Western Suffolk Community Safety Partnership

Domestic Homicide Review
Overview Report

The deaths of Oscar and Denise
November 2014

Report Author:
Mr Gary Goose MBE

Report completed: 30th January 2016

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Preface

Before formally introducing this Review, the Western Suffolk Domestic Homicide Review Panel would like to express their deepest sympathy to the families of all those involved in this tragedy. This Review could not have been completed without your challenge and support.

In particular, we would like to make special mention of the fact that our thoughts are with the surviving children of the deceased. No words that can be written within this report can adequately describe their loss. However, we are motivated to undertake a Review and compose a report that properly reflects the circumstances leading to the events of 13th November 2014 and ensures that any lessons learnt are identified so that others can benefit from that learning.

The Independent Chair and Author of this Review would also like to thank all those staff from statutory and voluntary agencies that assisted in compiling and reviewing the information culminating in this report. All have been touched by the circumstances.

This Review was commissioned by the Western Suffolk Community Safety Partnership following the notification of the deaths in circumstances which appeared to fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This Review relates to two victims. HM Coroner recorded a finding of unlawful killing in relation to one victim and found that the second victim killed themselves (suicide). This Review adopted the approach that both victims fall within the definition applied by the Home Office for Domestic Homicide Reviews as set out below:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

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

The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person dies as a result of domestic violence or abuse. In order for these lessons to be learned as widely and as thoroughly as possible, professionals need to be able to understand what happened in each case and most importantly what needs to change in order to reduce the risk of such tragedies happening in the future.

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Section 1. Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 At 12.11 pm on Thursday 13th November 2014 police were called by a member of the public who reported a man had been found injured outside a multi-storey car park in Suffolk. Police and paramedics attended the scene but the man was found to be deceased.

1.1.2 A vehicle was found on the top floor of the car park; the car had been left insecure and a search of the vehicle resulted in police learning the identity of the deceased. A search of the car resulted in the discovery of a bag containing a blood stained hand-axe.

1.1.3 As a result, police mounted enquiries to check upon the welfare of the deceased's family. This led to them attending an address in a nearby town which was the home address of his estranged wife. Police officers gained access to the rear of the property and at 2.39pm the deceased body of a woman, later confirmed to be his estranged wife, was discovered. She had suffered severe head trauma.

1.1.4 The couple were married but separated and had children. They were orphaned by these events.

1.1.5 As a result of these findings Suffolk Constabulary launched a murder investigation. They were subsequently satisfied that no other person was involved in the deaths and concluded that the evidence available suggested that the deceased male had killed his wife and then killed himself. A full report was prepared for HM Coroner.

1.1.6 On 29th July 2015 HM Coroner held an Inquest into both deaths. Members of the deceased male's family were present and the family of his wife were present by way of a telephone link to their home in Africa. At the conclusion of the Inquest, HM Coroner recorded findings of Unlawful Killing in respect of the death of the deceased female and Suicide in respect of the death of the male.

1.1.7 Given what is now known about the circumstances preceding the deaths, this Review will address the homicides of both.

1.2 Timescales

1.2.1 The Western Suffolk Community Safety Partnership was notified of both deaths by Suffolk Constabulary on 17th November 2014. There followed meetings of a Domestic Homicide Review Advisory Panel which took place on 25th November and 9th December 2014.

1.2.2 As a result of these meetings the Chair of the Community Safety Partnership made the decision to undertake a Domestic Homicide Review. The Home Office was notified of the decision on 12th December 2014.

1.2.3 An Independent Chair was appointed on 17th February 2015; the Review commenced immediately thereafter.

1.2.4 Three Domestic Homicide Review Panel meetings were held in this case: 30th March, 2nd July and 5th November 2015.

1.2.4 An Inquest, with witnesses, was held in relation to both deaths on 29th July 2015.

1.2.4 The Chair of the Review presented its draft findings to the Community Safety Partnership at its meeting on 18th November 2015. The Review was completed in January 2016.

1.2.5 It was not possible to complete the Review within the six month timescales set out within the statutory guidance due to appropriate care and sensitivity taken by all involved as to the importance of contact with the surviving children in this case and the proximity of this Review to HM Coroner's Inquest.

1.3 Confidentiality

1.3.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and where necessary their appropriate organisational management. It will remain confidential until such time as the Review has been approved for publication by the Home Office Quality Assurance Panel.

1.3.2 In order to protect the identity of the victims and their family members, the following pseudonyms have been used hereafter within this report:

Male victim: Oscar. He was 37 years old at the time of his death
Female victim: Denise. She was 39 years old at the time of her death.

1.3.3 Oscar was a White British male. Denise was an African female. They were married but separated. Oscar had custody of the couple's children.

1.3.4 To protect the identity of the children in this case, any details which may lead to their identification are being withheld from the report. In addition, details of the information they provided to assist the Review is included **only** where it is considered absolutely necessary to assist the readers understanding.

1.4 Dissemination

1.4.1 The following individuals/organisations will receive copies of this report:

- Chair of the Western Suffolk Community Safety Partnership
- Suffolk Police and Crime Commissioner
- Chief Constable, Suffolk Constabulary
- Chief Executive, Norfolk and Suffolk NHS Foundation Trust
- Chair, Western Suffolk Clinical Commissioning Group
- NHS England, Eastern Region
- Director of Children's Services, Suffolk County Council
- Chair, Suffolk Health and Wellbeing Board

- Chair, Suffolk Safeguarding Adults Board
- Chair, Suffolk Local Safeguarding Children's Board
- Chief Executive, East of England Ambulance Service
- GP Practices involved in this Review
- Children And Family Court Advisory Support Service (CAFCASS)
- Family of both victims

1.5 Terms of Reference

1.5.1 Statutory Guidance states the purpose of the Review is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.

Apply those lessons to service responses, including changes to policies and procedures as appropriate.

Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

To seek to establish whether the events leading up to the homicide could have been predicted or prevented.

1.5.2 Specific Terms of Reference for this Review

"Terms of Reference for the Domestic Homicide Review into the death of Denise and Oscar

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Western Suffolk Community Safety Partnership (WSCSP) in response to the deaths of Denise and Oscar on 13th November 2014.

1.2 The Review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the WSCSP has appointed Mr Gary Goose to undertake the role of Independent Chair and Overview Author for the purposes of this Review. Mr Goose is not employed by, or otherwise has any conflicting interest with any of the statutory or voluntary agencies involved in the Review.

2. Purpose of the Review

The purpose of the Review is to:

2.1 Establish the facts that led to the incident on 13th November 2014 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family. **The welfare of the surviving children in this case is of paramount importance and this Review will be cognisant of that at all stages of the inquiry.**

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Establish whether the agencies or inter-agency responses were appropriate leading up to and at the time of the incident on 13th November 2014; suggesting changes and/or identifying good practice where appropriate.

2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the Review process.

3. The Review process

3.1 The Review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2013).

3.2 It will be cognisant of the process agreed by Suffolk Community Safety Partnerships and contained within the reference document. "Conducting a Domestic Homicide Review (DHR): Suffolk Protocol and Guidance, July 2012 (revised 2014)".

3.3 This Review will be cognisant of, and consult with, any on-going criminal justice investigation and the process of Inquest held by HM Coroner.

3.4 The Review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the Review

The Review will:

4.1 Seek to establish whether the events of 13th November 2014 could have been reasonably predicted or prevented.

4.2 Consider the period of three calendar years prior to the events (or other timescales as appropriate, to be confirmed at the first Review Panel), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

4.3 Request Individual Management Reviews (IMRs) by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the Review.

4.4 Seek the involvement of family, employers, neighbours and friends to provide a robust analysis of the events, cognisant of point 2.1 above.

4.5 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken, the way they worked together and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.6 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the Inquest process, and any other emerging issues.

5. Family involvement

5.1 The Review will seek to involve the family in the Review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the Review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and Reviews avoiding duplication of effort and without increasing levels of anxiety and stress."

1.6 Methodology

1.6.1 The Western Suffolk Community Safety Partnership was notified of both deaths by Suffolk Constabulary by way of a report dated 17th November 2014. This was a timely notification and showed a good knowledge of the need for early referral by the Constabulary.

1.6.2 As a result of that notification, a Domestic Homicide Review Advisory Panel took place on 25th November 2014. This Panel was convened by the Chair of the Community Safety Partnership and was an initial information sharing exercise by key professionals in order to fully inform a wider Domestic Homicide Review Advisory Panel, which subsequently took place on 9th December 2014. Following the first meeting, contact was made with a wider range of local statutory and voluntary agencies to establish whether they had contact with the victim, perpetrator or

family members. Instruction was also given that any records indicating contact should be secured. It was also explicitly confirmed at the meeting that all considerations would be taken in accordance with the Home Office Statutory Guidance for Domestic Homicide Reviews (revised 2013).

1.6.3 The Domestic Homicide Review Advisory Panel of 9th December 2014 was again convened by the Chair of the Community Safety Partnership and comprised of an appropriate range of senior professionals from across the statutory agency local network. As a result of the information provided to these two meetings, the Chair of the Community Safety Partnership made the decision to undertake a Domestic Homicide Review. The Home Office was subsequently notified of the decision on 12th December 2014.

1.6.4 At the time of these incidents Suffolk had in place its own County-wide procedure and protocol for Domestic Homicide Reviews: *Suffolk Community Safety Partnerships; Domestic Homicide Review. Suffolk Protocol and Guidance*.

1.6.5 The Chair of this Review found that guidance to be useful and fit for purpose. It provided a clear roadmap for all agencies to adhere to and set the framework for the Domestic Abuse Advisory Panels, as mentioned above. The Suffolk document refers directly to the Home Office Statutory Guidance as the overriding framework for reviews but provides local direction.

1.6.6 In the view of the Chair of this Review, that the use of a Domestic Homicide Review Advisory Panel is a sound mechanism that ensures timely and well-informed decision making. Both meetings were confidentially minuted and those minutes made available for the Chair of this Review.

Example of good practice: The use of a Domestic Homicide Review Advisory Panel to provide rigour around early decision making by the Chair of the Community Safety Partnership.

1.6.7 The Chair of the Review would also like to acknowledge that the Chair of the CSP's active and direct involvement in both Advisory Panels indicates a good knowledge of that role and responsibility; in this case the Chair made explicit reference to the care that any Review should show towards the surviving children that indicates a level of good personal responsibility.

1.6.8 The initial information available to the Advisory Panel indicated minimal contact with statutory agencies by both deceased prior to their deaths. However, the Panel was made aware that Oscar was under the active care of the Norfolk and Suffolk NHS Foundation Trust (a commissioned mental health service provider) and that divorce proceedings were on-going on the local family court. The Norfolk and Suffolk NHS Foundation Trust appropriately made the Panel aware of their own internal Serious Case inquiry. It was noted that linkage between the Trust's internal inquiry and this Review would be desirable in order to ensure efficiency of resource and appropriate sharing of information.

1.6.9 The Independent Chair and Overview Author was appointed in February 2015 and the first full Domestic Homicide Review Panel was held on 30th March 2015. All statutory agencies were represented. The following were key outcomes:

- Draft Terms of Reference were agreed at the meeting subject to observations from the families of both deceased. Central to those Terms of Reference was the condition:
  The welfare of the surviving children in this case is of paramount importance and this review will be cognisant of that at all stages of the inquiry.
- Individual Management Reviews (IMRs) were required from Suffolk Constabulary, Norfolk and Suffolk NHS Foundation Trust, Suffolk County Council Children and Young Peoples' Services (Specialist Services), the General Practitioners for both the deceased.
- Reports covering the involvement of West Suffolk Hospital, East of England Ambulance Service, General Practitioners for the children,
- Further enquiries would be made through the County's Education Services with the children's schools to ascertain levels of knowledge and whether reports would be desirable from them,
- Contact would be made with the Coroner to ensure linkage of the Inquest process with that of the Review,
- Enquiries would be made by the Chair of solicitors representing both deceased as to whether they felt able to assist the Review given their knowledge of issues pertaining to the divorce proceedings,
- Enquiries would be made of CAFCASS and the Court by the Chair to seek their engagement in the process,
- The Chair would seek to further engage with both families by way of introduction through the police family liaison officers and/or the County's Children's Services officers, both of whom had pre-existing relationships with the families.

1.6.10 Information from records used in this Review were accessed in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purpose of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention or detection of crime, or the apprehension or prosecution of offenders. The purpose of a Domestic Homicide Review is to learn lessons in order to prevent similar crime.

1.6.11 Terms of Reference for the Review were agreed by the DHR Panel and these were shared with the victims' families.

1.6.12 In the case of Oscar's family, this was done through the family solicitor and then personally by the Chair of this Review at meetings with the family. They endorsed the Terms of Reference.

1.6.13 In the case of Denise's family, the purpose of the Review, its Terms of Reference and the Review's desire for their active engagement were conveyed by the police family liaison officer and then the Chair of the Review by email. The sister of Denise responded supporting the Review and its aims.

1.6.14 The Chair of the Review also sought to meet with the children to explain the Review, its purpose and to seek their engagement. The Chair however, at all times, took the view that this could only be entirely with the total agreement of the children's guardian who would consider the request on the basis of what was considered best

for the children in all the circumstances that prevailed at the time. It was agreed that the Inquest should initially be the focus of the children's attention and that no meeting was appropriate prior to that being concluded together with resultant media reporting. However, as the Review gathered more information and dialogue with the family continued, the Chair was able to meet with the children in November 2015 at the family home. The children actively engaged in the process, asked a number of questions and provided important background information that has helped to shape this Review.

1.6.15 The Chair wishes to place on record his gratitude to the children for taking part in the conversations with him, their openness and honesty and their stoicism in the light of such tragic events.

1.6.16 The Chair also wishes to place on record his acknowledgment of the incredible levels of support by the children's family for them in the face of such tragedy.

1.6.17 Subsequent to meeting with the children, the Chair met with the nanny appointed to the children and who was in place for several months leading up to the deaths. She has helpfully provided information to assist the Review.

1.6.18 A second Review Panel meeting was held on 2nd July 2015 at which draft IMRs and reports from all agencies were examined and discussed. All statutory agencies were represented as was the GPs practice. The following were key issues that arose:

- Further enquires were required of the County's Children and Young Peoples' services as information had arisen to suggest an abnormal amount of moving between the County's schools by the children.
- Further enquiries were required of the children's schools themselves.
- Solicitors representing Oscar's family were contributing, those who had represented Denise felt unable to assist.
- The Inquest was planned, with witnesses, for 29th July. The Chair of the Review would attend the Inquest to ensure any relevant information was captured.
- HM Coroner had authorised the confidential release of the police investigation report to the Chair of this Review in order to assist its direction.
- A meeting had been held between the Chair of the Review and the police family liaison officers representing both families in order to brief them on the Review and in particular seek Denise's family engagement.
- The County's Independent Chair of the Safeguarding Adults Board's and its Board manager had been consulted and would be invited to future meetings.
- The engagement of CAFCASS had not yet been resolved.

1.6.19 As a result of the additional work a further Panel was to be arranged post Inquest and when the Chair felt inquiries could conclude.

1.6.20 The Chair of this Review thereafter met with senior members of staff from the children's schools and entered into telephone and written dialogue with another of the children's schools.

1.6.21 Permission from the Court was sought to engage CAFCASS in the process. That permission was granted by the Judge who had overseen the family court and divorce proceedings. As a result, CAFCASS engaged fully in the Review from July 2015 onwards providing a detailed report to the Review.

1.6.22 The Chair wrote to, and subsequently met with, the Police and Crime Commissioner for the Suffolk area in order to engage the Commissioner in the Reviews. As a result, the Chair wrote to the lead officer for the County's Health and Wellbeing Board and subsequently met with the County Council's Head of Localities and Partnerships in order to understand the strategic oversight of Domestic Abuse services across the County.

1.6.23 As a result of inquires made by the Review; an independent Counsellor was identified who had supported both Oscar and Denise at times during the years leading up to their deaths. The Counsellor agreed to assist the Review and met with the Chair in November 2015 providing an invaluable insight into the relationship between the deceased.

1.6.24 A final Panel Meeting was held on 5th November 2015. A draft narrative had been prepared by the Overview Author based upon the information gathered from all at that time. The Panel included representatives from all statutory agencies. Additional attendees were representatives from the schools and the Head of Children's Safeguarding from the County Council. This Panel meeting agreed the general narrative, suggesting some areas for amendment, together with conclusion and findings. CAFCASS were unable to attend the meeting and corresponded with suggestions separately.

