abducted or killed during contact visits with violent or abusive parents.

This is because the new measures being introduced in January 2005 will not overrule case-law precedents, which state that "*contact is almost always in the interests of the child*"[13] and which require a higher standard of proof than the simple balance of probabilities in cases involving "*more serious allegations*".[14] Nor will they prevent the courts from enforcing contact orders in serious cases of domestic violence, because that is exactly what the Appeal Court did in *Re A v N.*[15]

At present confidentiality rules mean that there is no scrutiny of family proceedings and no effective means of holding family court professionals accountable for decisions, which result in children being killed or seriously harmed.

Serious Case Reviews should always be carried out when children are killed in circumstances which suggest previous information about violence or abuse within the family, and family court professionals should be required to take part whenever this is relevant. Mechanisms are needed for holding family court professionals accountable for decisions that result in children being killed or seriously harmed. If found to be responsible, professionals (judges, magistrates, barristers, solicitors, expert witnesses or family court advisors) should lose their right to adjudicate, represent parties, provide evidence or report to the court in family proceedings.

Another key national agency that has a critical role in contributing to the protection of children is the Children and Family Court Advisory and Support Service (CAFCASS), which, despite these child homicide cases, has not introduced a national policy on domestic violence or on risk assessment.

The requirement to undertake Serious Case Reviews

[13] Court of Appeal ruling in *Re O (Contact: Imposition of conditions)[1995]*
[14] House of Lords ruling in *Re H & R (Child sexual abuse: Standard of proof)[1995]*
[15] Court of Appeal ruling in *Re A v N (Committal: Refusal of contact)[1996].*

In 1991 the Government issued *Working Together Under the Children Act 1989,* a guide to arrangements for inter-agency co-operation for the protection of children from abuse. Part 8 of this document contains the following statements:

> *8.1 Whenever a case involves an incident leading to the death of a child where child abuse is confirmed or suspected, or a child protection issue likely to be of major public concern arises, there should be an individual review by each agency and a composite review by the ACPC. (…) The timely production of well-conducted case review reports with clear conclusions, and where necessary, positive recommendations for action, should in most cases enable the ACPC and individual agencies to be assured that all necessary lessons are learnt and public concern satisfied.*
>
> *8.19 The aim of the ACPC overview report should be to ensure that any lessons from the events under review are acted upon promptly and effectively.*

In 1999 this guidance was revised and reissued as *Working Together to Safeguard Children.* Part 8 now states:

> *8.1 When a child dies, and abuse or neglect are known or suspected to be a factor in the death, local agencies (…) should consider whether there are any lessons to be learned from the tragedy about the ways in which they work together to safeguard children. Consequently, when a child dies in such circumstances, the ACPC should always conduct a review into the involvement with the child and family of agencies and professionals.*

Paragraph 8.2 states that the purpose of reviews is to establish whether there are lessons to be learned and to identify those lessons and how they will be acted upon to improve inter-agency working and better safeguard children.

Paragraph 8.30 states:

> *In all cases, the ACPC overview report should contain an executive summary that will be made public, which includes as a minimum, information about the review process, key issues arising from the case and the recommendations which have been made. Such publication will need to be timed in accordance with the conclusion of any related court proceedings. The content will need to be suitably anonymised in order to protect the confidentiality of relevant family members and others.*

Please note, throughout this report on child contact homicides, statements made in quotation marks are taken directly from the executive summary of the relevant Serious Case Review, unless attributed to some other source. In the interests of confidentiality the names of the families and the local authorities have been omitted. For the same reason we have also not provided references for newspaper reports of coroner's hearings or murder trials. We are willing to provide this information to the Government, if requested.

Women's Aid questions

1. Did the court knowingly grant unsupervised contact or residence to a violent parent – and has anyone been held accountable for this?

It has not been possible for Women's Aid to identify all of the five cases where contact was ordered by the court and the children were subsequently killed[16]. This is because the executive summaries of the Serious Case Reviews do not always state whether contact or residence was ordered by the court or agreed informally by the parents.

However, in three cases it is clear that not only did the court grant orders for unsupervised contact or residence to very violent fathers but that these decisions were made against professional advice, without waiting for professional advice or without requesting professional advice:

- *In one case a judge granted residence of two children to a very violent father without waiting for a mental health assessment of the father, although the Social Services report "outlined an expectation that [the father] would receive treatment for his mental health needs". He had apparently taken an overdose recently and declined hospital admission. The court also determined "detailed direct and indirect contact between each child and the non-custodial parent". The child, who chose to live with the mother, was subsequently killed by the father during an unsupervised contact visit. It was reported at the father's trial that he had also left a note indicating that he intended to kill all three children to take revenge on his wife for leaving him. The Serious Case Review states that "**with hindsight, it could be argued that the Court should have waited before making a final decision until all the recommended reports were placed before them**". However, the executive summary does not contain any recommendations with regard to court practice.*

- *In another case the father was on bail, awaiting trial for injuring the mother during a violent incident. The executive summary states that "…no significant risks of a child protection nature were identified. Nevertheless the **Family Court Welfare Officers had recommended to the County Court that the (children's) contact with their father should not include overnight stays." In spite of this the mother's lawyer "encouraged her to make a compromise" and the judge "made the decision on contact, contrary to the recommendations in the Family Court Welfare report**." The children were killed during the first overnight stay. The local authority confirms that they brought this case to the attention of the Lord Chancellor's Department. Neither the judge nor the solicitor was involved in the Serious Case Review. The local authority states: "We took advice on this from SSI and were advised it would not be possible."*

- *In a third case two children were killed by their violent father after their mother was reluctantly persuaded at the door of the court to agree to a contact order by consent. The mother states that she asked in vain for reports from the police, the GP and a psychiatrist to be added to the court welfare report. After her children were killed, a member of her family wrote to inform the judge of what had happened, but she was appalled to discover*

[16] Letter dated 16.7.2002 to Women's Aid from Rosie Winterton MP, then Parliamentary Secretary, Lord Chancellor's Department.

> *subsequently that his secretary had concealed this letter from him because she was afraid that he would find it upsetting.* ***Despite considerable involvement with the police and medical services, no Serious Case Review was carried out in this case.***

We have not been able to identify the other two homicide cases in which contact was ordered by the court, as the executive summaries do not always state whether the family court was involved.

However, the three cases mentioned here raise serious questions about accountability within the family justice system. Indeed, with regard to these three homicide cases, it is not clear whether all the family court professionals involved even discussed the case following the killing of the children.

Women's Aid has written to the Chief Executive of the Children and Family Court Advisory and Support Service (CAFCASS) asking whether they have established procedures for responding to cases and ensuring that lessons are learnt when a child is killed or suffers significant harm as a result of decisions made within the family justice system. No reply has been received.

