torbaysafeguardingchildrenboard

Safeguarding Adults

Torbay **Safeguarding Children** Board

In association with Safer Communities Torbay & Torbay Safeguarding Adults Board

Serious Case Review C42

Jim Connelly-Webster & Lisa Jennings

November 2014

Keeping children safe is everyone's responsibility

Torbay Council Children's Services ■ Police ■ Health ■ Careers South West
Youth Offending Team ■ Probation ■ CAFCASS
Safer Communities ■ Fire Service ■ Schools ■ Community & Voluntary Sector
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This review was conducted using SCIE's Learning Together methodology, based on principles directly drawn from systems theory

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1. Introduction

Why this case was chosen to be reviewed

1.1 Child A died on the 12th July 2013, along with his mother following a fall. The body of Child B was found later that same day at their home address.

1.2 The incident was immediately recognised as serious and meriting a review through a Serious Case Review (SCR) process. This was discussed by the Independent Chair of the Torbay Safeguarding Children Board (TSCB) and the Director of Children's Services on the 15th July 2013, this decision was communicated to the SCR Subgroup for further consideration and ratification.

1.3 The circumstances surrounding the deaths were considered at a meeting of the SCR Subgroup on the 22nd July 2013 where it was agreed that the criteria for undertaking a SCR had been met. The decision was made with reference to guidance contained in Working Together 2013 (page 68):

1.4 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

1.5 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

1.6 (2) For the purposes of paragraph (1) (e) a serious case is one where:
   (a) abuse or neglect of a child is known or suspected; and
   (b) either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.7 The SCR Subgroup was aware that the family had been known to Torbay Children's Services since April 2013 when police had been called to a domestic incident.

1.8 A meeting of the Torbay Safeguarding Adult Board (TSAB) SCR Subgroup was held on the 2nd August 2013 to consider the death of the mother and concluded that the criteria for an adult SCR had been met in that a vulnerable adult had died and abuse or neglect was suspected to be a factor in the death. The decision was made with reference to the guidance contained in the TSAB Guidance for Conducting Serious Case Reviews[1].

1.9 On the 8th August 2013 the Community Safety Partnership (CSP) considered whether a Domestic Homicide Review (DHR) should be completed. A DHR is undertaken in circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

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[1] Torbay Safeguarding Adults Board (2009) *Procedures and Guidance for Serious Case Reviews* www.torbaycaretrust.nhs.uk/ourservices/SafeguardingAdults/Documents/SCR%20Procedures%20and%20Guidance.pdf

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself.

1.10 The review is held with a view to identifying the lessons to be learnt from the death[2].

1.11 The CSP recommended that the desired outcomes of a DHR (i.e. identifying learning and improvement) could be accomplished within the TSCB SCR without the need for an additional DHR process.

1.12 It was agreed by the respective partnerships that one review should be carried out, led by the TSCB which captured the requirements of a TSCB SCR, TSAB SCR and CSP DHR.

Succinct summary of case

1.13 This case is concerned with the services provided to two children and their mother following a domestic incident in April 2013 that resulted in the mother self harming in an apparent suicide attempt and the children being accommodated in foster care whilst the father was charged with assault.

1.14 Following the incident a range of services became involved to support the children and their mother. These initially included police and children's services, but soon expanded to include mental health services and domestic abuse support services.

1.15 The children were looked after by foster carers from the 28th April 2013 to the 17th May 2013 before returning to their mother's full time care. During this period the mother disclosed a history of domestic abuse and difficulties in her childhood.

1.16 The mother sought support in the form of counselling and was seen by the Depression and Anxiety Service (DAS) but was not eligible to receive a service whilst the court case against her partner was ongoing.

1.17 The mother continued to receive support from children's services in respect of the children and domestic abuse support services in relation to the pending court case against her partner. To family, friends and professionals she appeared to be coping well, there were no concerns that she would self harm or that she posed any risk to the children.

1.18 Tragically, several weeks before the court case, the mother aged just 24 years, took her own life and that of Child A on the 12th July 2013. The body of Child B was discovered later that same day at the home address.

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[2] Home Office (2013). *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

1.19 The inquest into the deaths was held on the 15th September 2014. The coroner ruled that the mother took her own life and that Child A was unlawfully killed. An open verdict was recorded in respect of Child B.

Family composition

1.20 The family comprised of the mother and her partner who was the father of their two children, Child A and Child B.

Timeframe

1.21 The timeframe for the review was set at the initial meeting between the Lead Reviewers and the Review Team on the 9th September 2013. The agreed time frame was from April 2013 (when the mother went missing and the children were placed in the care of the local authority) until the 12th July 2013.

1.22 Within the period under review, eight key practice episodes (KPE's) were identified (covering the period from 28th April 2013 until 10th July 2013). These KPE's were then analysed in detail to provide insight into not only what happened with the children and their mother but also why things happened as they did. It was from this process of detailed analysis that the learning from the review (presented later as findings) was generated.

Organisational learning and improvement

1.23 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

> Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. (Working Together 2013: 66)

1.24 The TSCB identified that the SCR of this case held the potential to shed light on particular areas of practice and set out to:

- establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of vulnerable adults and children;

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

- apply these lessons to service responses including changes to policies and procedures as appropriate; and

- improve intra and inter-agency working and better safeguard and promote the welfare of vulnerable adults and children.

Methodology

1.25 Statutory guidance requires SCRs to be conducted in such a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings. (Working Together 2013: 67)

1.26 It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process (Working Together 2013: 66-67)

1.27 In order to comply with these requirements the TSCB has used the SCIE Learning Together systems model (Fish, Munro & Bairstow 2010).

Reviewing expertise and independence

1.28 The review has been carried out by a Review Team led by two people, Jim Connelly-Webster, independent of the case under review and of the organisations whose actions are being reviewed and Lisa Jennings, TSCB Business Manager. Both are trained in the SCIE Learning Together systems model.

1.29 Jim Connelly-Webster, Independent Lead Reviewer
Jim is an independent consultant working in the fields of training and leadership. He served as a police officer for 31 years in posts across the country including Head of CID for Devon and Cornwall Police. He was an executive member of the Plymouth Children Safeguarding Board. He has conducted reviews in the UK and abroad. He has been trained in the SCIE methodology and has had the benefit of SCIE mentoring during this review.

1.30 Lisa Jennings, Lead Reviewer
Lisa is a registered Social Worker and has completed the SCIE Learning Together Foundation Course and has previous experience of undertaking SCIE reviews. Whilst undertaking the review she was independent of the services provided by the TSCB partners and was employed by the Board as Professional Adviser and Business Manager. Lisa now works for Torbay Council as Quality Assurance Manager for Children's Services.

1.31 The Lead Reviewers received supervision from SCIE as is standard for Learning Together reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence. This involved case consultation, supervision and a findings clinic for the Lead Reviewers. Additional mentoring through SCIE was also provided to support both Lead Reviewers.

1.32 The Review Team was made up of senior representatives from the different agencies that had been involved with the children and their mother. The role of the Review Team members is to provide expert knowledge in relation to the practice of their individual agency, to contribute to the analysis of practice and to the development of the findings from the review. No members of the Review Team had any direct case management responsibility in relation to the services offered to the children and their mother.

1.33 The Review Team was made up as follows:

Name	**Job Title**	**Organisation**
Jim Connelly-Webster	Lead Reviewer	Independent Reviewer
Lisa Jennings	Lead Reviewer	Torbay Safeguarding Children Board
	Head of Behaviour Support	Torbay Council

	Executive Head Community Safety	Torbay Council
	Designated Nurse for Child Safeguarding	South Devon and Torbay Clinical Commissioning Group
	Detective Sergeant	Devon & Cornwall Police
	Associate Director of Adult Social Services	Torbay and Southern Devon Health and Care NHS Trust
	Named Nurse for Safeguarding Children	Devon Partnership Trust
	Children in Need Service Manager	Torbay Council
	General Practitioner	

Structure of the review process

1.34 Professionals who worked with or made decisions about the family were invited to be part of the Case Group. They were invited to share their experiences of working with the children and their mother through a process of individual conversations. A total of twenty two conversations were held with individual practitioners. Two members of the Review Team were involved in each conversation.

1.35 Using the SCIE model, gathering and making sense of information about a case is a gradual and cumulative process. Following the individual conversations with practitioners the Review Team held a series of analysis meetings. The emerging narrative and learning from these, the findings as viewed at this point were presented to the Case Group in what are known as 'Follow On' meetings.