1.6.25 In addition to the receipt of IMRs, reports and personal interviews and attendance at the Inquest, the Chair of this Review has read a number of documents to assist in compiling this report including:

- Understanding Domestic Abuse in Suffolk; A study of the experiences of survivors 2015. This was a research paper commissioned by the Suffolk Police and Crime Commissioner
- Domestic Violence and Abuse: A partnership strategy for Suffolk 2015-18
- Suffolk Constabulary Domestic Abuse Action Plan 2014
- Domestic Abuse, Local Action Plan for Suffolk 2014
- Suffolk Safeguarding Children Board: Responding to Domestic Abuse training programme September 2015 – December 2015

1.6.26 The Review's active inquiries concluded in December 2015. The report was completed in January 2016.

1.7 Contributors to the Review

1.7.1 Those contributing to this Review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the Review to have regard for the guidance.

1.7.2 All Panel meetings included specific reference to the statutory guidance as the overriding source of reference for the Review. Any individual interviewed by the Chair or other body with whom the Chair sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it must be noted that whilst a person or organisational body can be directed to participate, the Chair and DHR Panel do not have the power or legal sanction to compel their cooperation or to attend the Panel for interview.

1.7.4 The following agencies contributed to the Review:

- Norfolk and Suffolk NHS Foundation Trust (Mental Health Services): By way of IMR and Panel membership.
- GP Practice (for both deceased and their children): By way of chronology and written Peer Review. Practice manager as Panel member.
- Ipswich Hospital NHS Trust: Chronology.
- Suffolk Constabulary: By way of IMR, provision of additional information on the murder investigation, family liaison officer engagement, Panel membership.
- HM Coroner: By way of engagement with the Review and provision of reports prepared by the police in readiness for the Inquest.
- Suffolk County Council, Specialist Domestic Abuse Advisor: By way of general information, provision of policy and practice. Panel membership.
- Suffolk County Council Children's Services: By way of IMR, additional information. Panel membership.
- Suffolk County Council Education Services: By way of written information and introduction to schools. Panel membership.
- Children And Family Court Advisory Support Service (CAFCASS): By way of written report
- Schools (anonymised to protect children's identity): By way of personal interview and correspondence. Panel membership.
- East of England Ambulance Service: By way of IMR and Panel membership.
- National Probation Service: By way of Panel membership
- Suffolk Police and Crime Commissioner: By way of personal interview by the Chair of the Review.

1.7.5 The following individuals contributed to the Review.

- Family of Oscar (including the surviving children): By way of personal interview with the Chair of the Review.
- Nanny appointed to the children of the deceased: By way of personal interview with the Chair of the Review.
- Family of Denise: By way of correspondence by email.
- Counsellor to Oscar and Denise: By way of personal interview with the Chair of the Review.
- Solicitor to Oscar: By way of background information

1.7.6 The following agencies declined to assist the Review:

- Solicitor who had represented Denise in the Family Court process

1.8 The Review Panel

1.8.1 The members of the DHR Panel conducting this Review were:

Name of panel member	Role or job title	Organisation
Gary Goose MBE	Independent Chair and Overview Author	
Peta Jones	Corporate Manager; Safe Communities	Babergh and Mid-Suffolk District Councils
Tim Peters	Detective Inspector	Suffolk Constabulary
Tina Wilson	Head of Safeguarding and Reviewing Officer Service	Suffolk County Council C&YPS
Michael Lozano	Patient Safety and Complaints Lead	Norfolk and Suffolk NHS Foundation Trust
Tim Sykes	MAPPA Manager	National Probation Service
Shirley Osbourne	Domestic Abuse Manager	Suffolk County Council
Simon Chase	Assistant General Manager	East of England Ambulance Service
John Morrison	Quality & Safety Manager	NHS Suffolk (East)
Gabrielle Irwin	Professional Lead	Suffolk Clinical Commissioning Group
Nicola Whitehead	Practice Manager	Long Melford Practice
Allison Hassey	County Safeguarding Manager and LADO	Suffolk County Council C&YPS
Janice Lee	Strategic Manager: Learning and Improvement	Suffolk County Council: Learning and Improvement Services

1.9 Author of the Overview Report

1.9.1 The Community Safety Partnership took the view that a combined role of Independent Chair and Overview Author was appropriate in this case. They appointed Mr Gary Goose MBE to that joint role.

1.9.2 Mr Goose is not employed by, nor otherwise has any conflicting interest with, any of the statutory or voluntary agencies involved in the Review.

1.9.3 Mr Goose has significant criminal justice, local government and partnership working experience. He is an experienced police officer having served for thirty years, mostly as a detective, within Cambridgeshire Constabulary. He retired as a Detective Chief Inspector in 2011. He was awarded an MBE for Services to Policing in the 2006 New Year's Honours list. From 2011 onwards he has been involved in local government as Head of Community Safety Services with Peterborough Unitary Authority, has worked for the Cambridgeshire Police and Crime Commissioner and as consultant providing Domestic Homicide Review services. He has previous experience of Domestic Homicide and Child Protection Reviews within both the police and local authority roles.

1.10 Parallel Reviews

1.10.1 At the time this Review began a police murder investigation was underway into the circumstances surrounding the death of Denise. Early contact between the Chair and the Constabulary was made and it was established that this Review was unlikely to affect the outcome of that investigation. That police investigation concluded that no-one else was being sought in connection with both deaths and accordingly no charges were to be brought against any other person. They came to the view that clear evidence existed to show that Oscar had killed Denise and that he had then killed himself.

1.10.2 At the conclusion of the murder investigation the police prepared a report for HM Coroner in order that the duty for Inquest be discharged.

1.10.3 The Chair of this Review made early contact with HM Coroner in order to ensure that nothing the Review did would prejudice the Coroner's Inquest. HM Coroner and the Chair shared information to ensure that both processes were as fully informed as possible in order to properly discharge their respective functions.

1.10.4 An Inquest, with witnesses, was held into both deaths. This took place on 29th July 2015. The Coroner came to findings that Denise was unlawfully killed and that Oscar took his own life.

1.10.5 The Norfolk and Suffolk NHS Foundation Trust undertook an internal Serious Case Review following the death of Oscar, as he was a patient under the care of their Home Treatment Team at the time of his death. That internal Review and the Trust's preparation of the IMR for this Review were undertaken concurrently. The Chair of this Review has seen the Trust's internal Review and is satisfied that its content is not materially different to that IMR the Trust prepared for this Review; they meet the requirements of their respective audience.

1.10.6 The Chair of this Review and the Independent Chair of the County's Safeguarding Adults Board (SAB) met at any early stage to determine whether this was a matter which should be subject of an SAB's Review as determined by the Care Act 2014. It was established that as a matter of legal fact such a Review was not required, however, in terms of good practice the SAB Board Manager was invited to attend this Review's Panel Meetings. This Review and its resultant Action Plan will be shared with the SAB upon completion and the agreement to publish by the Home Office.

1.10.7 The Chair of this Review made contact with the Local Safeguarding Children's Board (LSCB) Manager and an agreement was made that a copy of this Review and any learning points and recommendations contained therein would be shared with the LSCB. The LSCB was represented on this Review by the Head of the Safeguarding and Reviewing Officer Service, Suffolk County Council.

Section 2. The Facts

2.1 Introduction

2.1.1 Oscar is a white British man from a well-established family with roots in rural Suffolk. Denise is a Zambian national who came to the UK to further her education. The couple met whilst working in London and married in Zambia a matter of months later in 1998.

2.1.2 The wedding was unannounced; with none of Oscar's family being aware of its intention or that it had happened until the couple returned to the UK.

2.1.3 Together, the couple had children. At the time of the couple's deaths the children were all of school age.

2.1.4 This Review has learnt that the marriage was in difficulties from an early stage. In 2000, just over two years after the wedding, Oscar had a series of private counselling sessions where he disclosed that he knew he needed to end the marriage because of what he described as Denise's behaviour, including her heavy drinking. She had, at the time of those counselling sessions, left for Zambia with their child and it was unclear as to whether she would return.

2.1.5 What is apparent is that Denise was a troubled woman and became unfulfilled by her marriage. She quickly developed a significant alcohol problem and there is also evidence latterly of some illegal drug use. This Review has discovered some significant disclosures by her of serious issues she says she encountered in her childhood. Whilst at one point she began to discuss and perhaps began to address them within the confines of a professional counselling relationship, she ultimately failed to progress those discussions. She began to spend more and more time away from the family culminating in an unannounced lengthy stay in Brazil from September 2013 through to the May of 2014. When she left, Oscar began Family Court proceedings; in his view this was to protect his children from her behaviour. He subsequently commenced divorce proceedings.

2.1.6 During her absence she embarked upon an affair with a man with whom she had had a previous short-term relationship whilst at university and whom she had met again a month earlier on a previous trip to Brazil. During her time away she had little contact with her children. She returned to the UK after her visa had expired and made it clear that she did not intend to stay and wanted a divorce. Those divorce proceedings, already in train, became increasingly acrimonious and stressful for all involved. Denise continued to split her time between the family's home town and abroad and engaged to a degree in the divorce process. It is clear that a financial settlement was the subject of difficult, probably acrimonious, discussions between the two. As part of that divorce process the Court instructed the Children And Family Court Advisory and Support Service (CAFCASS) to carry out an assessment and at the time of the deaths the report was being prepared in readiness for a further Court hearing.

2.1.7 Oscar was a man who suffered periodically from stress and anxiety. He had sought to manage this condition over the years with help from his GP insisting over those years that the cause was always due to the pressure of work and explicitly, even

when asked, not anything to do with his home circumstances. It was not until 2013 that he first told his GP of the difficulties at home. He had, however, independently sought help from a Counsellor, firstly, as mentioned, in 2000 and then again in 2013 specifically to do with his relationship with his wife and thoughts of divorce.

2.1.8 From mid-2013 onwards what Oscar saw as a combination of his wife's behaviour, the Family Court proceedings, together with the impending divorce and its attendant issues, increased those levels of stress and anxiety to such an extent that he became very mentally unwell and suicidal. He was under the intensive care of his GP and the local Mental Health Trust at the time of the deaths.

2.1.9 On 13th November 2014 Oscar murdered Denise at her rented home in the village in which they all lived. He then drove to his nearest local town and killed himself by falling from the top floor of a multi-storey car park. These actions orphaned their children.

2.1.10 A full chronology of events and a summary of information known by family, friends, agencies and others will follow within this report.

2.2 Chronology

2.2.1 Background information

2.2.2 Denise was born in Zambia in January 1975. She was the second child of G and A M. The family lived in Lusaka. Denise is one of five children, with an older sister, a younger sister and two younger brothers. She was 39 years old at the time of her death.

2.2.3 Denise grew up in the higher echelons of Zambian society. She lived in Government provided homes with maids, nannies and gardeners. She was privately educated in a British school and moved to London in her late teens to undertake a diploma in law before moving to study at University.

2.2.4 Whilst studying she worked for Gap in London, it is here that she met Oscar.

2.2.5 Oscar was born in January 1977 in Suffolk. He is the youngest of the four children. He has two sisters and a brother. He was 37 years old at the time of his death.

2.2.6 Oscar grew up in rural Suffolk where his family owned a local business. He has been described as a sensitive, sometimes anxious, boy growing up.

2.2.7 At the age of 16 he became involved in a relationship with a woman some ten years his senior. That relationship ended after a relatively short period and it appears he took it very badly, was very emotional and took some time to recover.

2.2.8 Upon leaving school he worked in the family business for a while before going travelling and, at the age of 19, decided that he wanted to try something other than the family business. He thus settled in London to undertake some management training, working for Gap. It is there he met Denise.

2.2.9 When Oscar and Denise met they embarked upon an intense relationship and in 1998 Oscar told his family that he was going to go out to Zambia to meet with Denise's family.

2.2.10 Whilst in Zambia, they were married. A large family wedding appears to have been arranged by Denise's parents. None of Oscar's family were aware of the wedding and none attended.

2.2.11 When they returned to the UK, Oscar's parents arranged a further wedding celebration.

2.2.12 Over the course of the coming years the couple had children.

2.2.13 The early years of marriage saw the couple have minimal contact with any of the local statutory agencies. However, there is a body of evidence that suggests the relationship was showing signs of decline from the relatively early stages.

2.2.14 The family of Oscar recall vividly how, on the occasion of his mother's death in early 2000, whilst the rest of his siblings spent the night at the family home, he was 'not

allowed' to stay by Denise. It was an indication they say of how she controlled the relationship and how he would not do anything that had the capacity to upset her.

2.2.15 The family also recall the day of his mother's funeral when he arrived with a severe cut to his ear which was dressed in protective bandage but which was so obvious everyone must have seen it. Oscar confided to them that Denise had attacked him with a knife, causing the wound. There is some confusion as to whether he attended the Accident and Emergency Department regarding this or not. Records do not appear to support that he did. Oscar did not report this attack to the police or any other authority.

2.2.16 Whilst this Review cannot draw a causal link, it is worth noting that Oscar presented at his GP suffering from anxiety and depression in March of that year and in May he attended his GPs surgery with an ear infection.

2.2.17 (From May 2000 – May 2007 Oscar was seen by GP for a variety of medical conditions. These included two visits for chest pain but no issues were identified. Other visits were for matters that could normally be attributed to physical illnesses and are not considered relevant for mention within this report).

2.2.18 Conversely, the family of Denise describe Oscar as 'suffocating' Denise, they suggest he would not leave her alone, was obsessive and jealous, not allowing her any freedom. They suggest there was a clear culture clash in their lifestyles.

2.2.19 What we do know is that in October 2000 Oscar was introduced to an independent Counsellor by his father who was concerned about the effect of his mother's death and the marital relationship between Oscar and Denise.

2.2.20 Oscar attended five counselling sessions during which he told the Counsellor how his wife had left him and returned to Zambia with their child and that he knew he needed to work towards a divorce. He told the Counsellor that Denise was drinking heavily and that he said he didn't love her anymore because he didn't feel loved by her. Over the course of the sessions, and as Denise's impending return to the UK neared, Oscar became more confused as to the course of action he should take, suggesting he was 90% sure that he needed to divorce her but that he knew he might make a mistake when he saw her again. He cancelled the final planned session.

2.2.21 The family of Denise recalled her return to Zambia with her child in their statements to police, saying that she was unhappy.

2.2.22 Six months later, in April 2001, Oscar wrote to the Counsellor thanking her for her help and saying that his wife returned, was drinking less and that things were much better.

2.2.23 In May 2004 the first outwards signs of the struggles being faced by Denise emerged. A report was made to the police control room of a vehicle being driven by a female who was thought to be intoxicated. There were no aggravating features such as an indication that the vehicle contained children at the time. Police made a check on the vehicle registration and it was found to be registered to Oscar and was insured to be driven by both Oscar and Denise. Local police patrols did not locate

the vehicle. The matter was dealt with as a routine call and there were no other enquiries made.

2.2.24 In 2007, Oscar attended his GP where he was seen for what was described as a stress related issue. It is recorded that his home, business etc. were all well but that he was feeling overwhelmed. He did not disclose any relationship issues at the time.

2.2.25 During the early part of 2008 there were various visits to the GP by Oscar for medical issues and in September of that year he was seen by the GP after he complained of poor sleep patterns since a return from Africa. It is noted within the GPs notes that his wife is not returning for a couple more weeks but he put the stress down to work pressures. He was prescribed medication that he had been familiar with in the past.

2.2.26 There was a further incident in 2008 which indicate that issues had become very difficult for the two of them:

On 13th October Oscar attended a local Police Station reporting Denise as missing. It transpired Denise was not in fact missing but on holiday with friends in Brazil. Police contacted Denise in Brazil on her mobile phone and she was angry he had got the police involved. She stated she was intending to come home but she just needed some time and money. She had apparently been asking Oscar to buy her a return ticket but he had refused.

2.2.29 During the remainder of 2008, through 2009 and into 2010, Oscar attended his GP for stress and anxiety on three occasions. Whenever it is noted, he stated his concerns were about work pressures. He did not disclose any personal relationship issues as being stressors at this time to his GP.

2.3 Detailed Chronology from January 2011 to November 2014

2.3.1 On 22nd August 2011, Oscar attended his GP. The notes record: “Anxiety. Medication reviewed.” There is no commentary as to the stressors.

2.3.2 On 2nd November 2011, Oscar attended his GP. The notes record: “Discontinuation syndrome having stopped medication. Feeling more confident. Some stress still at work.”

2.3.3 At Christmas of 2011 Oscar’s family, including the children, recall an incident where Denise was very drunk at a family party. They describe her as hardly able to stand. Denise’s levels of drinking were becoming more known amongst the tight family group and certainly were by now known to the children, who were finding her behaviour difficult to understand. They describe their father as protecting Denise whenever he could and never blaming her despite the impact of her drinking upon the family.