In other professions where a person makes a decision that results directly or indirectly in the death of a child, there would normally be some means of holding that person to account. However, judges are immune from prosecution with regard to judicial decisions, and even after the death of a child, documents such as the court welfare report are still protected from scrutiny under the confidentiality rules in family court proceedings.

Until evidence is provided to the contrary, Women's Aid believes it would be wrong to assume that the pro-contact culture of the family justice system had no bearing on the other homicide cases, where contact was agreed informally. This is because any solicitor or family court adviser providing realistic advice for an abused woman, who is concerned about the safety of her child, would normally point out that contact is hardly ever refused so litigation is very unlikely to be successful. In our experience such advice often results in abused women reluctantly agreeing to unsafe informal contact arrangements.

One mother describes the pressure that can be put on an abused woman in this position. She states: *"They tell you, if you don't agree to give him access, the judge will just put you both in the witness box, you'll do a character assassination on each other, and he'll grant overnight access to him anyway. Their remit is, all children should see mum and dad. They think, no matter how badly he's beaten me, and no matter what sort of role model he might be, and no matter whether he would go on to harm them, the children should still see their father."* Her children were killed before Good Practice Guidelines were introduced in 2001 recommending, but not requiring, the courts to ensure the safety of the child and the resident parent before, during and after contact in cases of domestic violence.

If the courts are determined to grant contact even in high risk cases, professionals working in statutory agencies may feel that there is very little they can do to protect the children. This view is clearly expressed in one of the executive summaries, which states: *"Given the involvement of the court prior to [the child's] death in determining contact arrangements and the wishes of [the children] to see their father, there would seem to have been no opportunity nor grounds for any inter-agency intervention that could have prevented [the child's] death".*

Women's Aid recognises the difficulties but does not accept this view, particularly as this executive summary does not mention any attempt to provide support for the non-violent parent as recommended in *Working Together to Safeguard Children (see page 24).* These issues are examined further throughout this report.

2. Was domestic violence recognised as a serious child protection issue?

It is clear that domestic violence was involved in 11 out of the 13 families, where children were killed due to contact arrangements. In one of the two remaining cases the mother has spoken of her ex-partner's obsessively controlling behaviour (a characteristic feature of domestic violence) and in the other case domestic violence is not mentioned but it is clear that there were concerns about the child's safety.

The previous section has shown that domestic violence is not always recognised as a serious child protection issue by family court professionals dealing with private law contact or residence cases. However, the executive summaries indicate that before the children were killed, statutory agencies were also involved in 8 of the 10 cases, where Serious Case Reviews were subsequently carried out, so this section focuses on whether these professionals were aware of the risks to the children.

The central message of *Making an Impact,* a training pack launched in 1998 by the Department of Health, is that professionals working with children should be aware that domestic violence is an important indicator of risk of harm to children and that children are frequently abused physically, sexually and emotionally by the same perpetrator as their mother.[17] Children whose mothers experience domestic violence are also likely to have the worst outcomes in child protection cases.[18]

These risks frequently continue after the parents have separated. One third of all abuse occurs post-separation,[19] and contact is a particular danger point.[20] In these circumstances children are often abused, and the family justice system does not always ensure their safety. In 1999 a survey found that 76% out of 148 children ordered by the courts to have contact with a violent parent were said to have been abused as a result of contact visits.[21] More recently, a survey involving 178 specialist domestic violence organisations across England and Wales found that only 3% believe that appropriate measures are now being taken to ensure the safety of the child and the resident parent in most contact cases involving domestic violence.[22]

The widespread prevalence of domestic violence clearly makes it difficult for hard-pressed statutory agencies, such as social services and the police, to respond adequately to the needs of children in these families. However, in some of these cases there was considerable involvement with statutory agencies, which clearly did not result in the children being protected. So what went wrong?

Several executive summaries make it clear that the children were not viewed as being at risk of 'significant harm':

- "*It is known that [the father] had been violent to [the mother] on a number of occasions and all agencies had contact with the family. However**, at no point did any agency ever***

[17] Hester, Pearson & Harwin (1999) *Making an Impact.* Jessica Kingsley Publications.
[18] Farmer & Owen (1995) *Child Protection Practice: Private Risks & Public Remedies.* HMSO.
[19] *1996 British Crime Survey England & Wales (Issue 19.96)*
[20] Hester & Radford (1996) *Domestic Violence and Access Arrangements for Children in Denmark and England.* Policy Press, University of Bristol.
[21] Radford, Sayer & AMICA (1999) *Unreasonable Fears? Child contact in the context of domestic violence: A survey of mothers' perceptions of harm.* Bristol, Women's Aid Federation of England (p20).
[22] Saunders, H. & Barron, J. (2003) *Failure to Protect?* Women's Aid Federation of England.

believe there was a risk of 'significant harm' to the children or that they were in need of protection. *As a result the children were never the subjects of a Child Protection Investigation or Child Protection Committee." The executive summary also states: "Particular attention should clearly have been given to the children's whereabouts when the violence took place; the timing of the violence, it was clearly occurring in the early hours of the morning; and the exact nature of the incident ie. the fact that some incidents involved knives should have been treated very seriously." In this case the police had been called to a number of violent incidents, and the mother had disclosed that she believed [the father] was capable of 'taking a number of lives including his own'.*

- *In a second case the police had been called out to three domestic incidents following the parents' separation, including an incident where the mother was injured, and the father was remanded on bail. Despite this the executive summary states that* ***"no significant risks of a child protection nature were identified."***

- *In a third case "the police attended an incident following an argument when [the mother] alleged that [the father] had grabbed her around the neck. The children were present during this incident." Four days later "the police were called by neighbours who heard screaming", the father was charged with actual bodily harm and released with stringent bail conditions, which he broke within two days. The following month "it was reported that [the mother] had fallen out of a first floor window and that there had been an argument with her boyfriend when he had tried to kill her." The executive summary then states:* ***"Social Services staff highlighted to [the mother and father] the dangers for the children of domestic violence. The case was seen as one of family support rather than child protection."***

With regard to these cases it is tempting to ask just how much domestic violence needs to occur within a family before it is recognised as a serious child protection issue. It could also be argued that by focussing mainly on whether there was 'significant harm' to the children, the statutory agencies failed to take sufficient account of the escalating violence that would soon engulf the children.

In 2000 two eminent child psychiatrists, Sturge and Glaser wrote a report[23] about the effects of domestic violence on children for use in four test cases being heard by the Court of Appeal - *Re L, V, H & M.* The report emphasised that domestic violence has deleterious effects on children, that threats to the carer on whom the child is dependent have more serious consequences in young children than attacks on themselves, and that domestic violence involves a very serious failure in parenting.

The key learning point here is that, if the child's primary carer is facing a potentially lethal level of violence, this should always be recognised as a serious child protection issue and efforts should be made to ensure the safety of both the non-abusing parent and the child(ren).