1.36 Over the course of this review the Review Team met eight times. Three of these meetings included the Case Group, for half days - one for an introductory session and then for two half-day (Follow On) meetings to present the emerging analysis.

1.37 Attendance at all meetings was challenging for those involved. Despite this, all Review Team and Case Group members were committed and were keen to add value to the process. During the process there were a common core of attendees at the meetings and all Review Team members completed tasks between meetings. Within the Case Group and Review Team, there has been a willingness to engage with the process, however this was difficult and led to some members feeling pressurised to go through a difficult situation several times over.

Acronyms used and terminology explained

1.38 Statutory guidance requires that SCR reports be written in plain English and in a way that can be easily understood by professionals and the public alike (Working Together 2013: 70).

1.39 Writing for multiple audiences is always challenging. In the Appendix we provide a section on terminology to support readers who are not familiar with the processes and language of safeguarding and child protection work.

Perspectives of parents, family and friends

1.40 The Independent Chair of the Safeguarding Children Board wrote to the father of the children shortly after the decision was made to conduct a SCR to inform him that a review into the circumstances of the children's deaths and that of their mother was to be completed. Following the appointment of the Lead Reviewers further contact was made to invite him to meet with the Lead Reviewers if he wished to do so. Contact with the father of the children was not effective until after the inquest. The Lead Reviewers then met with him and he was able to set out his experiences and views.

1.41 The Independent Chair of the Safeguarding Children Board also wrote to the mother's father, the grandfather to the children, shortly after the decision was made to conduct a SCR to inform him that a review into the circumstances of the children's deaths and that of their mother was to be completed. Following the appointment of the Lead Reviewers further contact was made to invite mother's father to meet with the Lead Reviewers. The Lead Reviewers met with a 2nd cousin of the mother on the 17th October 2013 and the 28th October 2013. The Lead Reviewers also met with the mother's brother, uncle to the children on the 7th December 2013 and made telephone contact with the mother's sister, aunt to the children.

1.42 The Lead Reviewers also wrote to several close friends of the mother. Two friends indicated that they wished to be involved in the review. The Lead Reviewers met with the friends separately on the 13th November 2013 and the 14th November 2013.

1.43 The contribution of family members and friends was extremely helpful, both in terms of understanding what the children and their mother were like, as well as understanding the mother's experiences of what it was like to be involved with the services who were working to support her and the children. There were several key factors that came through in these conversations. The first and overriding message was that the children's mother was a loving, caring and competent mother, who in her normal life would do anything to protect her children. The next was that she was very keen to display a positive aspect to anyone in a position of authority; she was very able to understand and display what was expected of her. Several of those we spoke with indicated that while she was able to display this positive aspect, because of early interactions with children's services, she was in fear that if she did not do what was expected of her, her children might be taken back into the care of the local authority.

1.44 The mother's family and friends were as shocked as the professionals who worked with her by the tragic outcome; there were no signs that they could see that would have predicted what was to happen.

1.45 The extended family felt that they were a resource which could have been used to support the children's mother. They felt excluded from the work of the agencies with the mother but acknowledge that her consent would have been required.

2. The findings:

Introduction

2.1 Statutory guidance requires that SCR reports:

> Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence (Working Together 2013: 71).
>
> These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong (Working Together 2013: 65).

2.2 A case review plays an important part in efforts to achieve a safer child protection system, one that is more effective in its efforts to safeguard and protect children. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies in the child protection system. The particular case acts as 'a window on the system' (Vincent 2004: 13).

2.3 Case Review findings therefore need to say something more about the LSCB area/agencies and their usual patterns of working. They exist in the present and potentially impact in the future. It makes sense to prioritise the findings to pinpoint those that most urgently need tackling for the benefit of children and families – and these may not be the issues that appeared most critical in the context of a particular case.

2.4 In order to help with the identification and prioritisation, the systems model that SCIE has developed includes 6 broad categories of these underlying patterns. The ordering of these in any analysis is not set in stone and will shift according to which is felt to be most fundamental for systemic change:

1. Innate human biases (cognitive and emotional)
2. Family-professional interaction
3. Responses to incidents
4. Longer term work
5. Tools
6. Management systems

2.5 There is a brief explanation of the meaning of these headings in the summary of the findings. Each category may have many subcategories and it is the subcategories that are elaborated in this report. There is, of course, overlap between categories.

2.6 The Findings start by looking at how the issue manifested itself in the case, and attempts as far as possible to say in what way it is an underlying issue, and what the review has gleaned from those involved about its prevalence. They end by summarising the issue and raise questions for TSCB, TSAB and CSP consideration.

Appraisal of professional practice in this case: a synopsis

2.7 It is important to recognise that all of the practitioners involved in this case were concerned about the children and their mother. While the appraisal of practice below and the subsequent findings point out gaps in service delivery, the overall context of this case is one of caring professionals doing their best for a family they cared about.

2.8 The review has uncovered no evidence to suggest that the areas for improvement either had a causal relationship to the children and their mother's death or would have led to a different outcome if practice had been different.

2.9 The review has highlighted the pressure services are under to meet ever increasing demands at a time when they are faced with cut backs. As such the review has identified areas where inter agency and single agency work could have worked more effectively. This is a tragic case for all those that it has touched, but even where there are gaps in service delivery, these tragic deaths do not appear to have been predictable or preventable.

2.10 Prior to April 2013 there had been routine contact between the children, their mother and a variety of agencies including their school, nursery, GP and the housing department but nothing that caused, or should have caused, undue concern.

2.11 Concerns about the family emerged on the night of the 28th April 2013 when police were called to a domestic violence incident and on arrival found the children asleep upstairs while their father, the mother's partner, was drunk and aggressive outside. The children's mother had run away having taken an overdose of pills. The police immediately identified the serious nature of the situation and the risk posed to the children and their mother. The children's father was arrested and a large scale search started for their mother. Torbay Council Emergency Duty Service (EDS) attended and worked with the police to place the children with an emergency foster carer under police powers of protection. This was good practice, the police and children's services responded promptly and worked together to protect the children and their mother.

2.12 Despite a well organised police search the children's mother was not located until late afternoon on the following day. She was taken by ambulance to the emergency

department of the local hospital and following an initial assessment of her physical needs was referred to a ward for an assessment of her mental health.

2.13 Despite the overdose and being missing overnight the children's mother presented well, she revealed no current thoughts of self harm and the overdose was seen as an isolated incident which was a response to the domestic abuse. The significance of the domestic abuse as a contributory factor to her actions was recognised. The practitioner undertaking the assessment researched available support and provided the children's mother with relevant information in relation to local domestic abuse support services. This was good practice.

2.14 The assessment determined that there was no evidence of mental illness and it was decided that admission was not required and a referral to the GP was appropriate. This issue is considered in **Finding 2**. The children's mother was signposted to her GP Surgery for further support and the outcome of the assessment was sent to the surgery as per standard practice. However, the assessment was not communicated to children's services, nor asked for by them. The sharing of information at this point would have provided children's services with a fuller picture of the mother's situation. The issue of information sharing is explored further in **Finding 3**.

2.15 Following her discharge from hospital on the 30th of April the children's mother was video interviewed by the police and a specialist Domestic Abuse Police Officer completed a Domestic Abuse, Stalking and Honour Based Violence (DASH) tool to assess the risk to the mother. This placed the mother as a high risk and led to a referral to the Multi Agency Risk Assessment Conference (MARAC) and appointment of an Independent Domestic Violence Adviser (IDVA). The police also made arrangements for additional security measures to be installed in the family home. The use of the DASH tool nationally is good practice which seeks to standardise police approaches. In this instance it led to a proactive response to the domestic violence presented; however the lack of consistent assessment tools across different agencies is explored further in **Finding 2**.

2.16 On the same day the father of the children, mother's partner, appeared at court and was charged with common assault. He was released on bail with a range of bail conditions including not to contact the children or their mother.

2.17 During this time children's services were working to ensure the safety of the children who remained with foster carers. Whilst placed with foster carers Child A disclosed details of both domestic abuse and neglect that occurred within the family home. The foster carer appropriately referred this into children's services. This issue is discussed in **Finding 5**.

2.18 Assessments began into the mother's ability to care for the children and regular contact was facilitated between the children and their mother that was flexible and tailored to

the needs of the children. It also allowed children's services to assess mother's parenting ability.