2.3.4 On 25th January 2012, Oscar attended his GP. The note is recorded as: “Anxiety and stress. History: Has been on and off antidepressants…….” No indication of reasons for stress recorded.

2.3.5 On 28th May 2012, Oscar attended his GP. The notes record: "Review of medication." No additional commentary.

2.3.6 On 8th August 2012, Oscar attended his GP. The issues were recorded as "Problem: Tired all the time. History: No social/family/work/finance problems".

2.3.7 Whilst there were various other visits to the GP during 2012/13, all have been considered by this Review and concluded they are not relevant for the Reviews purpose.

2.3.8 During 2012 the children recall an occasion when Denise attended a school concert drunk and the children had to contact their grandfather to come and collect them all from school.

2.3.9 They recall another occasion at around the same time where Denise was driving the children whilst drunk and crashed the car at a petrol station. Oscar had to come and collect them in another vehicle after one of the children called him. There were no reports made to police or other people involved on this occasion.

2.3.9 At some point during 2012, Denise is alleged to have caused serious scratches to the faces of two children. This is described by the children as an assault, not an accident, and was a result of them challenging their mother over an issue.

2.3.10 The children say they were told by both parents to give a specific story to their schools as to how the injuries occurred; one of them stuck to that story, the other gave a different account.

2.3.11 Both parents were called to the respective schools for an explanation as to the children's injuries. They both lied, saying the children had been fighting.
(Enquiries made of the schools will be covered later within this report)

2.3.12 The children describe being regularly beaten by their mother and locked in their rooms without food as punishment; they called it being 'locked down'. They recall on one occasion one of them hiding in the bathroom with food for another who had been 'locked down'.

2.3.13 On 7th March 2013 Denise attended her GP. She indicated that she was suffering from stress in view of an impending visit to family in Zambia. Medication was prescribed. There is no further commentary as to what the specific stressors were.

2.3.14 On 3rd July 2013 Denise attended her GP. Discussed palpitations at night. Medication prescribed. No other details are recorded.

2.3.15 In early July 2013 Oscar turned up unannounced at the door of the private Counsellor he had seen back in 2000. She describes him as apologetic for turning up but very agitated and frantic, desperate for her to see his wife (Denise) who he described as being out of control with her abuse of alcohol and being neglectful and chaotic in her behaviour. The counsellor informed Oscar that she could only see Denise if she made contact herself. Denise did then make contact and arrangements were made for a meeting.

2.3.16 On 10th July 2013 Denise and Oscar attended the independent Counsellor. Initially discussions together and then the Counsellor spoke with Denise alone. Oscar detailed Denise's alcohol abuse, concern for their children and also suggested he knew of issues that had occurred with her childhood. Denise said privately that she was angry with Oscar for taking her, spoke of childhood, accepted that she drank too much but said she got frustrated and bored. She was not sure if she wanted to meet the Counsellor again but would call.

2.3.17 On 10th July 2013 the GP received a letter from Oscar thanking him for his 'kind words' the previous day and how he didn't want to leave the wrong impression as to why he wanted Denise to see someone. The letter indicates how he had managed to get Denise to see someone who is believed to be a Counsellor (Oscar clearly had seen in the past) in order to deal with her issues.

2.3.18 This letter contained explicit information about Denise drinking excessively. Oscar attended the appointment with Denise and this prompted a confrontation.

2.3.19 On 18th July 2013 Denise attended her GP. The notes of the meeting say 'past issues discussed: seeing (Counsellor). These past issues are likely to relate to incidents within her childhood.

2.3.20 On 19th August 2013 Denise attended a meeting with the independent Counsellor.

2.3.21 On 29th August 2013 Denise attended a meeting with the independent Counsellor.

2.3.22 One child recalls the summer of 2013 and being in the car with their mother who was clearly drunk. When the child checked the water bottle they found it to contain neat vodka.

2.3.23 Denise holidayed in Brazil for one week at some point during the summer of 2013.

2.3.24 On 4th September 2013 Oscar telephoned the independent Counsellor in a very distressed state. Said Denise had gone to Brazil following a row. She had been drinking heavily. He had told her she was an awful wife and mother. Counsellor described him as pre-occupied as to whether Denise had told the Counsellor whether she loves him or not. The Counsellor was very concerned at Oscar's state and advises him to see the GP. She followed this up with a phone call to the GP surgery alerting them as to her concern for him.

2.3.25 The same day the GPs made notes of a GP to GP discussion following a call from the Counsellor who wanted to discuss Oscar with them, he had been seeing her independently.
"His wife has left him, has been drinking heavily and gone to Brazil, xxxxxxx Counsellor phones, has left him with the children, Counsellor has been seeing Denise, he has said that he will rely on the scriptures but will ask surgery for some sleeping pills, advice that we would need to see him before prescribing"

2.3.26 On 5th September 2013 Oscar was seen by his GP. The notes record "Problem: Poor sleep pattern. Wife has alcohol problems many years, has gone to Brazil; he is left with children; has strong faith and is not depressed, but is struggling to cope without

sleep; no thoughts of self-harm; has used xxxx in past to good effect; cautioned re safe use i.e. short term, intermittent"

2.3.27 In September 2013, Oscar's sister recalled an incident at Oscar/ Denise's home where Denise was drunk and 'paralytic'. The children were hysterical, with Oscar shouting at Denise about divorce. Oscar confided to her that Denise is drunk most of the time and needs help. She also describes how Denise told Oscar she was going to London for the day but went to Brazil and stayed for several weeks.

2.3.28 On 10th September 2013 Oscar had a telephone consultation with his GP. The notes record "Problem: Domestic Stress. Medication Review"

2.3.29 On 13th September 2013 Oscar collapsed at home.
His GPs attended and recorded "Stress related problem. *History* collapse today says cannot cope cannot breathe very ill needs to be in hospital not getting any sleep taking 2 xxxx which only help for a couple of hours' heart beating out of chest not really eating or drinking properly"

2.3.30 The same day the GP made a referral for Oscar to the Norfolk and Suffolk NHS Foundation Trust (a commissioned mental health provider).
The GP felt the referral was urgent and record their text as follows:
"I would be grateful for your urgent help with this 36-year-old who finds himself in a crisis. His wife left him earlier in this month and has gone to Brazil leaving him with his children. He is finding it incredibly difficult to cope and has entered into a panic mode of extreme anxiety and feeling generally extremely unwell. He has a strong religious faith and says that he would not commit suicide but that he is unable to cope and continue. He was started on xxxx 10mg once daily on the 10th and given some xxxx to help with his sleep. He has not found the xxxx helpful and he is continuing to only have about 2 hours sleep a night. Today I have given him some xxxx 2mg tablets one to be taken twice a day as required with 28 tablets issued and some xxxxx 1mg tablet to be taken at night to replace the xxxx. He however is deeply distressed and feels that he cannot go on. His own view is that he requires to be in hospital. I would be grateful for your urgent assessment."

2.3.31 On 14th September 2013 Oscar was spoken to by staff from the Norfolk and Suffolk NHS Foundation Trust as a result of the previous day's referral. He declined further support, stating he had been in a "bad way" the day before. He was advised to contact his GP or out of hours' service if he felt the need to.

2.3.32 On 16th September 2013 the GP's updated their notes: "Access and Assessment team have been in touch and he has told them that he does not need their help"

2.3.33 On 24th September 2013 Oscar telephoned his GP to say that he had stopped taking the medication but requested a stand-by supply.

2.3.34 On 1st October 2013 Oscar telephoned his GP. The notes record as follows: "Telephone consultation Problem Domestic stress *(Review)* Comment requests more xxxx: wife due home in next few days: "

2.3.35 On 2nd October 2013 Oscar's GP's received a written response from Norfolk and Suffolk Foundation Trust following the previous referral. Recorded as follows:

"Response from Access and Assessment Team referral received – advising the practice that telephone triage to assess Oscar's condition was made on the 14th September 2013. Oscar stated that he was feeling better today and states "he feels he will get through this in his own way". He politely declined a service at this juncture and he was discharged."

2.3.36 On 8th October 2013 Oscar telephoned his GP. The notes record "Problem Anxiety with depression *(Review). Comment:* wife now not returning until next week: has thrown xxxx away and used up xxxx: advised re xxxx hazards: advise restart xxxx 20 mg daily and comply: further xxxx short-term only"

2.3.37 On 15th October 2013 Denise returned to the UK. Tells children that she does not want her current life or the children and that she is moving to Brazil and wanted a divorce.

2.3.38 On 26th October 2013 Oscar contacted the police to say that he has removed the children to his sister's house to protect them from their mother. He said that Denise is staying in bed most of the day drinking and smoking and is driving the children in a car whilst intoxicated.

The children were assessed by the police as well cared for. A joint strategy decision (police and children's services) was made and it was the opinion of the decision makers at the time that Oscar had appropriate measures in place for protecting the children; it was agreed this would be followed up by a single agency response and children's services sent Oscar a letter offering him support and explaining the CAF (Common Assessment Framework) process. Oscar stated he would appreciate the advice and support.

2.3.39 On 30th October 2013 Oscar made an application to the Family Court for a Residence and Prohibited Steps Order in respect of the children. He also sought a Non-Molestation Order and an Occupation Order. (This is an Order which regulates the family home such as: suspending rights to occupy or visit; evicting an abuser from the home; preventing an abuser from returning to the home; setting a 100 metres protection around the home.) Their mother, Denise, was named in the application as the respondent. At that time the children were living with their father.
Oscar listed in his application a wide range of risk issues in relation to his wife's approach in general and to their children in particular. Chief amongst these were:

- drug and alcohol problem use;
- driving the children while under the influence of alcohol;
- volatile and unpredictable behaviour;
- domestic violence;
- threats of removal of the children to Brazil.

2.3.40 On 1st November 2013 first hearing of Oscar's urgent application for residence and injunction at the local Family Court.
Interim Residence Order in favour of Oscar was granted in respect of the children pending a further order. (Substantive application for a Residence Order adjourned to the first available date after 1st May 2014).

- Mother be prohibited from removing the children from the jurisdiction of this Court, save for the purpose of agreed contact, specific details of which will have

been agreed in writing with the Applicant and/or his solicitors or for the purpose of contact as ordered by the Court

- Mother be prohibited from making any arrangements to remove the children of the family from their current schools and to enroll them at any alternative educational establishment, either in England or Wales, or elsewhere, save as expressly agreed in writing by the Applicant Father
- Father will make the children of the family available for indirect contact with the Mother every other day between 6pm and 6.30pm GMT (unless an alternative time is agreed between the parties) and will ensure arrangements are in place to enable video contact (via Skype or Facetime) and telephone contact (via landline, mobile, Skype or Viber) instant messaging (via What's App, texting, Facebook etc.) and by email and letter and will encourage all children of the family to communicate freely with the Respondent Mother via any of the above methods.
- Father will make the children of the family available for contact with the Respondent Mother upon such dates, times and venues as are agreed between the parties and /or their solicitors in writing

2.3.41 The solicitor representing Oscar delivers copies to each of the children's schools.

2.3.42 On 2nd November 2013 Denise left the family home and when her room was cleared out, Oscar's sisters find 15-20 empty vodka bottles. She left no forwarding address and had little contact with the children. Information suggests that Oscar became extremely stressed and struggled to cope.

2.3.43 On 5 November 2013 the case was allocated to a CAFCASS practitioner.

2.3.44 On 11th November 2013 Oscar visited his GP requesting repeat medication for anxiety with depression. The notes cite 'divorce proceedings'.
(A medication review took place in late November and Oscar attended the GP for an appointment relating to physical illness (viral infection) in January 2014.

2.3.45 On 18th December 2013 CAFCASS filed a safeguarding letter to the court.

2.3.46 In January 2014 Oscar began the early stages of a new relationship, confided about the marriage break-up and said that Denise had been involved in affairs in the UK and in Brazil.

2.3.47 In March 2014 Oscar appointed a full-time nanny to support the children.

2.3.48 On 6th May 2014 a follow-up Family Court Hearing took place. Oscar attended with his legal representative. Denise did not attend (it is unclear whether she had returned to the UK by the time of the hearing but it is accepted that she returned at some point in May). An Order was made confirming that the children should live with their father and that any contact with their mother should be 'indirect' only. [Indirect contact is not specifically defined though is usually taken to mean correspondence by letter or card although it sometimes includes telephone contact.] Denise was also prohibited from removing them from their school or attending the family home.
Denise returned to the UK after Oscar refused any further money for her and after her visa had run out.

2.3.49 On 23rd May 2014 Oscar attended his GP surgery for consultation and review. The notes are recorded as follows:
"Problem: Anxiety with depression *(Review)*
History: Stopped xxxx in January. Wife now back in the country and causing more problems. He looks after the children. Feels very anxious and stressed again; does not want to become how he did before. No thoughts of harming himself. Feels he has a strong religious belief."

2.3.50 In June 2014 Oscar had a conversation with a female friend where he asked her if she had ever thought about 'finishing off her husband' (she was separated from her husband at the time). He then told her he had thought about killing Denise when she had been in the UK in October 2013. He described how he could have done it. No one would have known she was even back in the country. The friend felt this was a light-hearted conversation. On another occasion, after Denise had returned to the UK in the months before the deaths, Oscar had gone to the same friend in an emotional state and said he had driven to the Orwell Bridge intending to jump and also gone to highest building he could find in his local town to jump off.

2.3.51 In July 2014 Denise applied to the Court to vary the Child Arrangement Order and CAFCASS received a notification from the Court with regard to an application made by Denise to vary the Child Arrangement Order made on 6 May 2014 to that of 'shared care'. A first Hearing Dispute Resolution Appointment was set for 19 August and the parents were instructed to attend a Mediation Information and Assessment Meeting, and to provide evidence that they had attended prior to the date of the Hearing. From July onwards the children had more access to their mother, with the exception of one child who refused to see her. Both sides appeared to breach the Orders by having more contact than the Court ordered. It is also likely that there were a number of conversations about finance.

2.3.52 On 24th July 2014 Oscar attended his GP surgery. (He had attended three other times in July for other matters including a stopping smoking programme).
"Notes: Anxiety with depression. On-going divorce, getting on top of him, some thoughts of wanting to end it but no plans. Has custody of children."
As a result, the GPs identify relevant Counsellors and contact Oscar with details.

2.3.53 On 12th August 2014 Oscar attended his GPs surgery. The notes record thoughts of self-harm for the first time.
"Says lot of thoughts re killing himself - mainly in last 4 days- does not want to be dead but can't see way out of issues re wife's access to children and possibility of her wanting money; has court case next week; no specific plans; says children stop him from doing anything.
Wakes up early; this morning made list of what his blessings are but also some unresolved issues - mainly around wife. Feels lot of responsibilities.
children…... Has carer for children. Father can also help. Has not accessed counselling. In a new relationship. Not sure how far he wants this to go. Long discussion with GP. Agrees further counselling."

He made further contact with the surgery on 13th and then 14th August. On 13th by telephone saying he was distressed, and then on 14th saying he felt better and had

less thoughts of killing himself. Had left a message with a Counsellor and had contacted the Samaritans.

2.3.54 On 19th August 2014 the Family Court held the First hearing of mother's application. The Court directed that both parties filed statements and that CAFCASS should prepare a report by 18th November with the case further listed for 2nd December 2014.

2.3.55 Towards the end of August and into September it has become clear there were some discussions between Oscar and Denise about a financial settlement. It has been suggested that Denise wanted around £700k immediately and that she also told Oscar that she had been recording all of their conversations in order to show that he had been breaching the Court Order.

2.3.56 On 29th September 2014 Oscar visited his GP for a review relating to his anxiety with depression. The notes say the following:
"Oscar going through divorce, has children at home, has a lot of financial concerns. trouble sleeping at night, thoughts going round head, requests xxxxxxx xxxxxx short supply to help. Aware addictive. no suicidal ideation. previously had xxxxxx not found it helps much - now run out. Having counselling once a week and good family support."

2.3.57 On 15th October 2014 Oscar attended his GP surgery. The notes say the following:
"feeling very stressed has been on xxxx felt worse and more anxious he says he has ADHD and this has made things worse feels he needs something to calm him down and feeling scared is having counselling at the moment feeling anxious and heart is racing has taken about 3 of xxxx given. Medication changed and cognitive behavioural therapy should be considered."