In one of the child homicide cases the violence was not only directed at the mother and child but also at professionals working within statutory agencies – and still this was not recognised as a dangerous situation for the children living in that family:

- *The executive summary states****: "When domestic violence was identified it was not deemed relevant to child protection concerns."*** *The Police and Social Services made two joint visits to the family, one as a result of a domestic violence incident, and the other "an alleged incident of non-accidental injury" to [the child whom the father subsequently*

[23] Sturge, C & Glaser, D. (2000) Contact *and Domestic Violence – The Experts' Court Report.* London, Family Law.

killed]. They concluded that "there was no evidence of any injuries to any of the children, or other concerns that would have warranted further action at the time." The executive summary also states that the father "had a criminal record which included offences of violence. In his contacts with professionals he was abusive both verbally and physically, and numerous occasions of this behaviour are recorded by all agencies. Legal advice was sought on at least two separate occasions about taking steps to prevent [the father] from entering local authority premises and to protect staff. If behaviour is so extreme as to warrant this type of action, questions about the safety of children in the family should have been asked."

There was also a tendency, noted in two cases, for professionals to focus on the needs of the adults rather than the children:

- *A young child remained in the family home with the violent father after the mother and an older child had fled to a refuge. The executive summary states: "It was known that [the father] had a history of violence towards his wife and as part of the communication process, a discussion took place between the duty social workers and the Police Domestic Violence Unit concerning the background. There was no suggestion of past violence towards children and there was no history of mental illness in this family. However, it appears that there was no mention of the history of violence to the duty CMHT (Community Mental Health Team) when their involvement was requested. Neither had there apparently been any mention of the fact that [the mother] had left the family home and was living in a refuge with her older child." "It was perhaps the very fact that [the child] did appear well and generally unaffected by events that led some of the professional interventions to become adult, rather than child-focussed." Instead concern shifted to the father's well-being and how difficult he would find life, if the child was not there "to keep his father together". In discussions with the extended family the Duty Social Worker challenged the view that there was no risk to the child from his father, but the Review Group found that "there was a lack of a child centred approach". The case was closed before the child was killed, although "no realistic assessment of risk to [the child] had been made."*

- *Another executive summary states in conclusion: "All agencies appeared to overlook the links between domestic violence and the protection needs of children. Overall, they tended to focus on the adults' behaviour and needs."*

Finally, in a case where there is no mention of domestic violence, the executive summary of the Serious Case Review includes the following recommendation:

> *"In every case referred to Psychiatry where the patient is a parent and there are issues of disputed custody, unsupervised contact etc, psychiatrists should be mindful of the broader family context and should consider consulting Social Services (Adult Services or Mental Health Services) and/or checking the Child Protection Register."*

With regard to this case it is not clear whether the family justice system was involved and, if so, whether the psychiatrist was an expert witness. We have included this information here, because **mental health issues including depression and suicide threats or attempts are mentioned with regard to 9 of the 13 fathers who killed their children.**

It should also be stressed that the failure of a psychiatrist to make such a basic check is extremely serious in the context of child protection and disputes about contact. A psychiatric report would usually be significant in determining the responses made by statutory agencies and would also be important evidence in family proceedings, so it is essential that basic checks are made. It is hoped that the information sharing measures outlined in the Children Act 2004 will make this easier.

3. Did professionals understand the dynamics of domestic violence?

It is widely acknowledged that domestic violence perpetrators have an obsessive need to exert power and control over their partners and also over their children.[24] Indeed, perpetrators maintain control by seeking to ensure that their victims are too frightened or too ashamed to mention the abuse to anyone else or to flee from the family home. Key tactics include making dire threats, isolating victims from their friends and relatives, and preventing them from having contact with helping agencies or sitting right beside them when they do. The following comments from executive summaries show that this was clearly a major problem in two cases:

> *"[The father] appeared to be able to control the decision-making of professionals in his absence. There are also examples of the control [he] exerted over his family. He also refused routine paediatric surveillance and immunisation of the children at times, and interfered with their normal medical care by frequent changes of GP and the refusal of consent for surgery for [the child whom he killed]."*

> *"[The child] was seen on two occasions by the duty social worker, once on a joint home visit with the Police after the failed attempt to return [the child] to the mother's care, and then a few days later when [the father] briefly attended the Social Service office with [the child]. On both these occasions [the father] was in control of the situation in terms of not allowing the professionals to have any meaningful contact with [the child]." In this case the father also refused to co-operate with professionals and did not accept the need for a mental health assessment.*

It is essential that statutory and voluntary agencies dealing with cases of domestic violence should be able to recognise controlling behaviour and to respond in a way that enables abused women and children to speak freely. More fundamentally, there is a need to build up trust with children and with the non-violent parent, so that they can feel confident enough to disclose what is happening within the family. This can be a slow and painful process, because most mothers who experience domestic violence say that their greatest fear is that their children will be taken into care,[25] and for this reason they are likely to be very distrustful of statutory agencies.

Frontline staff also need to be aware that abusers often monitor every interaction involving their partner, including phone-calls and letters, so any attempt to communicate in this way could potentially endanger both the non-violent parent and the children. One executive summary states:

> *"It is important in tackling violence against women that the women involved are encouraged and enabled to come forward to seek help and support. Contact therefore needs to be handled extremely sensitively to ensure the woman is not put at risk of further violence. It requires staff, particularly within statutory agencies, to develop a creative approach to making contact. For example, using the school and staff there as a contact point and/or communication channel. This ensures that letters are not sent to the home where the perpetrator of violence can open them. Unfortunately letters were sent in this way in this case."*

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[24] Pence, E. (1985) *Coordinated Community Response to Domestic Assault Cases.* Duluth, Minnesota, Domestic Abuse Intervention Project.
[25] Abrahams, C.(1994) *The Hidden Victims.* London, NCH Action for Children.

As perpetrators have such a strong need to maintain power and control over other family members, it is perhaps not surprising that they are often most dangerous when they can no longer control the situation eg. when the non-violent parent has fled from the family home taking the children. Indeed, research repeatedly shows that women are at greatest risk of homicide at the point of separation or after leaving a violent partner.[26]

For this reason it is crucial for professionals to be aware of the high risk of post-separation violence. That awareness is clearly lacking in one case. The executive summary states:

> *"…recent contact with the family did not indicate that circumstances had changed, apart from the recent separation of [the mother and father]. There was still no evidence of direct harm to the children."*

In two of the contact homicide cases, violent fathers were facing the ultimate loss of power and control, as they were awaiting trial with the possibility of being sent to prison for violent offences against their ex-partner. Instead both of them chose to kill themselves and their children. In one of these cases the court welfare report recommended that there should be no overnight stays. However, on the basis of this evidence **Women's Aid recommends that in those cases where a parent is awaiting trial for a violent offence against a family member, unsupervised contact of any kind should not be recommended or granted**.