2.19 Children's services completed a Section 47 Investigation and a core assessment. The outcome of the Section 47 Investigation was a recommendation that the children be reunited with their mother as soon as possible and that a comprehensive core assessment be completed alongside a risk assessment. Whilst a return home to their mother was child focused the Section 47 Investigation did not take into account the domestic violence witnessed by the children, the incident of self harm nor mother's mental health and the impact this would have on her ability to safeguard the children. While the father had been removed from the premises, the investigation did not take into account any subsequent risk he may have posed to the children. The issues surrounding the Section 47 Investigation are explored further in **Findings 1 and 5**.

2.20 The core assessment was informed by information from the police, school and the children's mother. The mother met with the Social Worker completing the assessment and it was during this meeting that she disclosed that she had experienced difficulties in her childhood. There was no contact with mental health services, the GP in respect of mother's health, health visiting or school nursing resulting in an incomplete assessment of the situation. The impact the childhood difficulties had on the children's mother and her parenting should also have been explored further. The Review Team felt this was a missed opportunity to look at the wider family situation and understand mother's overdose. See **Findings 2 and 3**.

2.21 The potential risks associated with the childhood difficulties mother disclosed were identified by children's services but there was no clear policy as to how such disclosures should be managed. The lack of a clear policy to escalate concerns is potentially unsafe and is explored in further detail in **Finding 4**.

2.22 The assessments were signed off by a manager, not the social worker's manager, late into the evening after the manager had already completed a full day at work and was finishing paperwork at home. This workload is unsafe practice and is not sustainable. The lack of multi-agency input in the core assessment was not challenged but an action plan was set out by the manager. This action plan included that the children return home under a written agreement, this did not happen. This demonstrates weaknesses in management challenge. Further explanation can be found in **Findings 1 and 2**.

2.23 On the 9th of May the children's mother was seen by her GP. She gave a history of having separated from her partner and disclosed being physically and emotionally abused by him, that he had been charged with assault and that her children were in foster care. The mother also disclosed a history that included difficulties in her childhood and unresolved grief following the death of her mother. The GP did not observe any evidence of mental illness or any indication of suicide risk and following a discussion about the support available through the Depression and Anxiety Service (DAS), the children's mother agreed to self refer and was provided with a leaflet.

2.24 Although the children's mother presented as a person who was progressing well, her situation was complex, involving a recent incident of self harm and an ongoing court process regarding domestic abuse amongst other factors. The referral to DAS merited more detail than the self-referral process allowed for. A written referral or telephone contact with the service may have revealed that DAS were not able to deal with this case and referral to another agency may have been achieved. This is discussed in **Finding 6**.

2.25 The children returned to their mother's full time care on the 17th of May. Additional support was provided in the form of a dedicated family support worker from children's services who provided ongoing support to the children and their mother. It was good practice that a series of child in need meetings were held to monitor progress and consider the ongoing needs of the children and support for their mother All the professionals involved believed the children's mother was looking forward to her future. The children were seen to be progressing well and there were no concerns about her parenting ability.

2.26 The case was discussed at MARAC on the 4th of June. The meeting considered information from health, education and children's services. Consideration was also given to mother's mental health in light of the self harm. It was felt that this had been a reaction to her domestic situation and as the relationship was over, there were no ongoing concerns. The meeting felt that the risks to the mother by her ex partner had been addressed by the support provided, mother's cooperation, her focus on the children and the bail conditions. As a result the case was discharged from the MARAC list. The Review Team felt that given what was known at the time this was a proportionate response.

2.27 The sharing of information at MARAC was good practice and provided a mechanism for partner agencies to share what information they had and reach an informed decision as to risk. However, there was no written record of the meeting, making it difficult for anyone unable to attend to access the information shared. See **Finding 2**.

2.28 The two IDVA's coordinated their support well. The children's mother was apprehensive about the impending court case but indicated that she supported the police investigation and proposed prosecution. A range of special measures were explored to support her. Although the IDVAs were preparing the children's mother for her court appearance, they were independent and focussed on her wishes, if she had indicated she did not want to proceed her views would have been advocated to the Crown Prosecution Service and police. The Review Team felt this was good practice.

2.29 On the 25th of June the children's mother was seen by the DAS service. The DAS target is to assess within 28 days, in this case she had to wait six weeks to be seen between self referral and assessment, indicating a service unable to meet its demands. The DAS service is discussed in **Findings 6 and 7**.

2.30 The children's mother was assessed using a national scoring tool as being moderately to severely depressed with severe anxiety. It was felt that there was nothing to indicate that she was actively suicidal or had serious thoughts of self harm. It was generally believed that her scores were in keeping with someone in her situation and that she was building a new life for herself and her children. This is explored further in **Finding 7**.

2.31 The mother's scores had deteriorated by the time of a follow up telephone call two weeks later, on the 10th of July, indicating deteriorating mental health. This was not considered unusual as scores often fluctuated and there was no clear evidence of active suicidal thoughts. See **Finding 2**. The DAS service did not share information on changing scores with other agencies due to client confidentiality other than with the GP via a letter.

2.32 The mother was advised during this call that there was an exclusion criteria for clients experiencing domestic abuse and she was therefore not appropriate for DAS services at that time, although she could access the service once the pending court case had concluded.

2.33 The mother was signposted to the Domestic Abuse Support Service (DASS) for further advice and support. This occurred some eight weeks after she first contacted DAS for support. It would have been helpful for the children's mother to have been signposted or referred to the correct service at the outset.

2.34 The series of referrals, from hospital to GP, from GP to DAS from DAS to DASS, was each individually rational, but the overall effect was that the children's mother believed she would receive some form of counselling along this referral route which she did not obtain. It would appear that she did not contact DASS, however, had she done so this was also unlikely to have resulted in a service as they will not take clients deemed to be at high risk and her case had been graded as such at the MARAC.

2.35 On the morning of the 11th of July the children's mother contacted Child A's school, leaving a message on the answer phone stating that Child A had a sickness bug so would not be in. Child A's absence the following day did not give rise to concern as the protocol is to be off school for 48 hours following a sickness bug. Given the relationship between the school and the children's mother this was proportionate.

2.36 On the 12th of July Child B was due to attend nursery, when Child B did not arrive and there was no contact from Child B's mother to explain the absence the nursery attempted to contact her by telephone. Unable to do so they notified children's services of Child B's absence. This was good practice. That same morning the Family Support Worker visited the home address. There was no answer as the children's mother and Child A had already left the family home and there was not sufficient concern for children's services to take further action at that time.

2.37 Tragically, later that day on the 12th July the children's mother took her own life and that of Child A; the body of Child B was discovered at the home address.

In what ways does this case provide a useful window on our systems

2.38 As with all cases there are features of this case that are unique to this family in terms of background and circumstances, however it was the view of the practitioners involved from the Case Group and the Review Team that there were a number of aspects of this case that were typical of the difficulties that professionals sometimes experience in Torbay.

2.39 This case illustrates the difficulties that professionals have in tending toward a parent centred practice rather than focusing on the needs of children. This case also illustrates the challenge for professionals in accessing appropriate and timely mental health services for clients in the community. The case also reminded those involved in the review of the need to constantly recognise the impact of domestic abuse across many aspects of life but specifically parenting capacity.

2.40 Another important issue which emerged in this case was the challenge for professionals of remaining 'respectfully uncertain' when dealing with very compliant and apparently engaging clients.

2.41 The Review Team has identified eight findings for the Board to consider. They are presented in priority order and give an insight into the functioning of the safeguarding system. The eight findings are:

MANAGEMENT SYSTEMS

Are elements of management systems a routine cause for concern?

Finding 1: The lack of management challenge within agencies of the work of practitioners creates the possibility of unsafe practice and does not promote the welfare of adults or safeguard the interests of children.

TOOLS

What has been learnt about the tools and their use by professionals?

Finding 2:

The use of different assessment tools (which themselves rely on client self-report) across and within agencies can lead to an absence of rigour in the assessment process and makes the prediction of future risky behaviour less likely.

RESPONSE TO INCIDENTS

Are there particular good or bad aspects to the patterns of how professionals respond to specific incidents e.g. allegations of abuse?

Finding 3: There is a culture of professionals working in isolation to address the individual needs of their clients/patients and not always linking with other professionals.

Finding 4: Not recognising the significance of historical abuse and responding appropriately limits the ability of professionals to offer appropriate support to victims and safeguard the welfare of children.

Finding 5: Over reliance on formal disclosure of abuse, via video interview or other means, can result in professionals ignoring other indicators of child abuse and neglect.