2.3.58 On 24th October 2014 he again attended the surgery, this time in the company of his sister. The notes say the following:
"Remains very anxious. Family (Court) case next week. Wife moving back to area soon. Lots of family support, plus nanny.
Feels that he worries and thinks about things too much and that this can stop him doing things. Seeing Counsellor once a week. No thoughts of self-harm. Discussed change of medication."

2.3.59 In October 2014 Denise returned to the family's home village. She rented a cottage a short distance from where Oscar and the children were living.

2.3.60 On 28th October 2014, Oscar, Denise and the children attended the CAFCASS Family Assessment Day.

2.3.61 On 5th November 2014, Oscar attended his GP surgery with his sister. The notes are descriptive of the meeting:
"Problem: Anxiety with depression *(Review)*
History: attends with sister anxiety levels spiralling not slept at all since CAFCAS meeting no rational thought suicidal court cases still on going all hanging in the air pressure of everything has a nanny family support is taking the xxxxx xxxxxxx is having a couple of xxxxx xxxxxxx taking 3 at night is taking the xxxxxx says he is feeling suicidal is considering suicide sister very concerned that he is beginning to

feel children are better off without things Examination sits quietly not really contributing.
Comment: emergency referral A&A."

Thus the GP made an immediate and urgent referral to the mental services team using the agreed protocol and pathway. Oscar, in the care of his sister was advised to return home to await contact during the day. The referral letter clearly set out the concerns regarding his wife, divorce and children. It also clearly indicates that there is family support. It identified that Oscar was a xxxxxxx and that he was considering suicide, though will not tell the GP exactly how, her concern that he lives above a xxxxxxxx shop (and therefore is likely to have access to xxxxxx xxx xxxxx xxxxxxx implements) is clearly expressed and she states that this is rather alarming.

Later that evening Oscar was taken by his sister to the Accident and Emergency Department of the local hospital where they were met and assessed by staff from the mental health trust. Oscar was voluntarily admitted onto a mental health inpatient unit. His sister was present at the appointment and noted by staff to be very supportive.

Notes made by the team working with Oscar are descriptive of his condition:

"Oscar was pre-occupied, tearful, and referred to a plan of suicide "jumping off a multi storey car park", he was concerned about an upcoming court appearance to look at the custody of his children as he was concerned that his wife had taped their conversations, he was expressing hopelessness. Oscar stated that his Christian beliefs no longer helped and that he had stopped attending church. There was no history of substance or alcohol use; although Oscar said he was a 'chain smoker'. No evidence of psychosis is recorded; no delusions or hallucinations. The mental health worker noted that Oscar presentation was incongruent with his description of his mood; low mood but laughing and smiling. He also disclosed embarking on a new relationship but felt this was not progressing due to his introversion."

2.3.62 In the early hours of the following morning Oscar expressed his wish to leave the unit. Staff recall him being concerned that being an inpatient would affect his bid for custody of his children. It was agreed that he would be suitable for assessment for home treatment following discharge from the ward. A plan made was to increase medication including; xxxxxx xxxxxxx, xxxxxxxxxxx and xxxxxxx. The risk assessment notes a low risk of suicide due to 'not wanting to die but for the situation to end', and Oscar stated his children were a protective factor against taking his own life.

That same morning, he was assessed by the Trust's Home Treatment Team (HTT) and taken on with the service. He agreed to stay with his family (brother), medication was prescribed as above. HTT agreed to phone Oscar later that evening and carry out a home visit the following day. Psychological input was recommended by the attending psychiatrist; it was noted that Oscar was to pursue this privately.

The Trust informed the GPs the same day of the result of the admission and discharge.

2.3.63 On 7th November 2014, The Trust's HTT visited him at Oscar brother's home. Oscar reported a good night's sleep, but feeling a bit 'fuzzy'. He described feelings of not

being in control and concerns that he had been taped, including saying his wife 'could have the children 3 days a week'. Oscar thought this would go against him in Court. Also concerned he could not "hold things together" for the children; he remained very anxious about the CAFCASS meeting outcome, but stated he did not feel suicidal. Oscar agreed to a home visit the following day. Oscar was due to see a psychiatrist in one weeks' time.

Later that day Oscar phoned into HTT to apologise and say he had been asleep prior to the visit earlier, stating also that he was no longer suicidal. His pre-occupation with the issue of taped conversations continued, Oscar concerned this would make him "look like someone he wasn't"; no explanation is available as to what this meant. Oscar stated he no longer wanted HTT input, he expressed the concern that HTT would refer him to Children's Services, he was advised this was not being considered. He said he was appreciative of the medication and felt it helpful. To be discharged from HTT; crisis contact number given.

There is also within the record, reference to a conversation between HTT staff and Oscar's solicitor who reported that she had had "intense communications" with Oscar and was unsure of his ability to make serious life decisions at this time. There is no expansion of what this reference meant (consent had been gained from Oscar to communicate with his solicitor).

Further telephone contact was made with Oscar later on 7th November and he agreed to continue with HTT after all and see a psychiatrist in a couple of days' time as planned, he also agreed to continue to use the crisis contact when needed.

2.3.64 On 10th November 2014 Oscar has telephoned the GP for a consultation. The GP recorded that Oscar self-admitted to Wedgewood Unit three days ago but discharged himself as he didn't like being locked up and that his family will collect and supervise medication.

2.3.65 On 11th November 2014 Oscar's family contacted the GP to say he has taken an overdose. They were advised to take him to Accident and Emergency where he was seen by the mental health liaison team psychiatrist. Oscar did not want to attend for a medical at A&E due to fears of being readmitted to the inpatient unit, he was concerned this would look bad for him in Court.

At an appointment with Trust staff later that day, they recorded that he said "he had not wanted to commit suicide but wanted to "numb out". Oscar's father had taken control of his medication to avoid further over medicating. Oscar was concerned that his ex-wife would take his family business and put him into financial difficulties. He denied suicidal plans." He was not deemed necessary to assess him as needing detention under the Mental Health Act 1983 (amended 2007) and although an inpatient stay was discussed, Oscar declined this.

2.3.66 The following day; 11th November 2014 Oscar made comments to his sister that the only way out he could see would be if he killed Denise. He immediately withdrew the comments and they were not taken as a serious threat.

2.3.67 On 12th November Oscar was seen at home by the Trust's Home Treatment Team. They recorded that when seen he denied any suicidal plans. He was beginning to

feel anxious about the busy Christmas period and the increase in business; he was concerned this would increase the pressure he was under and impact on his father.

A further home visit was arranged for the following day.

2.3.68 The last engagement with Oscar by any agency was a telephone call to him on the morning of 13th November when a staff member called at around 9am to check on him and confirm an appointment for him to be seen at home later in the day. The member of staff suggested to police that he sounded a little flustered, said he would be busy during the day, but agreed to a meeting that evening.

2.3.69 There is nothing learnt from the police investigation or that has arisen within this Review to suggest any particular trigger on that morning caused the events that then followed. What is able to be concluded is that at some time between 11:30 and about 11:40am that morning, Oscar arrived at the house where Denise was living and killed her with an axe. There were no signs of a struggle. He then drove to the top floor of the multi-storey car park in a nearby local town and fell to his death.

Section 3 Overview

3.1 Summary of information known to agencies, family and friends.

3.1.1 Both the deceased, together with their children, were well known locally. They lived in a small rural Suffolk town where Oscar had taken over the running of the well-established family business.

3.1.2 The paternal family were a close knit, supportive family unit. Oscar had three siblings all of whom lived nearby, his father and step-mother were also close by.

3.1.3 None of the maternal family lived in the UK. Denise was a Zambian national and her mother and sisters still lived there. Her mother visited the UK on occasions and Denise also visited Zambia.

3.1.4 Whilst they were well known locally, neither Oscar nor Denise had really come to the notice of any of the statutory agencies; other than in very recent years Oscar's increasingly frequent use of his GP and latterly mental health services. Denise was not really known to any statutory body for any other than what could be described as routine issues. The children too were not thought of a cause for concern by any agency that had contact with them prior to their parent's deaths. There were, however, some opportunities where information could have been linked together which may have resulted in additional support to the family. These points will be covered in detail later within this Review.

3.1.5 There is an abundance of information directly available about Oscar; information about Denise is relatively difficult to find. However, her interaction with figures of confidence such as Counsellors, GPs and CAFCASS together with the information held within the police investigation has provided us with sufficient detail to provide a broad overview of what had become a completely broken and damaging relationship between the two. The effect upon their children of firstly the relationship and its breakdown, and then the tragic events that followed cannot be overstated.

3.1.6 All of those who knew Oscar describe him as a caring father, completely devoted to his children but also completely devoted to and possibly obsessed by his wife. Equally, however, described as someone who really struggled with life. He was someone who would find it very difficult to sometimes know which way to turn. Illustrative of this are his visits to his Counsellor in early 2000, when, just over two years after marriage to Denise his was discussing how the relationship was failing, that he knew he had to leave her and they had to get divorced, but that maybe it would be alright when she returned. He would be absolutely convinced about something one day, and the next day would apologetically change his mind. In discussions between that Counsellor and the Chair of this Review the words 'lost and frantic' were ones that best described him when seen by her.

3.1.7 His children describe his as totally protective of his wife, even at the height of what they witnessed as her negative behaviour towards him. He found it difficult to stand up to her when she, in their words, regularly beat them. It was only when she was away in Brazil for the substantive period from September 2013 through to May of 2014 that he seems to have realised that their relationship was truly over.

3.1.8 During that critical period from September 2013 to May 2014, Oscar, initially full of stress, anxiety and loss, began to slowly recover to a period of relative calm. He employed a nanny, it appears he began a fledgling relationship and began to adjust to life without Denise around. Her return to the UK and the ensuing Family Court and divorce proceedings resulted in levels of stress and anxiety developing into clear mental ill-health, a brief and voluntary admission into a psychiatric unit and very real plans of suicide. His family describe those times vividly; he lost the will to get out of bed, he became at times unkempt, he was so suicidal that the family took turns to keep him under constant supervision. Through all of this the children were trying to maintain a normal life. They describe how he went through periods of 'God, God, God', where everything was about religion; how they would come across him sitting in darkness and how he even said to them at times he wanted to end it all. This was interspersed with periods of great lucidity and vigour where suddenly everything would be 'ok' and he would be apologetic for his behaviour.

3.1.9 One issue that has to be addressed is that on two occasions Oscar said he had thought about killing Denise. It was said to a new partner as part of what she considered a somewhat light-hearted conversation about the effect that partners can have on one. Secondly, he told his sister at his time of his deepest despair that he could only see one way out, that was to kill Denise and himself. He immediately retracted it and it was thought of as a figure of speech. Neither of these people should reproach themselves. They were aware of the context in which it was said and it is now, only with the benefit of the full horror of what is known that it takes on a different and sinister context.

3.1.9 Denise was an equally complex figure who dealt with issues in a different way to Oscar. She disclosed to the Counsellor whom she saw for only a few visits; to the CAFCASS officer and also her GP what were very significant issues of abuse which took place during her childhood. This, together with what she described as Oscar's overwhelming nature, made marriage, and then motherhood, very difficult to cope with. In fact, it is clear that she was trying to extricate herself from the marriage. She used alcohol as a coping mechanism and whilst never being formally diagnosed as an alcoholic, her behaviour would lend itself to any reasonable person coming to the conclusion that she was. Hiding the evidence, including vodka in her water bottles, the children's juice bottles, driving the children whilst heavily intoxicated and being so drunk she could not stand up on occasions is evidence in itself.

3.1.10 The children describe the levels of physical chastisement they received from their mother as 'beatings'. She denied this, accepting that she used to smack and hit them, but saying they were being disciplined which was acceptable in her culture. The children, however, also say that they were told by both their parents they must never tell anyone about the beatings otherwise they would end up being taken to an orphanage or their parent's would be taken away from them. To the Review, this indicates a level of knowledge that both parents knew the level of chastisement was wrong.

3.1.11 When Denise returned to the UK in 2014 she presented to the Court, through CAFCASS, that she acknowledged some of the effects of her behaviour upon the children and wanted to have a second-chance at getting it right. This was met with some level of scepticism by the officer. All of the evidence gathered by this Review

would support that scepticism. Whilst this Review would not suggest that Denise did not love her children, it seems clear that she could not continue to live within the family set-up and was continuing to try and find herself a new life.

3.1.12 This Review does not underestimate the pain and confusion that Denise must have been feeling; her resort to alcohol and some level of illegal drug use (low levels of xxxxxxx, xxxxxx and xxxxx were found as in her body as part of her post-mortem), together with her unannounced 'escapes' abroad, were, it seems, a way to help her cope. Her behaviour, resulting from what perhaps she felt as a desperate situation, had enormous impact upon the rest of the family. There is no evidence that she sought any professional help in trying to deal with her issues, other than one visit to the GP in 2013 and three visits to an independent Counsellor (one in company with Oscar) also in 2013. Whilst she spoke about her childhood issues, marriage and alcohol abuse with the Counsellor, she suddenly stopped visiting. The Counsellor felt her visits somewhat superficial and didn't feel she really looked to address any of the issues.

3.1.13 The police murder inquiry that was initiated after the deaths spoke with several additional people known to Denise. Her unhappiness in marriage, what she felt as Oscar's need for her to be a perfect wife and the need to divorce, were common themes. She did disclose that she felt Oscar had forged her signature on some documents relating to the divorce; the police found no evidence of this and its mention here is simply that it is perhaps another indicator of how difficult the divorce process became between them.

3.1.14 It is health professionals, in particular the GPs, who had more contact than any other body with the deceased prior to their deaths. A detailed chronology and analysis of their involvement follows further within Section 3. The majority of information concerns contact between the GPs, and latterly a local NHS Foundation Trust who provide mental health services, and Oscar. It is simply that that is where the bulk of interaction lay. There was little known contact between GPs and other health professionals and Denise. Equally, the contact with health professionals and the children is limited to routine and unremarkable instances.

3.1.15 Contact between the police and the family is limited to four potentially relevant interactions. A call from a member of the public in 2004, who reported a car being driven erratically with the female driver probably drunk. The family were not spoken to in relation to this report. In 2008, Oscar reported Denise as 'missing'. The police immediately followed this up and made contact with her in Brazil where she said she was on holiday. In 2012, Oscar was spoken to by police as a result of a verbal argument with a tenant of a property owned by him over rent. No further action was taken in respect of this. Finally, in 2013, Oscar reported his concerns for the children a result of Denise s behaviour. He described her staying in bed and drinking all day, driving them about when drunk and was concerned for their safety. The police dealt with this jointly with the County's Children's Services.

3.1.16 Contact between the County's Children's Services provision and the family was limited to that one occasion in 2013 where they jointly dealt with Oscar's referral to the police.

3.1.17 The children were all educated within the County's maintained schooling system. None of the schools felt it necessary to raise any safeguarding concerns with Children's Services. There was a limited knowledge within the schools of the circumstances under which the children were living in the months and years leading up to the tragedy.

3.1.18 The County's Court Services became involved in 2013 when Oscar applied to the family Court for a Residential and Prohibited Steps Order. The Court requested CAFCASS advise them and they became involved on three separate occasions; November 2013, May 2014 continuing through to October 2014. CAFCASS officers interviewed all of the family at a Family Assessment Day in October 2014 and their report was being prepared at the time of the deaths.

A detailed analysis of each agencies involvement will now follow.

3.2 Detailed Analysis of agency involvement

The chronology set out at Section 2 details how the information known to agencies evolved. Section 3.1 summaries the totality of the information known by those agencies and others with influence during the years leading up to the deaths. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement.

3.2.1 General Practitioner services provided to Oscar and Denise.

.1 It is clear from the chronology that Oscar was more familiar to the family's GP's than was Denise. However, there have been some helpful insights into Denise through the notes kept by the GP's during their interaction with Oscar.

.2 It is important to note at this stage that the GP and Hospital records for the children have all been brought to the attention of the Chair of this Review. The Chair is able to confirm that there are no issues contained within the children's medical history that could reasonably have prompted concern for their safety or indications of the circumstances which were prevailing in their home.

.3 The author is grateful for the Peer Review approach taken by the GP practice in compiling their information and contribution to this Review. The notes recorded by the GPs have been helpful in compiling this analysis.

.4 Oscar appears to have been relatively well known to his local GPs. That is not to say that until perhaps 2013 he attended his GP's more frequently than a number of men of his age. His presentations until that time were largely, but intermittently, for stress and a variety of reported physical conditions which could be described as largely unremarkable.

.5 Denise had minimal contact with her GPs however the interaction she did have is relevant to the purposes of this Review.