Finally, it is important to note that some violent parents kill their children as a means of taking revenge on their former partner for leaving them. It is very clear that five of these cases could be described as "revenge killings":

- *In one case the coroner described the father as vindictive and commented,* "*He viewed the children as his possessions. If he personally could not have them, then no one else would*."

- *At the trial of another father, the prosecution QC described him as follows: "He was seething. He knew he could no longer control his wife. Apart from seething, he was wallowing in self-pity. 999 calls will show us the self-pity he was feeling and the anger he felt towards his wife. He then took what he saw as being the ultimate revenge by killing their two children. This was the most vicious way he could strike back at her, because she had left him. He wanted to teach her a lesson she would never forget."*

- *One mother stated that her ex-partner phoned to tell her that he had killed their child and when she asked him why, he replied: "If I can't have you, you can't have [the child]."*

- *Another mother stated that her ex-partner phoned to let her know that he had killed the children and commented: "You've hurt me. Now I'm going to hurt you."*

- *One father told his ex-partner over the phone what he was doing, so that she could listen in horror as her children were asphyxiated. This was his response to learning that she had found a new partner, whom she was pregnant by. Apparently he commented: "I hope you're happy. I hope you have a grudge against that baby for the rest of your life."*

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[26] For example: Wilson & Daly (1992) *Homicide.* New York, Aldine de Gruyter; Walby & Myhill (2001) *Assessing and Managing Risk* in Taylor-Browne (2001) *What works in reducing domestic violence?* London, Whiting Birch. For an overview of research into homicide risks see Paradine & Wilkinson (2004) *A Research & Literature Overview: Protection and Accountability: the Reporting, Investigation and Prosecution of Domestic Violence Cases* HMCPSI / HMIC.

In the other cases the motivation for killing the children was not reported, but it could be argued that most of these child homicides were "revenge killings", and we would like to see the Government analyse these Serious Case Reviews to establish if revenge was indeed the motive for these killings.

4. Were children listened to and taken seriously?

The welfare checklist in Section 1(3) of the Children Act 1989 requires the family courts to have regard to "the ascertainable wishes and feelings of the child concerned" (considered in the light of his age and understanding). Whether or not the wishes and feelings of the children were considered is often not mentioned in the executive summaries of the Serious Case Reviews, but in some cases it is clear that professionals did not even talk to the children.

This can be very difficult in domestic violence cases, because the perpetrator will usually make sure that there is no opportunity for the non-violent parent or the children to speak freely. Often they will also be too frightened or too ashamed to say anything, even when the perpetrator is not there as they may be scared of the consequences of speaking out. As already noted, two of the executive summaries express frustration that the father was able to control the situation in this way. It is likely that similar constraints made it difficult to talk to the children in the other cases.

In one case the Review Panel concluded that the welfare report on the children was "sufficiently child-focussed". However, **in several cases the failure to talk to children meant that, in effect, there was no assessment of their needs:**

- *"The issue of the children's safety appears to have been lost in the concentration on the adults. It was noted by the Panel that the children appeared effectively hidden from view. It was apparent that no one ever asked the children directly about what they had witnessed and how it made them feel. In reality, no assessment of the children's needs really took place."*

- *"Another significant factor to emerge with the benefit of hindsight is the need to undertake full and holistic assessments of the needs of children and their carers. This would include the views of the children and the impact on them of living within their particular family. In respect of this family no single agency had the full picture or identified the need to make a full assessment of the situation. (…) This family was known to a number of agencies over a long period of time and in this situation there is the potential to respond and provide a service without taking full account of the presenting issues on each occasion. A sort of 'agency exhaustion' sets in. The additional fact with this family was the level of hostility and personal danger to professionals presented by [the father]."*

- *One executive summary contains the following recommendation: "Where a service user describes a history of marital violence that a detailed history is taken to establish the risk to the service user and any children." Apparently in this case the children were doing very well at school, so there was 'no indicator of need'.*

In some cases the fact that the children appeared to be healthy seems to have convinced statutory agencies that they were unaffected by the domestic violence and therefore not at risk:

> *In one case, where there is no mention of anyone talking to the children about the serious violence they had witnessed, the executive summary comments: "Both schools saw the [children] as normal healthy pupils who on the whole enjoyed the school experience and were very popular with other children. They did not disclose or indicate any distress to their teachers*." *Besides*, *"there were no known instances where any physical harm had come to the children in the past".*
>
> *In another case, there was a "very limited attempt" to ascertain the child's wishes and feelings, but it was noted that the child appeared physically well and "unaffected by events".*

One executive summary, which hardly says anything about the case, includes the following learning points:

- *"Getting the concerns of professionals through to the Courts in cases where private law proceedings are involved.*
- *"The importance of helping children to get their voice heard."*

This suggests that there were court proceedings in this case and that the children had concerns about their situation, which were not taken into account. However, due to the omission of case details, it is impossible to ascertain whether there was indeed a court order and, if so, whether the children's views were or were not reported to the court.

The psychiatrists' report by Sturge and Glaser[27] emphasises that emotional trauma can be deep-seated and persistent, and that children must be listened to and taken seriously if they do not want to see a violent parent. However, this does not appear to be happening in practice. In 2003 a Women's Aid survey involving 178 domestic violence services in England and Wales found that only **6%** believe that children who say they do not want contact with a violent parent are being listened to and taken seriously in most cases. Clearly this is a deep-seated problem, which urgently needs to be addressed by the family justice system and CAFCASS in particular.

Women's Aid recommends that all statutory workers with child protection responsibilities should receive training to enable them to understand the dynamics of domestic violence.

However, there is a further consideration. If a child says that he or she wants to see or live with a violent parent, should a 'child-centred' statutory agency always accede to the child's wishes? This issue is highlighted by the following comments in one of the executive summaries:

> *"The result of the Court proceedings was to determine residence and detailed direct and indirect contact between each child and [the] non-custodial parent. It appears at this time that the wishes and feelings of the children were being listened to and acted upon." (In this case there was a long-standing history of serious domestic violence and the father had also been violent or threatening to people outside the family, including professionals).*

As very few children are granted separate representation in private law contact and residence proceedings, it is vital that family court professionals should assess risk carefully and be aware of the need to protect children, particularly in cases involving domestic

[27] See footnote 23.

violence. Children should have a right to protection as well as a right to be heard – but this often seems to be overlooked in current family court practice.

Women's Aid also recommends that in cases where there are allegations of abuse but insufficient evidence to prove this, children should be assessed in a child-friendly environment using child-friendly techniques over several weeks to establish the child's perspective and whether the child is at risk and to make appropriate recommendations for the child's welfare. This is necessary because children are very unlikely to disclose abuse during a one-off interview with a person whom they do not know and trust.