Finding 6: Are there gaps in services in Torbay for people in need of psychological support but who do not present with acute needs?

Finding 7: The absence of overt symptoms of mental illness makes appropriate intervention and support to those at risk of suicide less likely.

FAMILY-PROFESSIONAL INTERACTION

What patterns are discernible in the ways that professionals are interacting with different family members, and how do they help and or hinder good quality work?

Finding 8: There is a pattern of professionals being positively disposed towards cooperative, help seeking adults, which in some cases can lead to the absence of rigour in the assessment processes and can adversely impact on promoting the safety and welfare of children.

Findings in detail

Finding 1

The lack of management challenge within agencies of the work of practitioners creates the possibility of unsafe practice and does not promote the welfare of adults or safeguard the interests of children. (Management systems)

How did this issue manifest itself in this case?

2.1.1 There were aspects of good management oversight in this case but there were also some agencies where the scrutiny by managers was limited and insufficient. Formal safeguarding supervision arrangements were not in place for all agencies and some members of the Case Group reported finding it difficult to access appropriate management support.

2.1.2 There was significant agency involvement in this case and the Review Team identified a number of areas of good practice in relation to management oversight. Examples included the school's provision of regular ongoing support to teaching staff and the structured supervision evident in both the DAS and the IDVA service. There was also good support available to foster carers.

2.1.3 The Review Team found limited management oversight in parts of health provision. One example of this was in the work of the Health Visiting Service. At the point of the initial domestic incident in April 2013 there was no prior involvement between the family and the service, other than for routine developmental assessments. Normal practice following such an incident, particularly when children are taken into care, would be for the Health Visiting Service to make contact with the mother and arrange a visit to see the children.

2.1.4 An attempt was made to contact the family via a letter; when there was no response to this letter this was not followed up. Given the risk factors present in the case it is expected it would have been taken to Child Protection Supervision for discussion. This did not happen and was a missed opportunity to provide management oversight and ensure the service actively engaged with the family and could then contribute to the assessments undertaken by children's services.

2.1.5 Management oversight in children's services was not sufficiently robust. Frequent changes in line management and managers with insufficient experience can lead to practitioners not receiving the challenge to practice, advice and support that they require.

2.1.6 The lack of available managers also meant that the S47 Inquiry was not signed off until six days after it was completed, at the same time that the core assessment was signed

off. When the assessments were signed off they were done so by a service manager, not the social worker's manager, late into the evening whilst the manager was working from home. The service manager had limited knowledge of the case resulting in the lack of rigour in the assessments going unchallenged, as set out in **Finding 2**.

How do we know it is an underlying issue and not something unique to this case?

2.1.7 Whilst there have been some improvements in supervision practice in children's services as noted by Ofsted[3] in March 2013 who observed supervision taking place more regularly they also found evidence in some cases that: *"supervision entries were brief and showed little evidence of challenge or consideration to the progress being made".*

2.1.8 All of those we spoke to in the course of this review from children's services talked of high workloads, with evening and weekend working routine and necessary. In the 12 months leading up to the period under review children's services had seen a 30% increase in the number of contacts received by the Safeguarding Hub. As a result case loads had risen significantly, especially in the initial response team.

How prevalent and widespread is this issue?

2.1.9 Previous SCRs in Torbay have identified a legacy of poor practice in this area. Several past reviews have cited supervision as an area for improvement culminating in the recommendation that the TSCB should consider the feasibility of the development of agreed standards for supervised structured safeguarding reflection (supervision) across the children's workforce that:

- is proportionate and appropriate to the role, ways of working, experience and competence;
- challenges assumptions and fixed thinking, promotes curiosity, critical and systematic thinking and the exercising of confident professional judgement;
- addresses the emotional impact of working with children and families.

2.1.10 A previous review also recommended that the TSCB develop a competency framework, supported by appropriate training and guidance to ensure that supervisors have the relevant knowledge, skills and attitudes to support this supervision.

Why does it matter? What are the implications for the reliability of the multi-agency child and adult protection system?

2.1.11 All professionals should have access to a supervisory relationship within which they can reflect on the biases, values and assumptions that may be influencing their assessments and decisions.

[3] Ofsted carried out an announced inspection in March 2013 which focused on Safeguarding and Looked After Children's Services in Torbay Council.

2.1.12 It is well recognised that good supervision and support is essential to good child protection. Supervision is, according to Lord Laming (2009) the 'cornerstone' of good social work practice; an opinion reiterated by the Munro Review (2011). Lessons from SCRs have reinforced this with Brandon and colleagues noting, for example:

- Practitioners who are well supported, receive supervision and have access to training are more likely to think clearly and exercise professional discretion (Brandon et al 2005)
- Effective and accessible supervision is essential if staff are to be helped to put in practice the critical thinking required … it needs to help practitioners to think, to explain, to understand … it is essential to help practitioners cope with the emotional demands of the job (Brandon et al 2008)

FINDING 1

The lack of management challenge within agencies of the work of practitioners creates the possibility of unsafe practice and does not promote the welfare of adults or safeguard the interests of children. (Management systems)

During the period under review and indeed subsequently staff across various agencies in Torbay worked under considerable pressure, dealing not only with their case load but the challenge of reducing resources. Professionals can develop an over committed approach to their work and it is at these times that effective supervision to maintain safe practice is even more important. If managers have to adopt the same over committed approach systems can become stretched, unreliable and potentially unsafe.

Questions for the Board

- Is the Board aware of the workload pressures within the partner agencies and the impact this has on service delivery?

- Is the Board satisfied that there is sufficient management oversight of practice across the partner agencies to deliver safe, effective solutions for adults and children?

- How will the Board be assured that adequate management oversight is in place?

Finding 2

The use of different assessment tools (which themselves rely on client self-report) across and within agencies can lead to an absence of rigour in the assessment process and makes the prediction of future risky behaviour less likely. (Tools)

How did this issue manifest itself in this case?

2.2.1 The significant agency involvement in this case led to a number of assessments being undertaken using a variety of different tools. These tools were either questionnaires as in Torbay Hospital and DAS, forms to complete as in the assessments carried out by children's social care and the police or scoring mechanisms as used by DAS. These were largely informed by the mother of the children's self reporting and did not take sufficient account of potential future risk.

2.2.2 Within health a range of assessment tools were used to score mother's mental health. Following the incident of self harm on the 28th of April a screening assessment was undertaken at the hospital to establish if the children's mother should be admitted or not. This was not designed to be a comprehensive mental health assessment and was only shared with the GP. It helped to inform the work of the GP, who was reassured by the content of the assessment which indicated that something in life had sparked this (the domestic violence) which had now been removed as the relationship had ended.

2.2.3 The children's mother was signposted to DAS for further support and was sent two nationally recognised questionnaires (PHQ9 and GAD7)[4] to complete. The questionnaires provide a useful framework to assess where people are in respect of their mental health and provide evidence as to whether someone is improving or not. The mother's score on the PHQ9 questionnaire was 19/27, indicating moderate/severe depression. On GAD7 she scored 17/21 for severe anxiety. At the follow up telephone appointment the assessment questionnaire and scores had deteriorated from 19 to 23 for depression and 17 to 19 for anxiety. This was not considered unusual as scores often fluctuated and was not shared with other agencies.

2.2.4 The police completed a Domestic Abuse, Stalking and Honour Based Violence (DASH) assessment tool to grade the risk posed to the children's mother. This is a standard approach to all domestic abuse incidents and is a required part of the record keeping by police. The data in the DASH form is used for police purposes and in high risk cases is shared with other agencies via the Multi-Agency Risk Assessment Process (MARAC). Lower risk cases can be shared with the consent of the client.

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[4] These easy to use self-administered patient questionnaires are used as a screening tool and severity measure for depression and generalised anxiety disorder.

2.2.5 The core assessment completed by children's social care was a key document that defined and guided the work of children's services. As a tool it provides a structured framework for children's social care to record information gathered from a variety of sources to provide evidence for their professional judgements, facilitate analysis, decision making and planning. However, the assessment in this case did not take into account the information held by partner agencies arising from their assessment processes. Based solely on information obtained from the children's mother the police and the school there was no contact with mental health services, the GP in respect of mother's health, health visiting or school nursing resulting in an incomplete assessment of the situation and did not lead to an overall judgment of risk.

How do we know it is an underlying issue and not something unique to this case?