.6 This Review has sought to include GPs involvement from the year 2000 in order to show the level of their interaction in context over time.

.7 It is clear that Oscar was prone to suffer from varying levels of stress and anxiety. In order to manage the condition, he sought his GP's advice and at times was prescribed medication.

.8 This Review does not take the stance that he was someone who was suffering from a long-term mental illness. However, it is clear that from 2013 onwards he did become mentally ill as the stress and anxiety grew to levels with which he was ultimately unable to cope.

.9 The GPs long-term interactions with him from 2000 onwards demonstrate the fluctuations in his levels of stress and their management of him.

.10 Oscar's mother died in early 2000 and his family have described difficulties he had with Denise around the time of the death and subsequent funeral. He presented himself to the GP's surgery suffering from anxiety and depression in March and April of that year. There is nothing in the records on those occasions to indicate what was

causing the issues but its proximity to the life events described above, and, importantly, what we now know of his interaction with an independent Counsellor around the same time, show a direct correlation of those visits to the loss of his mother and what he was describing to the Counsellor as very severe difficulties in his relationship with his wife.

.11 I make mention of this because throughout the period examined, Oscar would seem to know when his levels of stress and anxiety were such that he needed help and would seek that help from his GP.

.12 A number of members of Oscar's family describe that he suffered a knife wound to his ear which occurred the night before his mother's funeral as a result of an argument between he and Denise. Whilst there are no GP's notes relating directly to this there is a reference to him attending the surgery with an ear infection in May of 2000. I am unable to say whether this was connected or not.

.13 There is also additional information on this incident by way of notes held by the Counsellor seen by Oscar during 2000 where, at an appointment later in the year, he described how Denise had taken the top of his ear off with a basting fork.

.14 The Review concludes there is sufficient evidence to indicate this incident took place and indicates that Denise did have the propensity, at times, for volatile and violent behaviour towards Oscar.

.16 From 2000 through to 2007 his visits to the GP were for a variety of medical issues. They included presentations for issues such as chest pains and respiratory problems but there are no notes to suggest these were stress related; they appear to have been acknowledged as physical conditions.

.17 From 2008 through to 2012 he began to present again to his GP for anxiety and stress together with other issues such as chronic tiredness and excessive sweating. On none of these occasions did he disclose that the stress was related to home. This is despite the fact that in 2008 his relationship with his wife was clearly deteriorating further; we know that in October 2008 he reported her missing to the police. Certainly by 2012 the children were fully aware of Denise's excessive drinking and the significant problems that was now causing within the family.

.18 In fact, he always told his GPs that his stress was down to work pressure and in 2010 he acknowledged that he had perhaps been depressed for two years. He was prescribed medication, there appropriate reviews and at this stage there was nothing to suggest to the GPs that the stress was caused by anything other than what he was describing.

.19 It was Oscar's decision entirely not to tell the GPs that his relationship with his wife was a significant factor in his stress and anxiety. He had disclosed all to a Counsellor several years before and would later accept that it was a major factor, however, for the absence of any doubt, he chose not to tell the GPs prior to 2013 of any the relationship issues.

.20 It was in July 2013 that the GPs had the first insight into the problems within the family. Denise had attended the GP in early July for what was described as

palpitations at night. There is nothing to suggest that she disclosed her issues with drinking or any of the relationship issues she may have been facing at home. A week later Oscar wrote to the GP thanking him for his 'kind words'. The letter details that he and Denise had discussed her seeing a Counsellor because of her excessive drinking. The letter provides quite telling information about how that had prompted a confrontation between them and that he was hoping a structure put in place for Denise during the upcoming school holidays would help her control her alcohol problem.

.21 Oscar and Denise's interaction with the Counsellor will be dealt with in a separate section but both acknowledged in those meetings with the Counsellor that her alcohol problem was severe.

.22 A week after that July letter, Denise visited her GP. The notes say they talked about discussing 'past issues' and that she was now seeing a named Counsellor. There is nothing recorded about what these past issues were.

.23 In early September, the same Counsellor contacted the GPs in relation to immediate concerns she had about Oscar. She described how she had been seeing him independently and informed them that she was concerned about him as his wife had left him with the children to look after. The GPs immediately contacted Oscar and he was seen at the surgery the next day. It was at this meeting that he disclosed for the first time the extent of his wife's drinking, the fact that it had been going on for years and more about how he was struggling to cope without sleep and having to look after the Children. It is specifically recorded at this time that he had no thoughts of self-harm and that he had a strong faith and was not depressed.

.24 The Review has considered whether this interaction could have provided a signal for questions to be asked about the children's welfare and this will be addressed later within this section of the report.

.25 Three days after this, on 13th September 2013, Oscar collapsed at home, described as being unable to cope. He was visited by the GP who made a referral requesting that he be urgently assessed by the Norfolk and Suffolk NHS Foundation Trust (a commissioned acute mental health service provider). The GPs letter was descriptive of his condition, describing the circumstances that he was facing at home and that he had entered panic mode, being unable to cope.

.26 It was the expectation of the GP that the Trust would undertake a face to face referral with Oscar. In the event, the Trust carried out a telephone triage the following day. Oscar declined their assistance, effectively saying he had just had a bad day the day before. He was told to contact his GP service should he need further help. The Trust informed the GP of the result by telephone a couple of days later and by letter some two weeks later.

.27 **Lesson Learned:** It is clear that the expectations and understanding of the GPs and The Trust as to what constituted an urgent referral were at odds on this occasion. This Review would suggest that any existing protocol that exists between GPs and The Trust for emergency referrals be reviewed and clarity communicated about expectations. The Trust did not deal with this issue with the urgency that the GPs expected and thus an opportunity to engage with Oscar on the day of crisis was lost.

However, the Trust asserts that they adhered to the protocol for an urgent referral; hence the need for clarity of the process and expectations is clear. The issue of urgent referrals is returned to later within this report.

Recommendation 1: Any existing protocol that exists between GPs and The Trust for emergency referrals be reviewed and clarity communicated about expectations.

.28 There was some further contact between the GPs and Oscar during October and November 2013 which indicates his by then reliance on the GP when his stress levels rose. It is clear they rose whenever issues with Denise emerged, including by that time the opening of divorce proceedings and an anticipation that she would return to the UK. The GP's were managing Oscar's condition through face to face contact and medication. There were no indications of self-harm and this approach to treatment appears to have had some success as gradually a period of relative calm emerged in Oscar's life from around September 2013 through to May 2014. We now know this coincided with Denise remaining out of the country. Amongst other things that helped he had employed a nanny to help manage the day to day pressure of single-parenting the children. As a result, there were no further interactions between him and his GPs until Denise returned and he re-presented to the surgery with increased anxiety and depression from May 2014 onwards. The notes of the time describe Oscar saying how Denise was back in the country and causing more problems. His medication was reviewed and it is recorded that he has no thoughts of harming himself.

.29 From July 2014 onwards Oscar's interactions with the GPs increased and his condition clearly worsened. He disclosed thoughts of killing himself for the first time because of the pressure of the divorce, his wife's ongoing access to the children and her financial demands. He mitigated some concerns the GP's had about self-harm by talking about his children and his faith.

.30 He visited or contacted the GPs six times between July and October in relation to his condition. This is a significant period. Denise had moved back into the village; the family Court case was looming in October as was a CAFCASS family assessment day, thus he could see the whole issue of his and his family's future was coming to a head.

.31 On 5th November 2014 Oscar attended the GP with his sister. His sister and family were by now so concerned about his behaviour and potential for self-harm that between them they had moved him in to live with her and were taking it in turns to not let him out of their sight. On this occasion the GP was faced with a non-communicative patient in company with his sister who explained how he was now voicing suicide and thoughts that his children might be better off without him.

.32 As a result of this presentation the GP made what she understood to be an emergency referral to the Access and Assessment Team of the NHS Trust. The GP specifically requested a face to face consultation and Oscar was sent home in the care of his sister to await contact. In the letter (which was faxed as a referral on the morning of 5th) the GP provided a comprehensive overview of the circumstances and identified that Oscar was a xxxxxxx (thus had access to implements that could be used as weapons) and was suicidal. By mid-afternoon of that day no contact had been made by The Trust and Oscar's sister contacted the surgery again to chase up

what was happening. It is likely that the surgery chased the Trust as the Trust mention they received clarification from the GP that required a response within 4 hours, rather than the 72 hours which they understood was required for urgent referrals. The Trust say they did not receive the referral until nearly 5pm, the surgery say it was faxed at just after 11am. In the event Oscar was not seen until 10pm that evening and that was after the Trust had made contact with his sister by telephone and asked her to take him to the local hospital where he then progressed onto the psychiatric ward for voluntary assessment as an in-patient. We know that he was discharged a few hours later and it was agreed that he was best cared for by the Trust's Home Treatment Team.

.33 The GP received timely feedback from The Trust as to what action was taken following this referral. In particular, the report from the on-call psychiatrist showed a good grasp of Oscar's condition. He was described as having suicidal ideation, being pre-occupied by the on-going legal process and in particular that his wife may have been taping their conversations. He was further described as becoming more reclusive.

.34 As mentioned earlier, the protocols surrounding emergency referrals between GPs and the Trust's Access and Assessment Team require review to ascertain their fitness for purpose. On this occasion a very ill man was left at home in the care of his sister awaiting contact from the Trust. That contact was not within the timescales anticipated by the GP and must have been an incredibly difficult few hours for both. The need for Recommendation 1, previously mentioned, is further evidenced by this incident.

.35 On 10th November Oscar telephoned the surgery and advised them about how he discharged himself from the Wedgwood Unit (the in-patient psychiatric ward) three days previously because he didn't like being locked up. They discussed the medication he was prescribed and that the case was being followed up by the Community Psychiatry team. The following day Oscar's family telephoned the surgery to say that they thought he had taken an overdose and the surgery advised them to get him to Accident and Emergency immediately.

.36 There was no further contact by Oscar with his GPs.

.37 The Review has considered whether the GPs could have done more in respect of recognising the effect of the relationship between Oscar and Denise upon their children and whether a referral to the Early Help offer from the County Council could have provided additional support. The GP's have made it clear that they were aware of the home circumstances (Denise often absent, the busy business and the resultant changes in their lives), that they specifically asked about the children; how they were coping and their welfare. Oscar told them that his family were supporting and caring for the children. The GPs knew they were a close and strong family and had no specific significant concerns about the children and felt no need to explore possible support for them outside the family. This Review concludes that was a reasonable approach in this case.

.38 **Lesson Learned:** It is likely that many families and children going through the pressures of domestic abuse, divorce and family breakdown will not have similar levels of support that were prevalent within the wider family in this case. Thus the

Safeguarding Children's Board must ensure that the range of support available is clear to all professionals who engage in work with children and families.

Recommendation 2: That the Local Safeguarding Children's Board take steps to ensure that the range of support available is clear to all professionals who engage in work with children and families.

.39 The GPs feel that the NHS Foundation Trust did not grasp the urgency on either referral. The Author understands the view from the perspective of the GPs. However, there was clearly not a mutual understanding between these GPs and the Trust over what the emergency referral protocols were. This led, on the second referral in particular, to a response which was not as timely as the GP or the patient should have reasonably expected. Any misunderstanding over the protocol requires the action as set out at Recommendation 1.

This Review concludes that it is difficult to see what more the GP's could reasonably have done in this case:

- **Their case notes are informative.**
- **They carried out medication and treatment reviews where necessary.**
- **They made appropriate and proportionate staged referrals to specialist counselling as the risk of Oscar's self-harm emerged and on the two occasions where immediate harm was feared, they made immediate and urgent referrals to the NHS Mental Health provider through what they understood to be the appropriate channels.**
- **They considered the needs of the children and the support networks around them at the time.**

3.2.2 Norfolk and Suffolk NHS Foundation Trust

.1 The Norfolk and Suffolk NHS Foundation Trust are commissioned to provide acute and emergency mental health provision for patients within the geographic area covered by this Review.

.2 The Trust had no knowledge of Denise and their interaction with Oscar was confined to two episodes, both which were as a result of referrals made by his GP.

.3 This Review recognises the difficulties staff face in dealing on a day to day basis assessing risk of harm and self-harm. We place no criticism on staff that had interaction with Oscar; however, the Review has concerns surrounding the processes and policies for dealing with urgent referrals from GPs. On both occasions we feel the referral could and should have been acted on with greater speed.

.4 The Trust record their first referral as 14th September 2013. This is the day after the referral from the GP thus the 'urgent' referral status is already a day old. There is nothing to say that the referral had been initially looked at or informally assessed the previous day. The 14th September 2013 was a Saturday and it appears that the resultant assessment was done by way of a telephone call to Oscar who said he had

a bad day the day before but declined treatment. The Trust telephoned the surgery to update them two days later and followed this up with a letter after two weeks.

.5 The GPs referral was clear in that it requested an 'urgent assessment'. The content of the letter was as follows:

"I would be grateful for your urgent help with this 36-year-old who finds himself in a crisis. His wife left him earlier in this month and has gone to Brazil leaving him with his children. He is finding it incredibly difficult to cope and has entered into a panic mode of extreme anxiety and feeling generally extremely unwell. He has a strong religious faith and says that he would not commit suicide but that he is unable to cope and continue. He was started on xxxx 10mg once daily on the 10th and given some xxxx to help with his sleep. He has not found the xxxx helpful and he is continuing to only have about 2 hours sleep a night. Today I have given him some xxxx 2mg tablets one to be taken twice a day as required with 28 tablets issued and some xxxxx 1mg tablet to be taken at night to replace the xxxx. He however is deeply distressed and feels that he cannot go on. His own view is that he requires to be in hospital. I would be grateful for your urgent assessment."

The expectation of the GP was that this would prompt a face to face assessment. However, the content of the letter mitigates that in strict terms by describing that Oscar did not have thoughts of self-harm and was being managed by prescribed medication; it does however describe a fairly desperate situation.

.6 The commissioned framework for such a referral, as the Trust understood this to be, is for an assessment to be undertaken within 72 hours. The fact that misunderstanding is present between the GPs and the Trust is something that needs attention and I refer back to Recommendation 1 of this review.

.7 The Trust felt it reasonable in all the circumstances therefore, for the Trust's Access and Assessment Team to undertake a telephone triage when they addressed the referral the next day. The fact that Oscar declined their help is in-line with what this Review has learnt of his character and the extreme swings in mood he encountered when full of anxiety and stress. Given that declined offer of help, an improving situation and one that was not thought of as an immediate threat of serious harm the Trust took the view that there was no evidence to suggest that the mental distress was of a nature or degree to warrant assessment under the Mental Health Act 1983 (amended 2007) and therefore his basic human rights were upheld and his freedom to refuse or decline treatment was respected.

.8 The Trust telephoned the surgery to update them two days later and formally wrote back to the GP two weeks later with very minimal details of the triage. I do not believe this to be timely enough and same day feedback should be possible with modern communication.

.9 The GPs feel that the Trust did not meet their expectations in this instance. They feel that there was sufficient detail in the referral to warrant a face to face assessment of Oscar's condition. It is the view of the Review Chair that, on the basis of the referral letter, that on balance a face to face assessment would have been desirable, however the action taken by the Trust was understandable in this case. There was no indication of a chronically deteriorating condition; the letter indicated a crisis, prompted by an event that needed assessment. A form of assessment was

undertaken, within 24 hours, and given what we have learnt about Oscar's character, he was probably convincing when spoken to, that he was indeed just having a 'bad day' the previous day and would cope. Whilst it is always possible to suggest that a face to face intervention may have persuaded Oscar that support from the Trust or others could help him at that time, and thus mitigated some of his troubles, there is no evidence to suggest that is the case and it would be unwise to speculate to that degree.

.10 The second referral was in November 2014. The lack of joint understanding of the specific referral processes outlined previously again made this referral problematic.

.11 The referral arose out of a GP home visit to Oscar following his collapse at home. The GP faxed an urgent referral to the Access and Assessment Team immediately (around 11am). The referral was very clear in that it suggested that he was suicidal, potentially had access to weapons and in the view of the GP required urgent face to face assessment. However, the front sheet that accompanied the fax said 'urgent referral'. Again, the commissioned framework for 'urgent' referrals is 72 hours. A more immediate assessment is possible where the referral form is marked up as 'immediate'. On this occasion the Trust received the referral and it is likely that initially read the front page only. However, when they read the full referral letter a few hours later they telephone the GP's Surgery to clarify what response was needed. This was shortly before 5pm and at that point the immediacy of the response was need was recognised.