5. Did frontline staff recognise significant risk indicators?

*One executive summary states: "Clearly, women need to feel empowered and engaged if they are to leave violent relationships. However, the dilemma for statutory agencies is when the level, frequency and impact of the violence becomes so significant that those agencies need to take action because of the 'likelihood of significant harm' to the children**. In cases of domestic violence, staff require clear guidelines, protocols and, most importantly, risk assessment tools that guide them in deciding when this threshold has been reached. (…) It appeared to the Review Panel that the staff operating in this case had few of these 'tools' at their disposal and there was a lack of awareness about the link between domestic violence and risk to children**."*

Although some agencies, including the National Probation Service and some police forces, have formal systems for assessing and managing risk in the context of domestic violence experienced by adults, others do not. Many frontline practitioners – including police officers and social workers – have low levels of knowledge and understanding about indicators of potential serious harm in domestic violence cases.[28] However, to our knowledge, risk assessment and management tools have not been developed specifically to identify *children* who face a significant risk of being killed by a violent parent as a result of contact or residence arrangements.[29] As the recent criminal justice thematic inspection into domestic violence points out: "*We need to know more about risk factors associated with violence against children and domestic violence."*[30]

A recent study of 40 Serious Case Reviews found that 22 of the cases involved previously violent behaviour.[31] A similar study in 1996 found that nearly half (49 of 105) of the children studied had witnessed domestic violence and 28 out of the 51 children investigated intensively had been harmed by it.[32]

An overview of the literature identifies three antecedents to child homicide: prior history of child abuse; prior agency contact, and a history of domestic violence in the family. The review concludes: "*Confronting domestic violence amongst adults may provide multiple points of proactive intervention against child deaths in the home."*[33]

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[28] Paradine & Wilkinson (2004) A Research & Literature Overview: Protection and Accountability: the Reporting, Investigation and prosecution of Domestic Violence Cases HMCPSI / HMIC.
[29] The amended New Zealand Guardianship Act 1968 contains a very useful risk assessment checklist for use in family proceedings where there are allegations of domestic violence, but it would help to have a more detailed list of high risk indicators for use by statutory agencies.
[30] See footnote 28.
[31] Sinclair, R. & Bullock, R. (2002) Learning from Past Experience – A Review of Serious Case Reviews, DoH.
[32] Brandon, M. & Lewis, A. (1996) 'Significant harm and children: experiences of domestic violence', Child & Family Social Work, I, pp33-42.
[33] Websdale (1999) *Understanding Domestic Homicide.*

As it is essential that the family courts do not make orders which place children in danger, **Women's Aid urges the Government to commission research to identify significant risk indicators for children in cases of domestic violence where there are contact or residence proceedings or arrangements.** We consider this would be an appropriate response to these 29 child homicides.

The following significant risk indicators have been identified by Cardiff Women's Safety Unit, the NSPCC and South Wales Police as part of a co-ordinated multi-agency response to domestic violence. These were developed with reference to a review of 47 local domestic homicides, which identified the top 15 significant risk factors. These questions now form a checklist and each time the police attend a domestic incident they are completed. The process has been evaluated and found to be effective in identifying the level of risk faced by women and children in cases of domestic violence.[34]

Significant risk indicators include:

- Assailant's criminal record
- Use of weapons
- Injuries inflicted
- Financial problems
- Assailant's problems with alcohol, drugs or mental illness
- Victim is pregnant
- Assailant expressing or behaving in a jealous or controlling way
- Has been/ going to be a separation between victim and assailant
- Conflict over child contact
- Threats made to kill
- Attempts made to strangle/ choke
- Abuse becoming worse/ happening more often
- Assailant threatens/ attempts suicide
- Sexual abuse ie. rape, indecent assault
- Victim's own assessment.

Using the very limited information available on the 13 families who are the focus of this report, we have counted the following numbers of significant risk indicators in these cases:

- Assailant's criminal record (3)
- Use of weapons (4)
- Injuries inflicted (4)
- Financial problems (2)
- Assailant's problems with alcohol (2), drugs (2) or mental illness (9)
- Victim is pregnant (2)
- Assailant expressing or behaving in a jealous (7) or controlling way (8)
- Has been/ going to be a separation between victim and assailant (13)
- Conflict over child contact (12)
- Threats made to kill (3)
- Attempts made to strangle/ choke (1)
- Abuse becoming worse/ happening more often (7)
- Assailant threatens/ attempts suicide (6)

[34] For further information on the full assessment process see www.crarg.org.uk

- Sexual abuse ie. rape, indecent assault (2)
- Victim's own assessment (4)

In 3 cases there were 10 – 12 significant risk indicators; in 7 cases there were 5 – 8 significant risk indicators, in 2 cases there were 4 indicators and in 1 case there were 3 indicators. However, in this last case the child was on the Child Protection Register, so a risk had already been clearly identified. With regard to most of these cases, the number of significant risk indicators counted was proportionate to the amount of information available ie. any one who was familiar with the case could probably have identified more.

It is important to note that any risk assessment tool based on checklist categories will provide only a limited picture of the nature, severity and danger of a particular domestic violence situation. Previous assault is one of the most robust and straightforward risk indicators for domestic violence.[35]

There is always likely to be some risk in contact disputes where the parents have separated due to domestic violence. For this reason Women's Aid is calling for legislation to require the courts to assess risk and to prioritise the safety of the child in cases involving allegations of domestic violence.

There appears to be a high coincidence of domestic violence and the perpetrator's involvement with mental health professionals in these child homicide cases. Nine of the 13 fathers who killed their children were described as mentally ill, unstable, or suffering from depression and anxiety, while 6 of them had already threatened or attempted suicide. It must be stressed that domestic violence itself is not a form of mental illness, but these cases suggest that there is a need for further work on risk assessment and management protocols in the context of domestic violence and mental health.

The extent to which the perpetrator feels the need to control his or her partner is also a vital indicator of the possible level of risk. Two of the mothers whose children were killed provide examples of this:

> *"It's hard to explain, but it comes on really slowly, really gradually. You'll hear lots of women say the same thing. I'm ashamed to say this now, but I had an allowance to get me to work and back, and to buy my magazines and my lunch. I had no control over things like that, no credit card in my name. The bank account was in both names but he kept the cards. Then you find that you haven't got a car, and you haven't got your own money, and that actually, you're not in control at all. You suddenly realise that you have no power."*

> *"He was always watching me. He controlled where I went, who I was with, and what I wore. I had to be covered from head to toe, and if I wore a V neck top he would insist that I got f…ing changed before going to work. We had to have sex when he said. If a meal was late, he would be verbally abusive and would say he didn't want it – or sometimes he would throw the food at me. He demanded to know what I had bought and wanted to check receipts to make sure I had not spent money on anything else. He didn't like talking to my friends – when they came round, you could cut the air with a knife, so they stopped coming round. If I spoke to a man, it was even worse – he wanted to know who I was 'slagging around with'. It was like walking on eggshells, having to be so wary."*

[35] Buzawa and Buzawa (2003) *The Criminal Justice Response; Walby & Myhill (2001) Assessing and Managing Risk,* in Taylor-Browne (2001) *What works in reducing domestic violence?* London, Whiting Birch.