2.2.6 The majority of agencies involved in the review relied on some form of assessment tool in their day to day work with clients. It was clear from conversations with the Case Group that issues regarding capacity mean people often complete these tools hastily and use them as a recording tool as opposed to an aid to understanding and analysing risk.

2.2.7 The tools themselves rely on self reporting by the client which will be skewed if the client is seeking to portray a particular version to the professional.

How prevalent and widespread is this issue?

2.2.8 A number of screening and assessment tools have been validated and are generally available within health and social care.

2.2.9 Different professionals use a range of assessment tools for different situations. Although assessment tools are useful in determining risk, the tools themselves should never replace the process of analysis and reflection that is required for any assessment of an adult or child's situation.

Why does it matter? What are the implications for the reliability of the multi-agency child and adult protection system?

2.2.10 Whilst assessment tools can be helpful in guiding understanding they cannot be relied upon to provide definitive answers to levels of risk faced by adults and children.

2.2.11 In order to manage risk, assessments need to ask the right questions and identify what has been happening, what is happening now, what might happen, how likely it is and how serious it would be.

2.2.12 Evidence from a range of sources has identified that although practitioners are good at gathering information about children and families, they find it challenging analysing complex information in order to make judgments about whether a child is suffering, or

is likely to suffer, significant harm. This is consistent with recent research highlighting the poor accuracy of much decision making in the child protection field, with assessments being not wholly reliable (Dorsey et al 2008 in Barlow et al 2012).

2.2.13 There is also increasing consensus about the need to move toward the development of Structured Professional Judgment in which professional decision making is supported by the use of standardised tools.

2.2.14 Research by the Department for Education, (Barlow et al 2012) into the use of a variety of assessment tools has set out the importance of a unified, agreed set of assessment tools. The paper concludes with 8 criteria for such assessment tools.

- Provide a balance between professional judgement and standardised tools
- Encourage assessment and analysis that covers the full range of assessment domains
- Be sensitive to the various stages within an assessment
- Incorporate clear guidance with regard to assessing parental "capacity to change"
- Provide guidance or pointers to how the concept of Structured Professional Judgment could be incorporated into a whole system
- Be underpinned by a mode of "partnership working" with children and families
- Be clearly based on best available evidence about which factors are associated with significant harm to children
- Acknowledge and promote the tools use within the context of an effective relationship between the children's services professionals and the children and adults being assessed.

2.2.15 None of the tools reviewed for this DFE research met all of these criteria, though some provide partial fulfilment of them. The DFE work gives some clear direction for potential development in Torbay.

FINDING 2

The use of different assessment tools (which themselves rely on client self-report) across and within agencies can lead to an absence of rigour in the assessment process and makes the prediction of future risky behaviour less likely. (Tools)

Assessment tools are developed based on evidence, to guide practitioners to effective decisions. They allow for a structure to be put into complex decisions on resource allocation and service provision. They also allow for standardisation and comparison between cases. If practitioners do not fully understand the nature of the tool, or if tools are used mechanistically without understanding the underlying issues, or if they lack time or effective supervision, it can become just another form to fill in and its value can be lost.

Questions for the Board

- Does the Board think that practitioners fully understand the nature of risk and how it is assessed and analysed?
- Are there any models of risk assessment and analysis that are in use in partner agencies that can be adopted more widely to improve practice?
- Do partner agencies invest sufficient resources to train practitioners in risk assessment and analysis?
- Does the Board have a view about what "risk sensible" practice is in Torbay and how partner agencies can contribute to delivering appropriate, proportionate "risk sensible" interventions?
- Does the Board know how many assessment tools are in use in Torbay?
- Should the Board move toward a shared system of assessment and develop a process of structured professional judgement that allows the aggregating of agencies data?
- How will the Board monitor and measure progress on this issue?

Finding 3

There is a culture of professionals working in isolation to address the individual needs of their clients/patients and not always linking with other professionals. (Response to incidents)

How did this issue manifest itself in this case?

2.3.1 During the period between April 2013 and July 2013 there were a significant number of agencies involved in this case. The Hospital, GP, DAS, Health Visiting, School Nurse Service, Police, Children's Services, School, Nursery and IDVA Service were all involved but largely working independently of each other.

2.3.2 Although there were good examples of communication between professionals, practice in this area was not consistently good and some professionals did not actively look to seek or share information to assist assessment processes. There was a tendency for professionals to work in 'silos' i.e. to view aspects of need narrowly, solely from the perspective of their own discipline. This was compounded in part by a lack of awareness of other agencies and how they operate. For example, when the children's mother attended hospital following the incident of self harm on the 28th of April, the Senior Night Nurse tried to access appropriate domestic abuse support services for her but had no clear guide on where or how to refer her.

2.3.3 Most of the services had some knowledge of some indicators of potential risk and vulnerability but this was not brought together into a holistic assessment. An example is that the mental health assessments did not consider sharing information about the potential impact of mother's mental health with children's services, and in undertaking work on core assessments, children's services did not seek information from health professionals about mother's mental health.

How do we know it is an underlying issue and not something unique to this case?

2.3.4 In the course of this review it became evident from the Case Group that individual professionals do not always routinely seek or share information with other agencies as part of their assessment processes.

2.3.5 Developing a working knowledge and confidence in how other services operate, what they have to offer and how to refer and access information from them would help professionals to navigate local pathways for mental health and children's services.

How prevalent and widespread is this issue?

2.3.6 This tendency to work in isolation was highlighted in the recent Ofsted report *'What about the children?* (2013). In that report they found that 'in assessments where there were issues of parent or carer mental ill health, professionals did not routinely approach

the assessment as a shared activity between children's social workers and adult mental health practitioners, in which each professional drew on the other's expertise. As a result, the majority of assessments did not provide a comprehensive and reflective analysis of the impact on the child of living with a parent or carer with mental health difficulties.' The Ofsted report noted that in most cases they reviewed when parents had been admitted to hospital, joint working was poor in ensuring that plans for discharge took the children's needs into account.

2.3.7 Lessons from national SCRs also describe the extent to which help that is provided to vulnerable children or troubled families is delivered through a "silo" approach where individual people and services are focussed on their single agency issues (Brandon et al, 2008)

Why does it matter? What are the implications for the reliability of the multi-agency child and adult protection system?

2.3.8 The importance of sharing information effectively and using it to help inform assessments is essential in order to identify parent-based risk factors, address safeguarding issues and ensure that services share responsibility for improving outcomes for families.

2.3.9 Professor Eileen Munro's review of the child protection system called for a wider family focus to safeguarding children, so that all staff are aware of their responsibilities, and recognise that meeting the needs of family members who may put children at risk benefits the child, the adult, and the family as a whole.

FINDING 3

There is a culture of professionals working in isolation to address the individual needs of their clients/patients and not always linking with other professionals. (Response to incidents)

Hidden Harm (first published in 2003) alerted professionals working with adults to the need to regard their patients/clients and parents/carers to be aware of the possible impact of their personal difficulties on their parenting capacity.

All agencies that mainly serve adult service users must consider, when deciding if an individual meets their threshold for a service, the possible impact on the individual of any caring responsibilities for children. All agencies that mainly serve children and young people must also consider, when deciding if the child or young person meets their threshold for a service, the possible impact on the child or young person of having a parent/carer with additional problems (for example, families affected by domestic violence, drug or alcohol misuse, parental mental ill health, parental learning difficulties or disabilities, disabled parents or parents with long term health problems). Relevant information about ex partners should also be considered.

Questions for the Board

- Was the Board already aware of this issue?
- Does the Board understand the obstacles to effective inter and intra agency communication?
- What options are available to the Board to improve information sharing between adult and children's services?
- How will the Board know when information sharing and "joined-up" working has improved in Torbay?

Finding 4

Not recognising the significance of historical abuse and responding appropriately limits the ability of professionals to offer appropriate support to victims and safeguard the welfare of children. (Response to incidents)

How did this issue manifest itself in this case?

2.4.1 Following the incident of self harm on the 28th of April the children's mother disclosed that she had experienced difficulties in her childhood. She was not specific about this and whilst it was noted down it was not shared with other agencies.

How do we know it is an underlying issue and not something unique to this case?

2.4.2 In the course of this review it became clear to the Review Team that professionals were unclear about what processes to follow and when to take action in dealing with historic disclosures.