.12 **Lesson Learned:** Whatever the internal processes are for the Trust dealing with urgent referrals the fact remains that he was not seen by anyone from the Access and Assessment Team until gone 10pm that day. At a time of acute crisis, time is critical and Oscar's family were left with him at home, suicidal, awaiting contact from the Trust. The process for receiving urgent referrals, clarity of understanding over terminology with those agencies likely to make referrals and the timeliness of initial contact in order to manage expectations requires review to ensure it is fit for purpose.

.13 When Oscar was seen he was promptly assessed as requiring an inpatient admission and was admitted onto the ward at 11.30pm. This was an appropriate action given that he had expressed suicidal thoughts and a suicide plan; he reported symptoms of anxiety and low mood as well as displaying hopelessness and helplessness. His sister had also described a sudden deterioration in her brother that concerned her and the wider family. Oscar agreed to an informal admission.

.14 The Trust undertook a full in-patient assessment of him and there is no criticism of the process undertaken to assess that risk. Whilst suicidal, that risk was mitigated by talk of his children and not wanting to leave them.

.15 Within the risk assessment there is a section for completion on the experience of abuse that would appear not to have been asked; equally the forensic section was not explored. In practice this is a 'live' document and those sections not asked or answered at the initial assessment appointment would be further explored during the in on-going contact with the patient as the relationship progressed. To ask some of the more sensitive questions before a therapeutic relationship of trust has been established could be counterproductive and for some vulnerable service users particularly distressing.

.16 The Trust have identified this issue within their own review and have recommended that further training be rolled out regarding 'asking the abuse questions'. The Trust embarked upon such training in 2012/13 but recommend it is revisited. This Review agrees that recommendation as a single agency issue.

.17 The Trust have further identified within their own review that progression of the Triangle of Care and Think Family are progressed throughout the organisation to ensure that families are carers are fully involved in all aspects of care. This Review agrees that recommendation as a single agency response.

.18 The Review agrees with The Trust's own review and is not critical of staff who undertook that risk assessment process at that stage.

.19 Whilst there is clear evidence of Oscar being suicidal; there is no evidence that he ever suggested a threat to Denise to be within the knowledge of the Trust.

.20 It is clear that he found his admission to the unit worrying, he was worried about how his admission would look given his impending family Court hearing, it is also clear that he did not like the feeling of being 'locked up'. The unit in question is an adult patient ward and thus understandably has locked doors as most general hospital wards who care for those who are vulnerable do nowadays.

.21 In any event Oscar was discharged into the care of his family and therefore was not alone, his medication had been adjusted. He agreed to engage with the Home Treatment Team.

.22 Following his discharge, responsibility for managing Oscar's ongoing care fell to the Home Treatment Team of the Trust. There are appropriate levels of contact by telephone and home visits. The records held by the team display his fixation on two main irritants: awaiting the outcome of the CAFCASS review and the fact that his wife had apparently recorded their conversations. Oscar's mood swung regularly, for instance when met by the Team he voiced suicidal thoughts but then called them later to apologise and say he wasn't now suicidal.

.23 The Trust had further contact with him when he was seen at the A&E department of the local acute hospital, having attended there due to a suspected overdose. He did not want to attend A&E due to fears of being re-admitted to the inpatient unit, he was concerned this would be to his detriment in Court. He was advised to meet with a mental health practitioner once the physical observations were completed by A&E staff and he was confirmed as physically fit. At that later appointment he stated he had not wanted to commit suicide but wanted to "numb out". His father had taken control of his medication to avoid further over medicating. He was concerned that his ex-wife would take his family business and put him into financial difficulties. He denied suicidal plans. No changes were made to his medication. He was not deemed necessary to assess him as needing detention under the Mental Health Act 1983 (amended 2007) and although an inpatient stay was discussed he declined this, the mental health practitioner was aware that the previous admission appeared to have exacerbated his anxiety and therefore home treatment was a more appropriate alternative given that he was living with his family who were supportive and caring for him.

.24 Around this time the solicitor representing Oscar in the family Court also made contact with the Trust. The Trust records this that she reported that she had had "intense communications" with him and was unsure of his ability to make serious life decisions at this time. There is no expansion of what this reference meant. The lack of record keeping surrounding this call is disappointing, a solicitor suggesting that their client may lack ability to make serious life decisions should require at least commentary to support or negate that view.

.25 There was almost daily contact between the Home Treatment Team up to and including the day of his and Denise's death. This displays the staff's level of concern and their efforts to work with him and mitigate any harm.

.26 Whilst in the care of the Trust at no point were any threats or harm towards Denise voiced or intimated.

.27 This Review recognises the efforts made by the Trust and its staff to mitigate the very real risk of self-harm by Oscar in this case. He was being cared for by a close and supportive family and received significant support from the Trust's staff. The evidence of his diagnosis held by the Trust, together with his undoubted mood swings is apparent and made caring for him in a way that removed any risk an almost impossible task.

The Review concludes that given the pressures Oscar felt he was under and the resultant mental-ill health that he was suffering, it was likely that he was in a state of mind to take his own life at some point during that period of illness. Other than depriving him of his liberty, which this Review agrees was not appropriate in all the circumstances that prevailed at the time; it is difficult to see what the Trust could reasonably have done differently to mitigate that risk. In addition, there was no direct suggestion of a threat by Oscar to Denise and in fact there was no indirect evidence from which the Trust could reasonably have been expected to identify such a threat.

The Review has set out its recommendation that the process and protocol between GPs and the Trust be reviewed. It does not conclude that the issues surrounding that process contributed directly or indirectly to the deaths in this case.

3.2.3 Suffolk Constabulary

.1 Police engagement with the family before the 13th November 2014 was very limited.

.2 In 2004 a report was received from a member of the public that a vehicle registered to Oscar and insured by both him and Denise was being driven by a female who appeared intoxicated. The vehicle and driver were never located. Under the normal course of events the police control room would have circulated the details of the car for observations by patrol officers. If no officers came across the vehicle whilst on patrol the matter would have been left. This was a proportionate response to a single call.

.3 In 2008 Oscar made a report to police that Denise was missing. Police took the report seriously and made contact with Denise when it immediately transpired she

had left the country of her own volition to stay with friends in Brazil. This was the first indication the police would have had that problems between Oscar and Denise were beginning to manifest. This incident in isolation was dealt with appropriately in that Denise was spoken to and she confirmed she was alive and well and intending to return home. Oscar did not disclose any further issues that would prompt safeguarding action or concerns at that time.

.4 In November 2012 Oscar was spoken to by police regarding an incident where he had become abusive towards another man over a dispute about rent that was due to be paid to him; he immediately apologised for the outburst. Whilst this may give some indication that Oscar could be abusive when pushed it was the view of the police at the time that this was not a serious incident and was proportionately dealt with. The fact that no action was taken indicates the level of seriousness with which the police regarded his demeanour and the level of abuse it involved.

.5 On the 26th October 2013 Oscar reported to Police that he had decided to move his children from their home to his sister's address to protect them from their mother who was now staying in bed most of the day, drinking and smoking and driving the children in a car whilst intoxicated. The children were assessed by police as well cared for and it was agreed this would be followed up by a single agency; the County's Children and Young People's Services. Oscar stated he would appreciate advice and support. The police recorded this as a 'Domestic non-crime incident'. This is an appropriate way of recording an incident that does not amount to a recorded crime but that is 'domestic' related. It is a way of ensuring that incidents that could provide indicators of wider issues are properly recorded and retrievable if necessary. It was also recorded on the police CAT System (Case Admission and Tracking System used for safeguarding).

.6 The police state that having recorded the details, the process adopted at that time was that referrals were considered jointly by police in the Central Referral and Tasking Unit and Children Young Peoples Access Team (these two teams have now been superseded by a Multi-Agency Safeguarding Hub in line with national good practice). A strategy threshold decision was reached by a Senior Social Worker and a Detective Constable; it was the opinion of the decision makers at the time that Oscar had appropriate measures in place for protecting the children. It was jointly agreed that the County's Children's and Young People's Services would send Oscar a letter offering him support and explaining the Child Assessment Framework (CAF) process.

.7 The police had no further involvement prior to the deaths of Oscar and Denise.

This Review concludes that police actions appear to have been considered, proportionate and appropriate in each instance.

3.2.4 Suffolk County Council Children's and Young People's Services.

.1 There was only minimal engagement by the County's Children's and Young People's Services (CYPS) prior to the incident resulting in the deaths of Denise and Oscar. All of the children in this case were schooled within Suffolk and this Review has looked at possible safeguarding opportunities at the schools separately.

.2 The family were not known by the County's CYPS prior to a referral from the police following Oscar report to them on 26th October 2013 (see previous section).

.3 C&YPS record that they were contacted by the police on 28th October 2013 after Oscar had informed the police he was moving the children to his sisters for fear that Denise may take them from the country. At that time referrals were considered jointly by police in the Central Referral and Tasking Unit and CYP Access Team (these two teams have now been superseded by a Multi-Agency Safeguarding Hub). A strategy threshold decision was reached by a Senior Social Worker and a Detective Constable; the decisions were recorded within an electronic file for the children.

.4 The decision made in October 2013 following Oscar's contact with the Police was ''Information and Advice''. The children's father was consulting with a solicitor and acting protectively. There was no indication that Social Care involvement was required as the father had taken action to ensure the children were in a safe place with their needs being met. Therefore, the matter was not referred for Children's Social Care intervention and the children did not become 'open' cases. No details were passed to any of the children's schools.

.5 Information was sent from the Access Team regarding a 'CAF'. This was not followed up by Oscar, but his choosing not to follow up this support should not infer any criticism.

.6 This course of action, the joint decision making between police and County Council, appears to this Review, on balance, as a proportionate and appropriate decision not to refer on to Children's Social Care, given the thresholds that exist for Social Care referrals. A corporate memory was held by both the police and County Council's Children's Services departments at a level that seemed appropriate at the time.

.7 This Review is able to establish that CAFCASS made a request for any information held by C&YPS on 5th November 2013. An email trail seen by the Chair of this Review shows this to have been responded to by the duty officer of the services Integrated Access Team on 6th November providing details of the police referral. It is standard procedure, when involved in private law proceedings, for CAFCASS to request checks of any knowledge that the County Council's Children's Services may hold which could assist them in their role as appointed by the Court.

This Review concludes that in the only interaction by the County's C&YPS prior to the deaths; the response appears appropriate.

3.2.5 Suffolk County Council Education and Schools

.1 As this Review evolved it became clear that enquiries were necessary of some of the schools attended by the children. Initially these enquiries were centred on the way in which the schools managed the Court Order forbidding Denise from collecting her children from school, together with any additional information they may have been made aware of accompanying that Order. However, that scope widened when the full extent of the disclosures made by the children to CAFCASS emerged. This section will deal with the schools' knowledge and action in relation to the Court Order firstly, then move to the other issues.

.2 All of the children have been schooled within Suffolk's County maintained school system. None of the schools are academies. Given the children's ages, all schooling has been covered.

.3 It is fact to say that none of the schools had raised any safeguarding concerns in respect of any of the children prior to the deaths of their parents. Whilst some were aware of the parental separation (and Denise's absence) none had any concerns about the parenting by either; none of the schools had identified, or otherwise become aware of, for instance, Denise's alcohol abuse. They describe the children as always immaculately presented, polite and engaging. Oscar and Denise were both involved with the schools at various times.

.4 In November 2013. The first family Court hearing was held following Oscar's application for a Residence Order. Amongst the conditions imposed were the following:

> "Mother be prohibited from removing the children from the jurisdiction of this Court, save for the purpose of agreed contact, specific details of which will have been agreed in writing with the Applicant and/or his solicitors or for the purpose of contact as ordered by the Court
>
> Mother be prohibited from making any arrangements to remove the children of the family from their current schools and to enroll them at any alternative educational establishment, either in England or Wales, or elsewhere, save as expressly agreed in writing by the Applicant Father"

The solicitor representing Oscar ensured that copies of the Order were sent to each of the schools attended by the children at the time. Whilst it is of course important to note that the subject of the Order is the mother and not the schools, it could be argued as to how the schools are meant to know about the terms if they are not provided with Orders as a matter of course or indeed the context in which they are made.

.5 None of the reasons surrounding the application accompanied the Order. The Order had been made on the basis of Denise's absence, a perceived threat that she would remove the children, alcohol abuse, and safety issues arising out of concerns for physical and emotional abuse of the children. The Court had made their ruling before CAFCASS had been engaged and on the basis of Oscar's application. Had the schools been made aware of some of the concerns underpinning the Order then

they could have offered additional support to the children and been alert to any issues that arose subsequent to the Order.

.6 CAFCASS became involved in early November at the direction of the Court and undertook telephone assessments with Oscar. Denise did not engage with them. None of the information arising out of that assessment process was subsequently passed to the schools.

.7 This Review found that staff at each of the schools recalled receiving the Order. Each dealt with in a manner they thought was in accordance with the guidance set out by the County's Education Service. An example of the thinking is set out by one head-teacher below:

"I have been asked if I recall the school being served with a Court Order during 2013 which prevented (Denise) from collecting the children from school. I have also been asked about the process we adopted in relation to that Order. I do recall the school receiving the Court Order and can confirm that my staff placed the Order within the child's 'blue folder'. The blue folder is a physical folder that contains important information relating to the child and which then follows the child from school to school within the County's maintained schools. I can confirm in this case that the blue folder containing the Court Order followed (xx) when the child left for (the next) School. In addition to the physical blue folder an electronic record containing the child's unique reference number is updated with information such as school attendance, attainment levels etc. This electronic record may also have had a 'tick box' for notification of other documents such as the Court Order.

Safeguarding concerns are contained within files that are separate to both of the above described processes. Safeguarding files are maintained by me and held securely within my office. I can confirm that no safeguarding records were commenced in relation to any of the (xx) children whilst at our school.

I believe that the way in which we dealt with the receipt of the Court Order was in line with what would be expected of us by the County Council's Education Department who provide guidance and training on a number of issues including safeguarding.

I have been asked if we considered opening a safeguarding record when we received a copy of the Court Order whilst (xx) was at the school. I recall at the time we were aware that (Denise) was out of the country, I believe in Brazil, and thus there was no reason to open a safeguarding file. In any event, it is unlikely that the existence of the Court Order alone, without any further safeguarding concerns or background information relating to the circumstances of the Court Order, would have prompted us to open a safeguarding record or make a safeguarding referral. I recall the information about (Denise) being in Brazil coming from (Oscar) during a conversation we had at the school. "

.8 This Review acknowledges that the schools properly dealt with the Court Orders in accordance with the guidance set down for the County's maintained schools. It has carefully considered whether the current guidance should be amended for fear of unintentional gaps in safeguarding emerging. Currently, in circumstances such as this one, where family court proceedings have commenced, the onus is upon

CAFCASS on behalf of the Court to make safeguarding referrals to the County's C&YPS where they have concerns that require a referral in their view. If CAFCASS make such a referral the C&YPS would make an informed decision as to whether to pass some or all of the concerns to the school for safeguarding purposes. In the event that CAFCASS do not make a referral (either because they do not feel it meets a threshold or indeed there is a breakdown in the reporting process) then neither the schools nor the County have any record as to the reasons behind the Order.

.9 Court Orders are not made without good reason. A potential gap exists in current practice; in this case the schools, which provide a vital safeguarding role, are named within Court Orders without understanding the context in which the Order is made. They are able to offer support and advice to young people in their care but also, importantly, when aware of the circumstances those young people are facing at home, they are able to monitor the signs of distress and behavioural change.

.10 In this case, at this time, both the County Council's C&YPS and CAFCASS held broadly the same information. The Court made its Order on the same information. None of that information was shared with the schools. It took the actions of the solicitor representing Oscar to bring the Court Order to the attention of the school. This Review does not criticise any of those bodies because the information held did not reach the threshold standards for referral to Children's Social Care. However, the Court felt strongly enough to make an Order that prevented a mother seeking to move her children's schools. That is not made lightly.

Lesson Learned: This Review feels that when Courts make such Orders steps are taken to put in place a process to alert those responsible for the care of young people (including the schools), wherever possible, as to the context of such Orders. Each school has nominated Safeguarding Leads who can take steps to protect the integrity of such information.

.11 **Recommendation 3: That the Local Safeguarding Children's Board work in partnership with the County's Education Department, C&YPS, the Courts and CAFCASS to review current processes in relation to Court Orders so that it properly supports the children and closes any potential safeguarding gaps.**

.12 The second issue addressed with the schools was the way in which an incident reportedly involving two children was managed and whether a safeguarding referral was considered in respect of it. During the 2013 CAFCASS interview, Oscar disclosed that Denise was violent towards the children and on one occasion she had violently assaulted two children resulting in serious scratches to their faces. He went on to say that both parents had been called in by the respective schools to explain the injuries. Both parents lied to cover for Denise's actions, saying that the children had caused the injuries themselves by fighting. This incident was further reported by the children during their CACASS interview in 2014 and then to the Chair of this Review when interviewed by him in 2015. The incident was said to have happened sometime during 2012.