Jealousy is mentioned in half of the 13 child homicide cases. In two cases the children were killed after the parents had separated and the mother had started a new relationship, in one case becoming pregnant by her new partner. In a third case the parents had divorced two years previously and the mother had recently remarried without telling her ex-partner, who subsequently killed her and the children. This mother appears to have been aware of the risk, but jealousy is not mentioned in the executive summary. However, domestic violence training is listed as a learning point, and this should provide an understanding of the dynamics of domestic violence including jealous and possessive behaviour.

Another executive summary states*: "The context of domestic violence in this situation is critical to understanding how [the] children could be killed by their father. (…) Domestic violence can be an ongoing and long term feature of relationships and often the severity of the abuse increases over time. It is important to identify patterns over the long term and to understand how possessiveness, jealousy and control can be manifested and concealed. Ensuring agencies are aware of serious incidents but also the need for universal services to remain vigilant when things are less obvious is equally important. The period following separation and particularly when a new relationship is formed by the victim is often the time when increased harassment and risk is present."*

It is significant that, despite often suffering extreme violence themselves, only 4 of the 13 mothers expressed concern that their ex-partner might kill the children: most of them clearly found this inconceivable.

In two cases where threats to kill the children were made directly or reported to professionals, they also seem to have viewed this as inconceivable, as no child protection investigation was initiated. One executive summary states that the mother *"who knew [the father] best was confident that he would not harm the children"*. In the other case a local authority official explained that the mother *"had always made sensible decisions to protect her children in the past"*, and when she decided that the father did not mean what he had said, the local authority *"saw no reason to disbelieve her*". While it is commendable that these local authorities respected the mother's decision-making, it is also the role of frontline staff with child protection responsibilities to assess and manage risk and to offer appropriate information and advice. There is nothing in the executive summaries to indicate that anyone told these mothers that a threat to kill is a significant risk indicator or that there were other significant risk indicators in their respective cases. If this had been pointed out, would these mothers have handed over their children for contact?

This indicates a clear need for independent domestic violence advocacy and support services in every local area, that can support the mother, explore the risks involved and identify safe options for both the mother and her children. **Women's Aid recommends that specialist domestic violence advocacy services be developed in every local area, building on existing domestic violence services, as part of a co-ordinated community response to domestic violence.**

Women's Aid also recommends:

- **That all frontline staff with responsibilities for safeguarding and promoting the welfare of children should receive training to enable them to recognise significant risk indicators in cases of domestic violence; and**

- **That threats to kill or to commit suicide should always be recognised as significant risk indicators and taken seriously in cases of domestic violence, particularly during contact or residence disputes.**

6. Was Government guidance followed?

The welfare checklist in Section 1(3) of the Children Act 1989 requires the court to consider any risk of harm to the child, when making decisions with regard to children. In April 2001 this was reinforced by the introduction of Good Practice Guidelines, which state that in cases of domestic violence the court should "*only make an order for contact if it can be satisfied that the safety of the residential parent and the child can be secured before during and after contact*".[36]

As the 29 child homicides all occurred when the children were having unsupervised contact, or in one case residence, with the perpetrator, we can only conclude that in the five cases involving court orders insufficient attention was paid to assessing the risk of harm and ensuring the safety of the child(ren). **Several of the homicides occurred during overnight stays.**

With regard to statutory agencies, *The Framework for the Assessment of Children within their Families* sets out procedures for assessing if children are in need or at risk of significant harm, but it says very little about domestic violence. More detailed guidance is provided in *Working Together to Safeguard Children*[37], which states:

> *"Domestic violence is likely to have a damaging effect on the health and development of children, and it will often be appropriate for such children to be regarded as children in need. Everyone working with women and children should be alert to the frequent inter-relationship between domestic violence and the abuse and neglect of children" (para. 6.38).*
>
> *"Often supporting a non-violent parent is likely to be the most effective way of promoting the child's welfare"(para.6.40).*

Working Together to Safeguard Children also lists the following 'considerations' for statutory agencies when responding to situations where domestic violence is present:

- *Asking direct questions about domestic violence;*
- *Checking whether domestic violence has occurred whenever child abuse is suspected and considering the impact of this at all stages of assessment, enquiries and intervention;*
- *Identifying those who are responsible for domestic violence in order that relevant criminal justice responses may be made:*
- *Providing women with full information about their legal rights and the extent and limits of statutory duties and powers;*
- *Assisting women and children to escape from violence by providing relevant practical and other assistance;*
- *Supporting non-abusing parents in making safe choices for themselves and their children; and*

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[36] The Advisory Board on Family Law: Children Act Sub-Committee (2001) *Guidelines for Good Practice on Parental Contact in Cases where there is Domestic Violence.* London, Lord Chancellor's Department (para.1.5(b)).

[37] Department of Health (1999) Working *Together to Safeguard Children.* London, The Stationery Office.

- *Working separately with each parent where domestic violence prevents non-abusing parents from speaking freely and participating without fear of retribution (para. 6.41).*

The need to support the non-violent parent is critical because, in the experience of Women's Aid, abused women will usually be able to care for their children adequately, if they are given appropriate information, advice and support to enable them to be safe and to recover from their experiences of abuse. Although the mother and child will need different kinds of emotional support, they both need to be physically safe and usually they need to be safe *together*. As most abused women are afraid that their children might be taken into care,[38] agencies which focus on the safety of the child without considering the safety of the non-violent parent, may make the problem worse, because they are likely to be feared rather than trusted by that parent.

Women's Aid is concerned that the guidance on domestic violence in Working Together to Safeguard Children seems to have been overlooked in some of these homicide cases, particularly with regard to supporting the non-violent parent. It is clear in two cases that various agencies tried to provide support for the mother, but in other cases this seems to have been lacking. The need to support the non-violent parent sometimes features in the learning points or recommendations in the executive summaries – and sometimes it does not:

One executive summary lists the following learning points on domestic violence:

- *Training in recognition and offering help to victims, particularly for primary care workers.*
- *Assessing risk in cases where contact is in dispute – knowledge of new guidelines to the Courts when they come into operation.*[39]
- *Recognition of risk to children caught up in marital violence.*
- *Accessibility and publicity of help to victims – making services user friendly.*

Another executive summary contains the following learning points:

- *The Domestic Violence Team should have a small budget to assist families in an emergency where there is no recourse to benefits or where these have not yet been paid.*
- *Where a woman is fleeing marital violence, every effort should be made to maintain contact with her until it is established that she is no longer at risk.*

In one case the mother disclosed extreme abuse to the police, but despite a long history of domestic violence there is no mention in the executive summary of anyone advising or helping her and the children to apply as homeless or to move into a refuge. Nor is this included in the recommendations of the Serious Case Review, although "assisting women and children to escape" is specifically mentioned in the government guidance.