2.4.3 Part of the underlying issue is that professionals struggle to work with victims of historic abuse, to enable them to come forward as witnesses, to deal with their own needs for counselling or to consider the ethical challenge of breaching personal confidentiality in the interests of children generally. This is further complicated when there are not specific children at risk, thus it is not clearly one agencies responsibility and therefore rapidly becomes no-one's responsibility.

How prevalent and widespread is this issue?

2.4.4 There is an increased willingness on the part of victims to come forward and report historical offences of all kinds (MPS & NSPCC, 2013). We cannot know the number of disclosures which may be made but it is an important area for the Board to consider.

Why does it matter? What are the implications for the reliability of the multi-agency child and adult protection system?

2.4.4 The impact a history of child abuse and neglect has on an adult's quality of life is well documented. Evidence indicates that people who have experienced childhood abuse are at greater risk of social, physical, emotional and mental health problems in adult life; for example, such individuals are more at risk of self-harm and suicide than the general population. Adults who were abused themselves as children can have difficulties in keeping their own children safe. This makes it all the more important that when they do make a disclosure, they are provided with appropriate support.

FINDING 4

Not recognising the significance of historical abuse and responding appropriately limits the ability of professionals to offer appropriate support to victims and safeguard the welfare of children. (Response to incidents)

Events that happened many years ago can still have an impact on adults much later in their lives and can significantly impact on their ability to safeguard and promote their children's welfare. When an adult begins to disclose historical abuse professionals need to have a thought through process for managing both the potential crime and the emotional impact on their client and others.

Questions for the Board

- What significance does the Board attach to this finding?
- What does the Board consider would be "fit for purpose" arrangements to address this issue?
- How will the Board be assured that adequate arrangements have been made to address this issue?

Finding 5

Over reliance on formal disclosure of abuse, via video interview or other means, can result in professionals ignoring other indicators of child abuse and neglect. (Response to incidents)

How did this issue manifest itself in this case?

2.5.1 Following the incident on the 28th of April when the children's mother went missing the children were placed with foster carers. Child A disclosed to the foster carer details of both domestic abuse and neglect that had occurred within the family home. Child A was able to recount specific details. The foster carer appropriately referred this into children's services.

2.5.2 Children's services shared this information with the police and the child was seen at school later that day by a police officer and social worker. Child A was video interviewed two days later. Child A did not confirm the allegations neither when seen at school nor in the interview. As there was no formal disclosure no further criminal action was taken.

2.5.3 At the time of the disclosure and police interview the S47 Investigation was ongoing; despite this consideration was not given to the concerns about abuse and neglect of the children and the potential risk to them was given no further consideration in the core assessment and was not subsequently used in care planning.

How do we know it is an underlying issue and not something unique to this case?

2.5.4 The Review Team were of the view that this approach is not unusual and were able to recall other occasions where the lack of a formal disclosure resulted in no further safeguarding action being taken.

How prevalent and widespread is this issue?

2.5.5 We do not know how widespread an issue this is but it is an important area for the Board to consider.

Why does it matter? What are the implications for the reliability of the multi-agency child and adult protection system.

2.5.6 All disclosures of abuse and neglect by children need to be taken seriously. The fact that the disclosure was not repeated in the video interview did not mean that the abuse and neglect had not happened. This information should have been taken into account in the assessments that followed in order to assess risk and to help inform future assessments.

2.5.7 The police and Crown Prosecution Service (CPS) must seek evidence to progress a criminal prosecution. A prosecution must pass the two tests for crown prosecutors, firstly that conviction is more likely than acquittal and secondly that the prosecution is in the public interest. If the police/CPS determine that no prosecution will follow this does not mean that a child is not suffering or is not likely to suffer significant harm.

2.5.8 Local authorities, with the help of other organisations as appropriate, have a duty to make enquiries under Section 47 of the Children Act 1989 if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, to enable them to decide whether they should take any action to safeguard and promote the child's welfare.

2.5.9 A good assessment, as set out in Working Together 2013 is one which investigates the following three domains:

1. the child's developmental needs, including whether they are suffering or likely to suffer significant harm;
2. parents' or carers' capacity to respond to those needs; and
3. the impact and influence of wider family, community and environmental circumstances.

It is important to gather comprehensive data from all relevant agencies.

FINDING 5

Over reliance on formal disclosure of abuse, via video interview or other means, can result in professionals ignoring other indicators of child abuse and neglect. (Response to incidents)

This case demonstrates the importance of different practitioners within the safeguarding system understanding the constraints within which agencies work. If practitioners place undue emphasis on there being an evidential disclosure of abuse to the police in order for action to be taken, this can prevent or limit other action.

The police will seek evidence to prove a case "beyond reasonable doubt", where as children's services practitioners take protective action on "balance of probability" or "reasonable suspicion". It will often be the case that police decide that there is insufficient evidence to support a prosecution; this should not prevent further action or assessment by children's services or other agencies involved.

Questions for the Board

- Does the Board recognise this finding as problematic?
- Is the current guidance for practitioners about their individual role and responsibilities

sufficiently clear?

- What options are available to resolve this issue?
- How will the Board be assured that practice has improved?

Finding 6

Are there gaps in services in Torbay for people in need of psychological support but who do not present with acute needs? (Response to incidents)

How did this issue manifest itself in this case?

2.6.1 Following the incident of self-harm in April 2013 the children's mother was seen by her GP and requested some form of counselling. Having considered the options available the GP referred her to DAS, a cognitive therapy service. This service undertook an assessment of the mother but determined that their service was not appropriate. At the time of her death she had not received a service despite the request being made six weeks earlier.

2.6.2 The referral to DAS was for cognitive therapy which is not counselling, rather a procedure to help with the management of thinking. The children's mother was seeking "help to cope". The GP had 4 options for referral:

a. A&E in an emergency
b. Crisis Resolution Home Treatment Team for those who are actively suicidal
c. Well Being & Access Team by written referral
d. Depression & Anxiety Service by self referral / written referral

2.6.3 Of these the Depression & Anxiety Service (DAS) seemed the most appropriate route. In any event, due to her current situation and ongoing domestic abuse proceedings DAS service criteria meant the children's mother was not able to receive support from them at that time. Utilising a self-referral process, supported by a leaflet, meant that DAS did not receive the full picture of the mother's complex situation until their first meeting. A written referral would have assisted and is likely to have led to a telephone discussion with the referring GP.

2.6.4 The children's mother was a woman who was well able to engage with professionals and explain her situation. She did not give evidence of critical need, rather as was recorded in a variety of assessments, she presented as a person who had been through a difficult time and was finding a way out of it. If her need had appeared more critical or if she had presented as a person at real risk of taking her own life, there were referral routes available. In the mother's case, the range of options, including DAS, DASS and IDVA support had different exclusion factors and scoring regimes that together left her in a complex maze of service offers, which did not in the end lead to the service provision she was seeking.

How do we know it is an underlying issue and not something unique to this case?

2.6.5 Members of the Case Group reflected on the situation that the mother found herself in and felt that it was not unusual in Torbay and referred to other similar situations in conversations and follow on meetings.

2.6.6 The issue of referral into DAS, the subsequent proposal that she self refer into DASS and the lack of any counselling support has been discussed in detail with the Case Group and the Review Team. Each step is logical on its own, but taken as a whole system can leave the individual without effective service delivery.

2.6.7 The issue of DAS exclusion criteria has now been addressed by DAS with further communication to GPs and others. This issue is not simply DAS service exclusions, but rather the range of options open to GPs and others to refer patients into who do not have acute needs. The 2014 Torbay Mental Health Directory set out some 22 routes for emotional support and 34 for counselling with a further 3 national bodies. There were routes and services available, but no clear guide to help a client through the routes.

2.6.8 This issue has been addressed in the 2011-2016 Torbay Mental Health, Housing, Support, Accommodation and Day Service Strategy. It describes mental ill health / poor mental health as generally referring to difficulties we may experience with our mental health that affect us in our everyday lives. Poor mental health can affect the way we feel, the way we think and the way we function. They can be mild or serious, fleeting or long-lasting. The strategy sets out various aims including, "Services should be commissioned (bought) within a "Right Service, Right Time, Right People" philosophy (way of life and values). The strategy sets out the importance of GPs being able to commission a range of services to support people with mental health problems. In this case the client was offered a referral route which did not meet this aspiration.

How prevalent and widespread is this issue?

2.6.9 The Review Group reflected that the range of services available to refer into for non-acute mental health services is complex and poorly coordinated. It is also apparent that since this review was started there have been cuts to the budgets of some of the agencies mentioned. Some of the services provided to the children's mother would not now be available.