.13 Both schools identified have confirmed that no safeguarding record was created or referral made as a result of this incident. Neither of the schools have any record of the incident, of any action that was taken and by whom. The children recall this as a significant event, even to the extent that Denise was so concerned about the injuries

to one of the children that she attended school and removed that child under a pretext of an appointment for some unidentified issue. The children say they were told what to say by their parents should the school ask them about the injuries. They remembered it to such an extent that one stuck to the story given to them by their parents whereas the other deviated from it. Neither disclosed the truth.

.14 This Review does not seek to unduly criticise the schools over their handling of this issue. Whilst there is no record of it within the schools, or within the records that accompany the children as they have moved schools, it seems clear it did happen and that both schools embarked upon an investigation to ascertain how the children got injured. Having called the parents in, and been given a version of events that was plausible, the matter was closed. The incident happened outside of school and thus no record was made. Both children were at different schools and neither school would have been aware of the other's involvement.

.15 **Lesson Learned:** This Review has considered whether a record should have been kept of the incident; it comes to the conclusion that it should. However, at the time, the schools were of the view that it was not something that they were expected to record. Whilst the children had injuries, an explanation given by the children's parents was accepted as the truth and the matter happened away from the schools. This Review however, does feel that where children attend a school with unexplained injuries and any form of inquiry is begun by the school as to how those injuries occurred, even if that enquiry is closed with what is considered a satisfactory explanation, then a record must be kept.

Recommendation 4: That the Local Safeguarding Children's Board work with the County's Education Authority to review the policy about recording of incidents such as this within its schools with a view to ensuring all unexplained injuries are recorded and what steps are taken to seek explanation.

.16 Whilst this Review is not about blame, I think it can properly use that word in connection with this issue. The blame for this issue not being further reported to the authorities sits firmly at the door of Oscar and Denise who deliberately covered up the issue. Had this been reported it would have undoubtedly prompted investigation of physical abuse which may in turn have provided the family with more support as their situation deteriorated.

.17 Finally, in relation to the schools, the Review has been told that Oscar was under pressure from Denise to regularly move the children in order that no one school ever got close enough to understand the problems they were facing. A review of the number of schools attended by the children does indicate what is considered to be higher than average level of movement. There is currently no process that oversees children's school movements to the extent that irregular movement could be noted. Each move is left to the individual schools to examine the reasons for wanting to move and for ensuring the associated documents accompany them. In this case, some of those moves went to appeal so additional scrutiny was placed around the motivation and reasons for wanting to move the children. Given the number of school children within Suffolk any analysis of school movements would have to be intelligence-led and if parents collude and deceive as part of that process then it is difficult to see how any system to provide appropriate alerts would be successful.

This Review concludes that whilst there were opportunities to record and report safeguarding concerns it recognises that these are made with the value of hindsight. However, a review of guidance around children attending school with injuries and a review of processes in relation to Court Orders would be of benefit to all.

Having visited a number of the schools attended by the children in this case; the Chair of this Review would like to place on record his view that they afford the children a supportive and caring environment.

3.2.6 CAFCASS (Children And Family Court Advisory Support Service)

.1 The role of CAFCASS is to represent children in family Court cases. Their aim is to make sure that children's voices are heard and that any decisions taken are taken in their best interests.

.2 The service is appointed by the Courts to provide advice but remains independent of the Court and also independent of other agencies such as local authorities, social services, police, health and education.

.3 CAFCASS is not a statutory body and therefore could not be compelled to assist this Review. Thus, the Chair would like to place on record his thanks for the way they have co-operated and have answered all the questions put to them.

.4 It is clear in this case that Oscar became fixated on the CAFCASS process and it became a cause of significant, perhaps almost overwhelming stress to him. He certainly took steps not to be entirely open with them about his levels of mental ill-health in the weeks immediately leading up to the family court and divorce proceedings. His view of what the outcome of the family assessment day might have been was clearly very negative and he feared for what the assessment might say about him as a parent and his ability to look after his children. The gap between the assessment day (28th October) and the next Court hearing (some 3 weeks) clearly increased that feeling of acute stress which he placed upon himself.

.4 This case was first brought to the attention of CAFCASS on 30th October 2013 when the application by Oscar for a Residence and Prohibited Steps Order was listed by the Court. A wide range of information was included in the application and included the following allegations against Denise: drug and alcohol abuse, driving the children around whilst intoxicated, volatile and unpredictable behaviour, domestic violence, and threats to remove the children to Brazil.

.5 The initial hearing took place before the case had been allocated to CAFCASS and the Court made its early decisions without the benefit of safeguarding information, including checks with the police and social services. CAFCASS brought this to the attention of the Court and they were instructed to bring a safeguarding report back to the Court after receipt of the safeguarding information.

.6 In order to progress the case, the allocated CAFCASS officer made contact with Oscar by telephone to ascertain information around the safety of the children. They were unable to contact Denise who was out of the UK. Efforts to make contact in

Brazil were unsuccessful. Amongst the information Oscar provided was information about Denise's intoxication and the assault on the two children, aforementioned. This information was not passed on to the County Council by CAFCASS.

.7 This Review has considered whether it feels a safeguarding referral should have been made by CAFCASS to the County Council at this time. CAFCASS child protection policy sets out the threshold for a child protection referral - where the practitioner believes that a child may be suffering, or is likely to suffer, significant harm - and the process by which this should be made. This is a matter of professional judgement. At the time this information was learnt (November/December 2013) the alleged perpetrator of the behaviour which was causing concern was out of the country, the children were not in immediate threat of danger and were being cared for within a supportive wider family environment. Certainly the information laid before the Court and supplemented by the CAFCASS officer's conversation with Oscar contains information that was far more of a concern than it appears had been placed before the police and County Council. The CAFCASS officer would not necessarily know that but actually on its own, "drug and alcohol abuse, driving the children around whilst intoxicated, volatile and unpredictable behaviour, domestic violence, and threats to remove the children to Brazil" should have made their way into the formal safeguarding arena. Thus given the information known at the time, this Review feels on balance that a referral should have been made. It could have led to more timely discussions with the schools about the issue of assault and could have led to greater support for the family at a time of difficulty. However, these are difficult decisions and ones that are made at the time in light of a myriad of other extraneous information that is not available now but which affects the decisions made at a moment in time.

.7 CAFCASS submitted their safeguarding letter to the Court in mid-December. At the time of the letter Denise was out of the country and the children were being looked after by Oscar with the support of his family. The CAFCASS review of their involvement in this case suggested that the response from the County Council had not been received until early December and showed neither Oscar nor Denise to known to the County Council. As set out at 3.2.4.7 within this report, the County Council records show an email trail responding to the request for checks on 6th November, and that the checks included the fact that both were known by way of the referral initially to police made by Oscar on 26th October.

.8 Whilst there has clearly been some administrative issue at some point in the chain this Review does not contend that this issue made any material difference to the outcome. At the time, the only information known was the single referral by Oscar, initially to police. The same set of facts was laid before the Court as part of Oscar's application for a Residence and Prohibited Steps Order. This Review does not feel it necessary to become disproportionately burdened by this single issue.

.9 The case was relisted at the Family Court for early May 2014. At this hearing, attended by Oscar but not Denise, the case was finalised. A Child Arrangement Order was made by the Court that the children should live with Oscar and that contact with Denise should be indirect only. The case was closed by CAFCASS at that stage.

.10 In July 2014 CAFCASS were notified that Denise had applied to vary the Order and the case was re-opened. The Court instructed that both Oscar and Denise engage in a process of mediation and it was relisted for 19th August. CAFCASS were engaged in preparation of a further safeguarding letter which included information received from a further telephone consultation with Oscar. His fear that the children would be removed from the country had been mitigated by the fact that he had blocked their passports and he was accepting of the fact that the children needed to see their mother, he was of the view however that this should be in a controlled manner. The letter suggests that he did not now have concerns over any further physical assaults on the children which he had outlined previously to CAFCASS. Denise did not engage in the process at this stage despite efforts by CAFCASS to engage with her.

.11 The further Court hearing took place on 21st August, at which Denise attended. The CAFCASS officer spoke to her about the alleged assault which Denise denied. Unfortunately, in both the letter to the Court and the interview with Denise, the wrong child had been named as victim of the alleged assault.

.12 The Court instructed that a Section 7 report be prepared for the Court by CAFCASS (A Section 7 report is a more in-depth report commissioned by the Court about a child's welfare).

.13 A different CAFCASS officer was allocated the case and began dialogue with Oscar in particular. The dialogue is described as frequent with Oscar often calling to change his mind about statements he had previously made. The CAFCASS officer was aware that he had been seeing his GP for help in dealing with stress and that he had also been attending a Separated Parents Programme to help him understand his role as a single parent and the continued care of the children. There is no evidence that Denise engaged with CAFCASS at this point.

.14 CAFCASS involvement progressed to a Family Assessment Day which took place on 28th October 2014. Both Oscar and Denise attended, as did the children. Oscar and Denise were spoken to separately as were the children.

.15 The arrangements for, and the progress of, the Family Assessment Day are set out by CAFCASS below. The following is in response to a view held by the children that they had been interviewed with their father present.

"A family assessment day was arranged by (Officer) on 28 October 2014 and took place at the CAFCASS Office in Ipswich. Assessment days are usually held on one day although sometimes may take place over two. This form of assessment means that relevant members of the family, which can include those who are not party to the proceedings can be seen together if appropriate, though this would usually only be undertaken if assessed as being safe and appropriate.

The children were not interviewed with their father present in the room with them. This is in line with *How it looks to me – guidance on the child impact tool.* Children are generally interviewed alone, though (officers) are expected to exercise their professional judgement on this matter, in the light of age, understanding, affect etc. An individual interview took place between (officer) and x, while the others were

spoken to collectively. Oscar was neither present nor visible during any of these interviews, both of which lasted around half an hour.

In addition, (the children) were observed with their father in order to better understand the relationship between them by way of dynamics within the family, attachments and family functioning. It may be that this is the meeting that the children recall? They were also observed with their mother later on the same day with the exception of x, who made it clear that they did not wish to meet with their mother.

Denise arrived at the Ipswich office later – when the children and Oscar were not in the building as their father had taken them for lunch. When they came back they went directly into interview room 1 and Denise waited in a different part of the building in order to avoid any chance of them meeting. X was adamant that they did not want to see their mother – and did not. X was uncomfortable about spending time with their mother. X did meet with Denise but did not engage. X was clearly angry and this came across in their refusal to engage. The other children did engage with their mother and this was observable.

Relationships with their father were relaxed, vocal and confident."

.16 At the same assessment day the children all recounted how they were regularly hit by their mother when in her care. They said that it was in their mothers 'culture to hit kids'. That beatings included shoes and belts. Denise acknowledges that this did happen but said that type of punishment was acceptable in her culture but she rejected it being a beating.

.17 Oscar repeated his concerns of Denise's alcohol abuse, the effect of Denise's frequent absences upon the children and his fears of the effect that Denise's recent move back into the village would have upon the children. Denise acknowledged that she had been inconsistent in her contact but suggested that she wanted to be more consistent moving forward. She did accept her high levels of alcohol abuse, that she had driven the children whilst drunk and had at times hidden vodka in the children's juice bottles. She accepted that she physically smacked and hit the children but denied it was a beating, she acknowledged that this was more likely when she was intoxicated.

.18 Whilst not convinced about Denise's apparent change in approach and intentions it was the view of the CAFCASS officer that any on-going contact between Denise and the children should be professionally supported.

.19 No safeguarding referrals were made to the County Council as a result of the information gained through this family assessment process. Their report was due to be with the Court by 18th November, some three weeks after the assessment day.

.20 As previously stated CAFCASS Child Protection Policy sets out the threshold for child protection referrals: 'where the practitioner believes that a child may be suffering, or is likely to suffer, significant harm'. It also sets out the process by which this should be made. This is a matter of professional judgement. In this case each of the three practitioners involved was made aware of concerns but did not report these to

the County Council. An internal review by CAFCASS following the deaths took the view that on balance a referral should have been made in this case.

.22 As a result of their review into this case CAFCASS have identified two areas of organisational learning:

1. CAFCASS Child Protection Policy sets out the threshold for a child protection referral - where the practitioner believes that a child may be suffering, or is likely to suffer, significant harm - and the process by which this should be made. This is a matter of professional judgement. In this case each of the three practitioners involved were made aware of concerns but did not report these to the County Council. The service manager who quality assured the case after the deaths came to the view that a referral should have been made, a view with which I concur.

2. Particular care must be taken with the identification of individual children in reports to Court - highlighted in this case when a mistake was made about naming a child of the family where, at that point, there had been no allegation of harm caused to that child.

.21 **Lesson Learned:** This Review acknowledges the difficult task undertaken by officers when completing such assessments. However, it does concur with CAFCASS's own view in that on balance a referral should have been made in this case.

This Review has reflected upon CAFCASS's own position and had further conversations with them about their quality assurance process. Three opportunities for referral were not taken by its staff. For a service manager to quality assure the case after the deaths and come to a conclusion that on balance referrals should have been made prompts the question of what quality assurance was undertaken in real time. As a result of its enquires this Review is content that CAFCASS have in place a system of quality assurance which they believe ensures all reports have to be quality assured before submission to the Court. However, this case must prompt a review of such arrangements to ensure that they provide robust checking and challenge for the professional view of officers.

This Review does not suggest however, that making a referral in this case would have prevented the tragedy the occurred.

Recommendation 5: That CAFCASS reviews its working practice to ensure that all staff completing assessments have adequate levels of quality assurance.

.22 **Lesson Learned:** In addition, 3.2.6.3 above sets out that CAFCASS are currently not a statutory body required by law to assist Reviews such as this. Whilst this Review acknowledges the absolute independence of the Courts, and that CAFCASS act on entirely on behalf of the Courts, their involvement in this case and the Chair suspects in many others, is so integral that the Home Office should consider working with the Ministry of Justice and review whether a change of status to include them as a statutory body is appropriate.

Recommendation 6: That the Home Office work with the Ministry of Justice to consider adding CAFCASS as a statutory body within the meaning of the Act.

.23 There remains negative feeling towards the CAFCASS process from the family of Oscar and the children in particular. In general terms they feel:

- that the system did not protect them;
- it did not respond to their disclosures of physical and emotional abuse;
- they asked why the CAFCASS officers questioned Oscar's father as to why he wrote to them, in particular asking him if Oscar had 'put him up to it';
- that having to wait several weeks for the report to be prepared for Court increased the stress on them all rather than mitigated it; and,
- they feel had the same disclosures been made about their father then any contact with him would have been blocked pending a proper investigation.

The Chair of this Review understands why those feelings have emerged. He agrees that on balance a referral should have been made once the children had made their referrals, although he can understand why the decision not to was undertaken. The issue of timeliness and the stress caused by the delay from assessment day is one that CAFCASS had no control over; the dates are set by the Courts. CAFCASS were recommending that the children stay with Oscar, he had not been told this and thus his concerns about having the children taken away were unfounded. It is difficult to see how CAFCASS could have told him what they were recommending as their report is part of the Court process and the Judge is the decision maker not them. Had they given him any indication of their recommendation and it made its way to Denise then the process itself could be called into question and more difficulties ensue.

The Review asked CAFCASS whether why that had been done. They responded as follows:

"(Oscar) rang xxxx and said he was unhappy and upset to learn that his father had written as he did not want his father to interfere in any way at all. Xxxx's impression of (Oscar) was that he was hoping that the family as a whole could 'move on' and thought that his father writing to voice his views could be seen as a retrograde step. During our discussion xxxx emphasised that (Oscar) was frequently in contact with xxxx during the period of the proceedings and often rang to either minimise or seek to change the import of what he had earlier said to her. He expressed this as 'what I'm trying to say xxxx is…' and then was unable to put into words what he meant. xxxx impression was that what he sought for the children was confused and changed day by day although he was consistently very loving and caring about them."

This Review has considered carefully whether this was an issue where a sub-conscious gender bias could have played a role. Had those referrals been made about their father, would they have been taken more seriously or referred for further safeguarding action?

The individual CAFCASS officer was spoken to specifically regarding this and responded,

''This is not gender driven for me. Exactly the same approach would have been taken whether it was a mother or father. I have really searched myself about this and am clear that no matter who is reported as having caused harm to a child I would report the issue".