Seeking to ensure the safety of abused women and children should be recognised as a basic requirement for all statutory agencies dealing with domestic violence cases. Identifying the perpetrator is also crucial in dealing with domestic violence, but in some of the child homicide cases there seems to be a reluctance to do this, even when it is abundantly clear who has been violent. For example, two Review Panels use terms that suggest that both parents are responsible for the violence. One executive summary states that the parents *"appear to have had a physically, sexually and emotionally abusive relationship."* Another executive summary refers to *"marital conflict"* and *"marital violence".* This kind of

[38] Abrahams, C. (1994) *The Hidden Victims.* London, NCH Action for Children.
[39] This was shortly before the introduction of the Good Practice Guidelines in 2001.

approach means that not only is the perpetrator not identified, held to account and prosecuted, but there is also no recognition of the need to provide support for the non-violent parent.

Women's Aid recommends that the Government require professionals working in statutory agencies and within the family justice system to prioritise supporting non-violent parents in making safe choices for themselves and their children. This is particularly necessary as the establishment of children's services under the Children At 2004 is likely to reinforce the idea that the child's safety should be considered separately from the safety of the mother, even when both are at risk from the same domestic violence perpetrator.

7. Why were Serious Case Reviews not carried out in three of these child homicide cases?

In three cases involving a total of seven children there was no Serious Case Review. One Child Protection Co-ordinator stated: *"I had checked all the other names (for the parents) and could find no record of our involvement. I spoke to my boss who was in my job at the time of the incident and he had no recollection of the case. We have no record under (mother's surname) either. I spoke to our Police CPU and officers could remember the case but did not think there was any involvement by ACPC. Also our Named Nurse Child Protection recalls the case but agrees that the ACPC was not involved."* No reason was given for the failure to review the case.

With regard to another contact homicide case Women's Aid was informed over the phone that Social Services have no records on the family, but we have not received the letter confirming this in writing. The officer dealing with Serious Case Reviews stated that she could not remember this case and that CAFCASS also had no recollection of the case. Newspaper reports state that the father had been violent to the mother and was "fighting for custody" – but it is not clear if contact was ordered by the court or if the Family Court Welfare Service (as it was then) was involved. No reason was given for the failure to review the case.

From informal discussions with statutory agencies, Women's Aid understanding is that if statutory agencies such as social services, the health service and the police are not involved with a family before the killing of a child, the ACPC may decide that there is no need for a Serious Case Review as there are no lessons to be learnt. However, this is certainly not true in the third case, where there was considerable involvement with the police and where the father's GP and the hospital were aware of his mental instability. In this case we have been informed that the ACPC decided not to conduct a Serious Case Review, but the local authority was unable to give a reason for this. The mother states***: "I cannot tell you how upset I am that a Serious Case Review was overlooked. Right from the beginning I felt badly let down by the court system. (…) Now, I find out that a lot could have been done at the very beginning to learn lessons. I am absolutely furious and devastated to realise that not only did the legal team not care about the children's safety when they were alive, but they don't care that they are dead. And they don't care about learning lessons."***

Women's Aid recommends that Serious Case Reviews should always be carried out when children are killed in circumstances, which suggest violence or abuse, and family court professionals should be required to take part whenever this is relevant.

Current opportunities and challenges

Information sharing

As a result of Lord Laming's recommendations in the inquiry report into the death of Victoria Climbié,[40] local authorities are now setting up databases containing basic details on all children in their area and facilities to enable professionals to indicate their involvement with individual children and to share information.

[40] Lord Laming (2003) *The Victoria Climbie Inquiry Report.* Department of Health & Home Office.

Statements in some of the executive summaries of Serious Case Reviews relating to the 29 child homicides indicate that the failure to share information was a problem:

> *"In respect of this family no single agency had the full picture or identified the need to make a full assessment of the situation. The fact remains that within each agency there was considerable information available that could have been collated and analysed."*

> *"What is clear in this case is that no one single incident gave sufficient cause for concern for any agency to identify; that based on that incident alone there was a risk of significant harm. However, this is commonly the situation in cases where domestic violence is prevalent. That is, the picture emerges over a period of time, which on analysis gives insight into the realities of the family's functioning. There is no evidence that an approach based on examining the chronology of information available over time, even on a single agency basis, was taken by any of the agencies within this case."*

> *"Any enquiry made from Social Services to the Police regarding concerns about a child or family, should lead to a full list of known incidents being provided, that reflects all the contact that has been made between the family and the Police, whatever its classification."*

There is also advice for refuge organisations, relating to a case where the mother's "horrific" disclosures were vividly remembered but not recorded in the file:

> *"In such cases it would seem appropriate that the refuge, as a minimum, speak to the woman about the known impact on children of living in such a hostile and violent environment. It would also be legitimate to ask whether the children had witnessed the violence or been caught up in it. Their role should be to persuade the woman to let them contact other agencies on her behalf where levels of concern are high. The fact that these issues have been discussed and the outcome should be clearly recorded in the refuge's file."*

This information could have been extremely useful if the case had gone to court, and for this reason it is vital that all agencies including refuge organisations keep accurate records about the impact of domestic violence on children.

The information sharing databases could provide a very powerful means of collecting evidence of domestic violence and its adverse affects on children, and it is vital that this evidence is made available to the family justice system. For this reason it is important that CAFCASS officers should be able to access the databases, so that they are aware when other agencies have concerns about a child.

However, **there is also an urgent need for safeguards to ensure that the basic details contained on the information sharing databases cannot be used by domestic violence perpetrators to track down their victims.** Women's Aid will be pressing the Department for Education and Skills to ensure that adequate safety measures are included in the regulations.

Making the link between domestic violence and child protection, when the definition of 'harm' is extended[41]

[41] As defined in s.31 of the Children Act 1989, amended by the Children and Adoption Act 2003 (due to be implemented in January 2005)

The sharing of information in cases of domestic violence will be of limited value, and could even be dangerous, if professionals do not understand the nature of the problem or recognise the risk to both the non-violent parent and the children. This failure to understand domestic violence is reflected in one executive summary:

> *"..it is clear that a number of agencies had an awareness of matters concerning domestic violence in the family and that in some cases the problem was seen as a relationship matter rather than a family matter."*

With regard to four cases the Review Panel concluded that training in understanding domestic violence should be provided for frontline staff in various agencies, and one of these also stressed the need for risk assessment tools and joint protocols. In a fifth case the ACPC decided to *"review and update its Domestic Violence Practice Guidance document*". Another Review Panel recommended considering *"whether work to monitor the implementation of the child protection procedures should be undertaken*" with regard to domestic violence.