Why does it matter? What are the implications for the reliability of the multi-agency child and adult protection system?

2.6.10 Services are initially designed to meet client population needs, within the constraints of resources. Referrers can only refer into the services that are available. If individual client need does not meet available services there is a risk that the referrer is driven to fit the client into the best available referral route. This can lead to the client receiving either an inappropriate service or no service and the initial reason for attending the GP or elsewhere remaining unaddressed.

FINDING 6

Are there gaps in services in Torbay for people in need of psychological support but who do not present with acute needs? (Response to incidents)

Some of the most vulnerable people in Torbay, at their most vulnerable periods, seek a form of help which they would refer to as counselling. They want someone to talk through how they feel and how it is affecting their lives and hope that the medical and mental health professionals can help them. The services that are in fact available are limited in scope and duration but importantly have exclusion criteria which can prevent the most needy receiving them. These exclusion criteria are not sufficiently clear to clients or referrers.

Questions for the Board

- Was the Board aware of the issue prior to this Serious Case Review?
- What level of priority does the Board believe should be given to this issue on the overall provision of services to people with mental health difficulties?
- Is there a role for the Community Mental Health Team to play a greater part in assisting people through the maze of service options?
- What are the commissioning options available to deliver a person focused approach for clients in need of psychological support?

Finding 7

The absence of overt symptoms of mental illness makes appropriate intervention and support to those at risk of suicide less likely. (Response to incidents)

How did this issue manifest itself in this case?

2.7.1 Between April 2013 and July 2013 when the children's mother became known to a number of agencies she engaged positively and in a way which appeared to indicate that she was making good progress. All agencies involved found her positive to work with and felt that she was making good progress. However, she had very recently carried out a significant act of self harm i.e. taking an overdose and fleeing her house. Her positive engagement appears to have blocked the view of her underlying issues.

2.7.2 A number of professionals observed that there was no evidence of mental illness; rather that the mother's behaviour was an appropriate response to her current circumstances. This was apparent in the various assessments that were carried out including by the Hospital, GP and DAS. The DAS assessment indicated high levels of depression and anxiety, but these were seen as consistent with her current situation, rather than indicative of deeper, underlying problems.

2.7.3 Each professional that the children's mother was engaged with thought that, in the light of her domestic abuse situation and her financial difficulties, she was coping remarkably well. She indicated perceived appropriate behaviour for someone in her situation and appeared to be looking forward to a future on her own with her two children who were considered a strong buffer against any future self harm.

2.7.4 Family, friends and the professionals involved with the children's mother did not think that suicide, let alone the death of her children, was likely.

How do we know it is an underlying issue and not something unique to this case?

2.7.5 In the course of this review it became clear to the Review Team that professionals were less likely to consider the risk of suicide when there are no obvious symptoms of mental ill health.

2.7.6 Many people who commit suicide do so without disclosing they are thinking about it or planning it and whilst some people who commit suicide have an identifiable mental health problem others do not (DoH, 2014).

How prevalent and widespread is this issue?

2.7.7 About 5,000 people die every year in the UK by suicide with suicide more than three times as common in males (12.4 per 100,000 for males in 2010-12, compared to 3.7 for

females) and over half of those who die by suicide having a history of self-harm (DoH, 2014).

2.7.8 The unlawful killing of a child followed by the suicide of a parent (filicide-suicide) is thankfully very rare. Research indicates that it is more often motivated by altruism where the parent's suicidal feelings are often extended to the child, because they do not want to leave them behind.

2.7.9 A study of 297 cases of convicted filicide and 45 cases of filicide-suicides in England and Wales occurring between January 1997 and December 2006 found that 37 per cent of parents and step-parents who killed their children were suffering from some form of mental illness and 12% had been in contact with mental health services within a year of the offence (Sandra et al, 2013).

2.7.10 Lessons from national SCRs highlight that parental mental health problems feature in the majority of SCRs with suicidal or self-harming behaviour particularly prominent. Brandon et al noted that:

> *"Parental suicidal or self-harming behaviour needs to be taken very seriously, and the potential risks to the children thoroughly assessed. Being a parent is generally perceived to be a protective factor in relation to adult suicide or self-harm; thus when a parent is threatening or actually carrying out suicidal or self-harming behaviour, this protective element may have been lost".* (Brandon et al, 2012)

Why does it matter? What are the implications for the reliability of the multi-agency child and adult protection system?

2.7.11 Whilst cases of filicide-suicide are very rare the seriousness of the outcome make it even more important that agencies need to entertain the possibility of suicide where an attempt has been carried out, particularly where there is any history of mental health issues.

FINDING 7

The absence of overt symptoms of mental illness makes appropriate intervention and support to those at risk of suicide less likely. (Response to incidents)

Research and experience suggest that there is a high correlation between mental illness and suicide. The connection between overt symptoms of depression and self-destruction is probably the most clear. However, as was evident in this case, it is not always necessary for the individual to appear suicidal (or to give notice of their intentions) before they kill themselves. A failure to recognise this and a willingness of practitioners to accept at face value assurances by clients that they are positive and forward looking without looking more sceptically at the individuals circumstances and behaviours make the prediction of suicidal behaviour more problematic.

Questions for the Board

- Was the Board aware of this issue before the review?
- Are practitioners from partner agencies sufficiently well trained in recognising and responding to people at risk of suicide particularly those who wish to disguise their intentions?
- Does the Board have a view about the tension between the individuals' right to self-determination and the professionals' duty of care to adults and children?
- Does the Board believe that additional guidance is required for practitioners? Which agencies are best placed to develop such guidance?

Finding 8

There is a pattern of professionals being positively disposed towards cooperative, help seeking adults, which in some cases can lead to the absence of rigour in the assessment processes and can adversely impact on promoting the safety and welfare of children. (Family-professional interaction)

How did this issue manifest itself in this case?

2.8.1 In the course of this review professionals held a view of the children's mother which helped allay their concerns and led to underlying issues and background not being fully considered in the assessment processes. There was however, evidence of checking and challenging, particularly in relation to her relationship with her estranged partner.

2.8.2 From the time the children's mother became involved with agencies in April 2013 she cooperated with professionals, doing everything that was asked of her. For the agencies involved this was a very positive case to be involved with. It was a good story, in that she was engaging and making progress. The children's mother was described as *"showing all signs of putting her life back together"* … that it was *"unusual to have a family wanting to work with us"* and that "*there was nothing of concern with this case"*.

2.8.3 The mother's cooperation, which was always considered to be genuine, contributed to a lack of focus on the children. For example; having taken an overdose and going missing overnight she was admitted to hospital on the 29th of April. Whilst in hospital she was assessed by a mental health worker and spoken to by the police and children's services. As set out in **Findings 6 and 7** she was seen to be 'seeking help' and the incident of self harm was perceived to be a response to a difficult period which she had now removed herself from.

2.8.4 The mother's overriding concern at this stage was the welfare of her children who had been placed in emergency foster care. This led professionals to see her as a *"loving protective mum"* and that the children were *"strong buffers"* against any further self harm. Insufficient consideration appears to have been given to the fact that she had fled the family home leaving the children behind. The focus of children's services appears to have been to ensure the children returned to the care of their mother as swiftly as was safely possible.

2.8.5 The result was that no in depth analysis was undertaken of the mother's parenting capacity. The significance of mother's attempted overdose and potential risks to the children were overlooked as the focus centred on reuniting the children to the care of their mother.

How do we know it is an underlying issue and not something unique to this case?

2.8.6 The 'rule of optimism' that can affect decision making in child protection was first identified by Dingwall et al (1983). The key concern here is that the worker wishes to see the best in people, and have hope and optimism that their interventions can help a family function better, including for the child involved.

2.8.7 From discussions with the Case Group and individual conversations with professionals the Review Team were left with a feeling that workers wish to see the best in client's / patients.

2.8.8 In the Victoria Climbié inquiry, Lord Laming (2003) suggested social workers needed to practice "respectful uncertainty", applying critical evaluation to any information they receive and maintaining an open mind.

How prevalent and widespread is this issue?

2.8.9 Research findings and systematic reviews of child abuse death inquiries / SCRs demonstrate that this is a widespread concern. Ofsted's evaluation of 67 Serious Case Reviews (2011) concluded that *"practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child"*.

2.8.10 In Brandon et al's review of 189 serious case reviews between 2005-7, they found that "*good parental engagement sometimes masked risks of harm to the child'.*

Why does it matter? What are the implications for the reliability of the multi-agency child and adult protection system?