Contact is based on the needs of the child not the adult. The Children Act (1989) – as amended by the Children and Families Act (2014) – sets out a presumption 'that each parent's involvement in the child's life will further the child's welfare, where it is safe'. A referral to a Local Authority does not automatically lead to a Court stopping contact; I am unable to speculate what determination the Court would have made in this case, beyond suggesting that it would have balanced the presumption of involvement against risk. CAFCASS made clear in their report to the Court that: 'notwithstanding, the changes that (Denise) was intending to make they were of the professional view that any contact between the children and (Denise) should be professionally supported.

This Review concludes that there were opportunities for referrals or information sharing across agencies that may have prompted an intervention and additional support for a family in crisis. There is no way of knowing whether such intervention would have prevented what happened; it may have done but equally it may have only hastened the same tragic end.

3.2.7 East of England Ambulance Service

The Ambulance Service have been valuable contributors to this Review through the Panel. Their agency involvement with the family is confined entirely to the day of the deaths and thus is not further mentioned within this analysis.

3.3 Other issues considered

3.3.1 Throughout the process of this Review it has considered the services provided within Suffolk and the operational effective, operation effectiveness and the strategic governance thereof.

3.3.2 The Review considers there to be a good understanding of domestic abuse, its signs, how to signpost and where to go for advice and support at an operational level. The development of a Multi-Agency Safeguarding Hub (MASH) is a positive example of good partnership working at an operational level. Its development has been noticeable by positive comment at each of the Panel's meetings. The MASH is widely publicised and is explained as follows on the Constabulary (but also other statutory agencies) website:

"A range of organisations in Suffolk with responsibility for safeguarding both adults and children such as Suffolk County Council, Suffolk Police, Health Services, District and Borough Council Housing Services, Education, Probation and the Youth Offending Service have come together to create a Multi-Agency Safeguarding Hub (MASH).
The Suffolk MASH has been developed as a result of learning from previous experiences, especially from lessons highlighted by Reviews of serious safeguarding incidents across the country. A recurring theme of these Reviews is the importance of information sharing and close working arrangements between relevant agencies. The MASH model has been strongly endorsed in the OFSTED report 'Good Practice by Local Safeguarding Boards' and 'The Munro Review of Child Protection'. The Care Act 2014 draft guidance also highlights a MASH which includes adult safeguarding as best practice.
The MASH is being implemented in stages to make sure that the high standards of safeguarding already in Suffolk don't suffer during the transition from current arrangements to a fully functioning MASH by the end of the summer. Once fully operational the MASH will be made up of approximately 60 professionals from the County Council Children and Adult Services, Suffolk Police, Health and Mental Health Services, Youth Offending Services, Housing and Probation. The majority of these staff will be located at Landmark House in Ipswich.
The main advantage of the MASH is that officers can share the information their agency may have on a child or adult immediately to ensure the decisions taken about how to help an individual are done so, taking into account all available information."

3.3.3 A revised County-wide Domestic Abuse Strategy was produced in 2015 by the Suffolk Domestic Abuse Partnership. Entitled 'Domestic Violence and Abuse: A Partnership Strategy for Suffolk. 2015-2018'. This is a comprehensive document and should drive Domestic Abuse strategy, thinking and delivery for the next three years.

3.3.4 However, this Review is concerned about what is perceived by some to be a lack of demonstrative strategic oversight of domestic abuse service provision and the strategic leadership for domestic abuse issues within the County.

3.3.5 The Chair of this Review asked a number of people and organisations 'who provides the strategic leadership for domestic abuse'. The answers were disparate and on

more than one occasion were met with, “we were hoping you would tell us”. This situation needs urgently resolving.

3.3.6 The County’s Police and Crime Commissioner has helpfully made tackling Domestic Abuse one of his top priorities and took a lead in commissioning a research paper: “Understanding Domestic Abuse: A study of the experience of survivors”. This could have been a catalyst for providing a new and fresh structure. It is well referenced within the new County Strategy document outlined above. However, this Review has been told anecdotally that this approach was not well received across some agencies and as a result had some resistance.

3.3.7 The Chair was pleased that one theme within the County’s Health and Wellbeing Boards’ work programme will look to lead on domestic abuse. However, the Police and Crime Commissioner is not a statutory member of the Health and Wellbeing Board with the resultant risk that areas for which the Police and Crime Commissioner has primacy are not necessarily linked with those that the Health and Wellbeing Board have primacy.

Lesson Learned: The two-tier structure of the Local Authority, the independent nature of Community Safety Partnerships with no direct county-wide oversight, the emergence of the Police and Crime Commissioner and Health and Wellbeing Boards has the potential for making a clear governance structure difficult to achieve. However, it also provides great opportunity for strong partnership arrangements that drive down to a local level. The Chair of this Review has been struck by how many individuals truly want to make a difference. It is therefore essential that the senior leadership across the County’s structures and organisations agree a clear governance structure for Domestic Abuse in order to harness everyone’s undoubted passion for making a difference.

Recommendation 7: That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk.

Section 4: Conclusions

This was a truly tragic case resulting in two untimely deaths and orphaned children.

Whilst there was some prior service involvement with the deceased, this was largely within the domain of the health services. The services provided by them were largely proportionate and escalated appropriately in a timely manner. Whilst there were significant indications to them that Oscar was a clear suicide risk, they were not made aware of any threat that he posed to Denise. In addition, it is not reasonable to conclude they should have been identified such a threat.

Other agencies had more limited involvement, the police and County Council's Children's Services departments had minimal knowledge of either of the deceased and the one specific referral they received from Oscar they shared and responded to appropriately at the time.

The County's schools provided a caring environment for the children; however, two schools could have made a safeguarding referral when two children arrived at school with significant injuries to their faces which we now know were caused by their mother. The schools embarked upon an investigation and were satisfied with the explanation they received from both parents who lied to them. The fact that they did not make a referral is understandable and was in accordance with existing practice. The fact that no record was made of the incident by either school is regrettable but also in line with what was existing practice.

The Court engaged CAFCASS to provide them with an assessment of safeguarding issues in this case. CAFCASS had three opportunities to make referrals based upon information provided to them from the family, in particular the children. None were made. This Review acknowledges that decisions as to safeguarding referrals should not be made lightly and are a professionally subjective decision affected by many more factors than are available to us in hindsight. However, it does feel on balance that referrals should have been made in this case.

This is a case that once again highlights the stigma that still exists in relation to mental ill-health. The father, prone to stress and anxiety, felt he could not tell those who were charged with making decisions about the long term care of his children, for fear of it being held against him.

As with many cases, some decisions could have been made differently. There are lessons to be learned and this Review has identified a number of recommendations for further action, in order to try and prevent anything similar. There were opportunities for referrals or information sharing across agencies that may have prompted an intervention and additional support for a family in crisis. There is no way of knowing whether such intervention would have prevented what happened; it may have done but equally it may have only hastened the same tragic end.

Our thoughts are with the surviving children.

Appendix A

Summary of Examples of good practice, lessons learned and recommendations.

Example of good practice

The use of a Domestic Homicide Review Advisory Panel to provide rigour around early decision making by the Chair of the Community Safety Partnership.

Lessons learnt

Lesson Learned: It is clear that the expectations and understanding of the GPs and The NHS Foundation Trust as to what constituted an urgent referral were at odds on this occasion. This Review would suggest that any existing protocol that exists between GPs and The Trust for emergency referrals be reviewed and clarity communicated about expectations. The Trust did not deal with this issue with the urgency that the GPs expected and thus an opportunity to engage with Oscar on the day of crisis was lost. However, the Trust asserts that they adhered to the protocol for an urgent referral; hence the need for clarity of the process and expectations is clear. The issue of urgent referrals is returned to later within this report.

Recommendation 1: Any existing protocol that exists between GPs and The Trust for emergency referrals be reviewed and clarity communicated about expectations.

Lesson Learned: It is likely that many families and children going through the pressures of domestic abuse, divorce and family breakdown will not have similar levels of support that were prevalent within the wider family in this case. Thus the Safeguarding Children's Board should satisfy themselves that the range of support available is clear to all professionals who engage in work with children and families.

Recommendation 2: That the Local Safeguarding Children's Board take steps to ensure that the range of support available is clear to all professionals who engage in work with children and families.

Lesson Learned: This Review feels that when Courts make such Orders, steps are taken to put in place a process to alert those responsible for the care of young people (including the schools), wherever possible, as to the context of such Orders. Each school has nominated Safeguarding Leads who can take steps to protect the integrity of such information.

Recommendation 3: That the Local Safeguarding Children's Board work in partnership with the County's Education Department, C&YPS, the Courts and CAFCASS to review current processes in relation to Court Orders so that it properly supports the children and closes any potential safeguarding gaps.

Lesson Learned: This Review has considered whether a record should have been kept of the incident where the children attended school with injuries to their faces; it comes to the conclusion that it should. However, at the time, the schools were of the view that it was not something that they were expected to record. Whilst the children had injuries, an explanation given by the children's parents was accepted as the truth and the matter

happened away from the schools. This Review however, does feel that where children attend a school with unexplained injuries and any form of inquiry is begun by the school as to how those injuries occurred, even if that enquiry is closed with what is considered a satisfactory explanation, then a record must be kept.

Recommendation 4: That the Local Safeguarding Children's Board work with the local Education Authority to review the policy about recording of incidents such as this within its schools with a view to ensuring all unexplained injuries are recorded and what steps are taken to seek explanation.

Lesson Learned: This Review acknowledges the difficult task undertaken by officers when completing such assessments. However, it does concur with CAFCASS's own view in that on balance a referral should have been made in this case.

This Review has reflected upon CAFCASS's own position and had further conversations with them about their quality assurance process. Three opportunities for referral were not taken by its staff. For a service manager to quality assure the case after the deaths and come to a conclusion that on balance referrals should have been made prompts the question of what quality assurance was undertaken in real time. As a result of its enquires this Review is content that CAFCASS have in place a system of quality assurance which they believe ensures all reports have to be quality assured before submission to the Court. However, this case must prompt a review of such arrangements to ensure that they provide robust checking and challenge for the professional view of officers.

This Review does not suggest however, that making a referral in this case would have prevented the tragedy the occurred.

Recommendation 5: That CAFCASS reviews its working practice to ensure that all staff completing assessments have adequate levels of quality assurance.

Lesson Learned: CAFCASS are currently not a statutory body required by law to assist Reviews such as this. Whilst this Review acknowledges the absolute independence of the Courts, and that CAFCASS act on entirely on behalf of the Courts, their involvement in this case and the Chair suspects in many others, is so integral that the Home Office should consider working with the Ministry of Justice and review whether it is appropriate to make a change of status to include them as a statutory body participating body within the Act.

Recommendation 6: That the Home Office consider adding CAFCASS as a statutory body within the meaning of the Act.

Lesson Learned: The two-tier structure of the Local Authority, the independent nature of Community Safety Partnerships with no direct county-wide oversight, the emergence of the Police and Crime Commissioner and Health and Wellbeing Boards has the potential for making a clear governance structure difficult to achieve. However, it also provides great opportunity for strong partnership arrangements that drive down to a local level. The Chair of this Review has been struck by how many individuals truly want to make a difference. It is therefore essential that the senior leadership across the county's structures and organisations agree a clear governance structure for Domestic Abuse in order to harness everyone's undoubted passion for making a difference.

Recommendation 7: That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk.

Appendix B

Multi-agency Action Plan

RECOMMENDATION	Scope of Recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target date	Progress indicator	Date of completion and outcome
What is the over-arching recommendation?	Local, regional or national level?	How relevant agency will make this recommendation happen? What actions need to occur?			From date of publication of report.	Red Amber Green	
Recommendation 1: **Any existing protocol that exists between GPs and The Trust for emergency referrals be reviewed and clarity communicated about expectations.**	Local	Review existing current protocols for GP referral to mental health services Develop and agree language used for level of immediacy of referral and assessment Ensure clear and effective processes are in place for communicating referrals, level of concern and outcomes	Norfolk and Suffolk Foundation Trust Clinical Commissioning Group (CCG)	Review existing protocols Amendments as required Communication to all parties of new protocols Review effectiveness of new protocols	By 31/12/2016 By 31/01/2017 By 31/01/2017 By 31/03/2017		

Recommendation 2: **That the Local Safeguarding Children's Board take steps to ensure that the range of support available is clear to all professionals who engage in work with children and families.**	Local	Review current support services for families experiencing domestic violence Ensure all staff are aware of services available and have knowledge and understanding of how to access these services for families and offer these services Identify gaps in current provision and develop plan of how to address these gaps to maximise support to families and minimise risk to children and families	Local Safeguarding Children's Board	List of support services available Publication / dissemination of above list to all relevant organisations Gaps in service identified Plan developed to address gaps	By 01/12/2016 By 31/12/2016 By 31/12/2016 By 28/02/2017		
Recommendation 3: That the Local Safeguarding Children's Board work in partnership with the County's Education Department, C&YPS, the Courts and	Local and Regional	Review current protocols for information sharing for court orders Ensure protocols enable information to be shared when required to minimise risk to children	Local Safeguarding Children's Board	Current protocols reviewed Clear processes for information sharing in place	By 31/12/2016 By 31/01/2017		Email sent 12 August 2016 by Rebecca Dale, Safeguarding Administrator on behalf of Richard Green, Cafcass

CAFCASS to review current processes in relation to Court Orders so that it properly supports the children and closes any potential safeguarding gaps.		Develop a partnership agreement as to how information is to be shared and how a lead professional in each organisation could be identified to work with the courts and child/young person to ensure effective and relevant information flow and provide support to the child/young person.		Partnership agreement in place	By 28/02/2017		National Child Care Policy Manager: The recommendation is to the LSCB and it is for them to decide whether and how to action it. However, as we previously explained, Cafcass is bound to comply with the Family Procedure Rules regarding the sharing of information, other than where this is in the

							furtherance of child protection. Schools do not fall within that definition, so the permission of the court would be required.
Recommendation 4: That the Local Safeguarding Children's Board work with the local Education Authority to review the policy about recording of incidents such as this within its schools with a view to ensuring all unexplained injuries are recorded and what steps are taken to seek explanation.	Local	Review current protocols for recording all unexplained injuries as noted by schools. Amend and update the above aforementioned protocols as required Ensure all schools are made aware of any changes and their role in recording and reporting any unexplained injuries and that this is disseminated to all staff Ensure all staff have suitable level of safeguarding training and awareness of when and	Local Safeguarding Children's Board	Current protocols reviewed Protocols updated Information communicated to all Suffolk schools with clear guidance on informing staff All staff have up to date	By 31/12/2016		

		how to report any safeguarding concerns		safeguarding training			
Recommendation 5: That CAFCASS reviews its working practice to ensure that all staff completing assessments have adequate levels of quality assurance.		Review current quality assurance process within CAFCASS Amend processes if necessary to ensure that there is sufficient senior level quality assurance of the work undertaken Ensure all staff have up to date safeguarding training and awareness of when to report any concerns	CAFCASS				Email sent 12 August 2016 by Rebecca Dale, Safeguarding Administrator on behalf of Richard Green, Cafcass National Child Care Policy Manager: This seems an odd recommendation in light of one of the findings of the report (page 62) is that Cafcass has a fit-for-purpose system of quality assurance. However (and

							more pertinently) the mechanisms by which Cafcass quality assures have been reviewed several times since these deaths occurred nearly two years ago. In February this year we produced an updated Quality Assurance and Impact Framework. Establishing that work is of the required standard is

							undertaken by a range of different mechanisms including: performance and learning reviews; situational supervision; national audits of safeguarding practice (which have found sustained improvement); thematic audits; Area Quality Reviews; dip sampling by senior managers etc. We are not persuaded currently that

							a further formal review is required. Can we suggest therefore that the recommendation is removed?
Recommendation 6: That the Home Office consider adding CAFCASS as a statutory body within the meaning of the Act.	National	For the Home Office to review role of statutory bodies within the Act and whether CAFCASS should be an addition	Home Office				
Recommendation 7: That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk	Regional	Identify and gain agreement of key organisation required to develop a county wide strategic leadership approach Develop a governance arrangement for strategic leadership for domestic abuse across Suffolk Identify leads for domestic abuse within each	Chair of Community Safety Partnership to co-ordinate with Police and Crime Commissioner		By 31/01/2017		

		organisation Develop clear terms of reference for strategic roles to enable each organisation to understand their role and function within the county in preventing and reducing harm caused by domestic abuse.					