From all these comments **it is clear that there is an urgent need to raise awareness within statutory agencies that domestic violence is a serious child protection issue.** One Review Panel specifically links this to the extension of the definition of harm due to be implemented in January 2005:

> *"The recent change in the definition of significant harm may assist agencies in protecting children at risk of significant harm in the context of domestic violence. Section 31 of the Children Act was amended and the words "including, for example, impairment suffered from seeing or hearing the ill-treatment of another" were inserted at the end of the definition of 'harm' in subsection (9). Skilled assessments in the context of good knowledge of the impact of domestic violence are necessary, if the benefits of this legislative change are to be fully realised for children in the context of domestic violence."*

Women's Aid also hopes that this will improve the protection of children who have experienced domestic violence. However, on the basis of the evidence presented in this report, we are extremely concerned that identifying children who are "impaired" due to witnessing domestic violence will not be easy, because they often appear well and healthy and it can be very difficult to have any meaningful communication with these children.

As the guidance on supporting the non-violent parent appears to have been overlooked in several of these homicide cases *(see page 24),* we are concerned that extending the definition of harm in this way could result in more abused women being accused of failing to protect their children and more children being taken into care. Moreover, we do not think this amendment will substantially improve family court practice, because it does not overrule the case-law precedents which have been so damaging in cases of abuse (*see page 30).*

In cases of domestic violence it is crucial that the Government takes urgent measures to ensure that adequate support is provided for the non-violent parent and the children, not only in statutory agencies but also in the family justice system. This is essential to ensure:

- **new information sharing arrangements do not deter mothers from disclosing abuse, to and seeking help;**

- **the extended definition of harm is used to protect children and the non-violent parent instead of being used inappropriately to accuse mothers of failing to protect their children and taking the children into care;**

- **unsafe contact orders are not enforced in cases of domestic violence or child abuse.**

Conclusion

It is the responsibility of both the state and individuals to ensure that children are adequately protected. This is even more important, when there is a clearly identified risk of preventable harm.

As domestic violence features in nearly three quarters of cases where children are on the 'at risk' register[42] and also in about half of all child homicides,[43] clearly this is a major child protection issue that needs to be addressed urgently.

The Government already has information showing that in five cases children have been killed during contact visits ordered by the family courts.[44] Despite evidence that children are still not being adequately protected in contact or residence proceedings with violent or abusive parents,[45] the Government has failed to address the root cause of this problem – specifically the rulings in the following case-law precedents:

- That contact is almost always in the interests of the child – Appeal Court ruling in *Re O (Contact: Imposition of conditions)[1995];*

- That a higher standard of proof than the simple balance of probabilities should be required by the family courts in cases involving more serious allegations – House of Lords ruling in *Re H & R (Child sexual abuse; Standard of proof)[1995].*

- That the welfare of the child is not the paramount consideration, when a parent is facing committal to prison for not complying with a contact order[46] - Appeal Court ruling in *Re A v N (Committal: Refusal of contact) [1996].*

These problems must be addressed and adequate safeguards provided before the Government introduces new legislation to enforce contact orders more rigorously. Failure to do so will inevitably place more children in danger.

There is an urgent need for accountability within the family justice system, so that professionals who disregard risk and make decisions that put children in danger can be overruled or struck off.

New Government guidance on child protection should emphasise that children are often abused physically, sexually and emotionally by the same perpetrator who is abusing their mother. Guidance should also remind statutory agencies that providing support for the non-abusing parent is often the most effective way of ensuring the safety of the child in cases of domestic violence.

All frontline staff in statutory agencies should receive training to enable them not only to understand domestic violence but also to recognise significant risk indicators.

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[42] See footnote 2.
[43] See footnotes 31.
[44] See footnote 16.
[45] Saunders, H. & Barron, J. (2003) *Failure to Protect?* Women's Aid Federation of England.
[46] In this case it was acknowledged that the father had a history of violence including a serious assault on his former wife for which he had been sent to prison.

Finally we would point out that the New Zealand legislation provides a practical and effective model for tackling domestic violence and ensuring that contact is safe. Here are the key features of their legislation:

- The legislation contains a clear, comprehensive and gender-neutral definition of domestic violence, which includes abuse to children;

- If a parent is found to be violent within the family, the court must not grant an order for unsupervised contact or residence to that parent unless it is satisfied that the child will be safe;

- A mandatory risk assessment checklist is used in all family proceedings involving allegations of domestic violence or child abuse;

- Even if there is not sufficient evidence to prove that a parent has been violent within the family, the court can make whatever order it considers necessary if it is satisfied that there is a genuine risk to the child. (This would be very helpful in overruling the House of Lords ruling in *Re H & R)*.

The New Zealand legislation does not ban child contact in cases of domestic violence but requires the court to be satisfied that the child will be safe. Women's Aid believes that children in the UK deserve no less.

Women's Aid recommendations

- Serious Case Reviews should always be carried out when children are killed in circumstances which suggest violence or abuse in the family, and family court professionals should be required to take part whenever this is relevant.

- Mechanisms are required for holding family court professionals accountable for decisions that result in children being killed or seriously harmed. If found to be responsible, professionals (judges, magistrates, barristers, solicitors, expert witness or family court adviser) should lose their right to adjudicate, represent parties, provide evidence or report to the court in family proceedings.

- All statutory workers with child protection responsibilities should receive training to enable them to understand the dynamics of domestic violence and its links with child protection, and to recognise significant risk indicators.

- Legislation should require the courts to assess risk and to prioritise the safety of the child in all cases involving allegations of abuse, because there is always likely to be risk in contact disputes involving domestic violence.

- The Government should require professionals working in statutory agencies and within the family justice system to prioritise supporting non-violent parents in making safe choices for themselves and their children.

- A person who is awaiting trial for a violent offence against a family member should not be allowed to have unsupervised contact with a child.

- In cases where there are allegations of abuse but insufficient evidence to prove this, children should be assessed in a child-friendly environment using appropriate techniques over several weeks to establish the child's perspective and whether the child is at risk and to make appropriate recommendations for the child's welfare, because children are very unlikely to disclose abuse during a one-off interview with a person, whom they do not know and trust.

- Independent domestic violence advocacy services and supervised contact facilities should be available in every local area as part of a co-ordinated community response to domestic violence.

- The Government should commission research to identify significant risk indicators for children in cases of domestic violence where there are contact or residence proceedings or arrangements.

- Evidence from information sharing databases of domestic violence and its adverse affects on children should be made available to the family justice system, including CAFCASS. Safeguards must also be provided to ensure that the basic details

contained on the databases cannot be used by domestic violence perpetrators to track down their victims.