2.8.11 The rule of optimism is more likely to exist when staff feel under pressure and this can be very dangerous for children who are at risk. This is also where good supervision can make a real difference.

2.8.12 A safe system would recognise the error and bias that parent centred practice and 'rule of optimism' thinking can introduce into the risk assessment process. A safe system would have in place processes including challenging, reflective supervision and access to specialist support. **See Finding 1**.

FINDING 8

There is a pattern of professionals being positively disposed towards cooperative, help seeking adults, which in some cases can lead to the absence of rigour in the assessment processes and can adversely impact on promoting the safety and welfare of children. (Family-professional interaction)

This case is an example of parented centred practice and 'rule of optimism' thinking (as in so many other SCR's). Professionals, family and friends did what they did because of the way they interacted with the children's mother, she told them things that they believed. When she said she felt better (even when she didn't) they were reassured.

Questions for the Board

- Is the Board aware of the risks that such practice introduces into the safeguarding system?
- What are the options available to counter such potentially unsafe practice?
- How will the Board be assured that practice in this area has improved?

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Appendix 1

Glossary of terms

Case Group: Staff directly involved in the case from all agencies
Child in Need Meeting: A regular multi-agency meeting to develop and review plans for a child/children
Cognitive Therapy: A form of psychotherapy (a psychological approach to treatment) based on scientific principles that help people change the way they think, feel and behave
Core Assessment: An in depth assessment undertaken by a social worker to help establish whether action is required to safeguard and promote the welfare of the child or children who are subject of the enquiries
CSP (Community Safety Partnership): A partnership made up of statutory agencies to reduce crime and disorder and make areas safer
CPS (Crown Prosecution Service): The Crown Prosecution Service is responsible for prosecuting criminal cases investigated by the police in England and Wales
DAS (Depression and Anxiety Service): A psychological therapy service for people in the South and West of Devon who are over 18 years of age and who are feeling stressed, anxious, low in mood or depressed
DASH (Domestic Abuse, Stalking and Honour Based Violence) Assessment Tool: A common checklist used by the police for identifying and assessing risk
DASS (Domestic Abuse Support Services): Provides support to men, women and transgender individuals in Torbay who are experiencing or have experienced domestic abuse
DHR (Domestic Homicide Review): A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect
EDS (Emergency Duty Service): The Emergency Duty Service is a generic social work service covering Childcare, Adult and Mental Health referrals out of normal office hours within the Torbay area
Findings: What has been learnt from the particular case about the general functioning of the local multi-agency child protection system
First follow-on meeting: Discussion meetings held where staff directly involved in the case are asked to check, correct and amplify the analysis of the Review Team to date
IDVA (Independent Domestic Violence Advisor): An IDVA's role is to support 'high' risk victims of domestic abuse. The key outcome is to increase the safety of survivors of domestic violence; and their children
KPEs (Key Practice Episodes): Episodes in the case that have been highlighted for detailed analysis
Lead Reviewers: The pair who lead the case review process
MARAC (Multi-Agency Risk Assessment Conference): A meeting to discuss high risk victims of domestic abuse
Operation Yewtree: A police investigation into sexual abuse allegations, predominantly the abuse of children, against the British media personality Jimmy Savile and others. The investigation, led by the Metropolitan Police Service, started in October 2012

Police Powers of Protection: The power of the police to intervene to safeguard children. These powers are governed by Section 46 of the Children Act 1989. Under this law, the police have the power to remove children to a safe location for up to 72 hours to protect them from "significant harm". Police do not require a court order to take such a step

Review Team: Group of senior representatives from the involved agencies who conduct the case review. Generally the expectation is that they should have had no direct decision making role in relation to the case

Risk Assessment: an assessment to determine how safe children are in their environments and what is the level of risk for future harm

SCIE (Social Care Institute for Excellence): SCIE is an independent charity and, working with Professor Munro, has been developing the Learning Together systems methodology for case reviews and SCRs since 2006

SCR (Serious Case Review): A review of the circumstances in which a child or adult dies or is seriously injured and abuse or neglect is known or suspected. The aim is to help agencies learn lessons about how they can work better together to protect children and adults from serious abuse

Second follow-on meeting: Discussion meetings held where staff directly involved in the case are asked to compare their handling of the particular case with their ways of working in other cases and more generally

Section 47 Investigation: An investigation carried out by children's services under the Children Act 1989 when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm

Window on the system: The phrase has been coined by a health academic called Charles Vincent to capture the goal of a case review

Written agreement: Used by children's services to help ensure the safety and welfare of children during periods of assessment and/or intervention, by outlining what is required from parents in terms of compliance with assessments and appointments, living arrangements or involving supervisory arrangements with other family members

Appendix 2

Summary of recent changes (at time of SCR completion)

The SCR was initiated in July 2013 and was signed off following the inquest in October 2014. In this time, agencies have reported that there have been a number of actions taken in response to the findings which are detailed below:

Torbay Safeguarding Children Board

In order to help improve the quality of decision making and interventions the Board has developed a set of standards for supervision that help challenge assumptions and fixed thinking, promote curiosity, critical and systematic thinking and the exercising of confident professional judgement. To support the standards the Board is developing a competency framework, supported by appropriate training and guidance, to ensure that supervisors have the relevant knowledge, skills and attitudes to support this supervision.

In order to enable partner agencies to work together more effectively the Board has introduced regular Best Practice Forums. The forums are open to all frontline staff and managers from across the partnership and meet on a regular basis to look at safeguarding issues.

The Board has arranged a series of targeted workshops for children's services and adult mental health services to improve relationships and explore opportunities for joint working.

The Board has also undertaken a review of its SCR procedures and produced a new toolkit. The toolkit contains guidance as to how the Board determines whether to undertake a SCR, a judgment about the methodology to be adopted in particular cases and how best to support staff through the process.

Depression and Anxiety Service (DAS)

DAS have completed a number of actions, including:

- A review of their 'decision tree' so that it is more specific regarding risk which has been circulated to all GP surgeries.
- Staff, particularly in the Torbay team have received information and training regarding domestic violence and the role of the IDVAs.
- Representatives from DAS have attended the adult mental health directorate meeting and asked for guarantees that all DPT staff will not facilitate self-referrals and will write formal referrals to DAS.
- DAS will continue to liaise with services to ensure the appropriateness of referrals.

Children's Services

Children's Services now has a stable work force with reduced workloads and an appropriate level of expertise.

The service is in the process of implementing a Single Assessment Framework (SAF) in order to provide a systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider context of the community in which they live. This multi-agency assessment will reduce the need for other professional assessments and allow professionals working with a family to have a shared understanding of the families' strengths and what support they need to thrive. It will mean that families don't have to experience multiple assessments undertaken by a wide variety of professionals.

The service is also in the process of introducing a new social work model 'Signs of Safety' which is intended to help practitioners with risk assessment and safety planning in child protection cases. Its purpose is to enable practitioners across different disciplines to work collaboratively and in partnership with families and children. The introduction of Signs of Safety is supported by the Safeguarding Children Board along with health and education.

A policy for managing historical allegations and a programme of mandatory refresher training in relation to assessments and supervision is in the process of being rolled out to all relevant staff within social care.

South Devon and Torbay Clinical Commissioning Group (CCG)

South Devon and Torbay CCG have had a consistent engagement process with the local community with over 500 people attending 7 specific mental health focused events. All of the feedback from these has helped shape a Devon wide mental health strategy and has supported the transformation planning of an enhanced local Acute Care Pathway.

There has been an enhanced perinatal mental health service to include all pregnant women. The "Head Up Heart Strong", a film about recovery from perinatal mental health problems, starring 6 women from Devon and Torbay has been produced and shown widely across the county particularly within services and wider stakeholders to raise awareness among practitioners across organisations to improve the join up and coordinated approach to women.

There has also been an extension of existing liaison psychiatry and night nurse practitioner services as well as plans to introduce telephone helpline and peer support.

Safer Communities

A contract for an Integrated Domestic Abuse Service in Torbay was awarded to the Sanctuary Group and the service began on 2 September 2014. The service provides outcome focused integrated domestic abuse services for high and medium risk victims, survivors and members of their household including children. The service aims to deliver enhanced safety, promotion of recovery and support to prevent reoccurrence.

The service includes the following components:

- Independent Domestic Violence Advisors (IDVAs)
- Outreach / floating support
- Accommodation via a Refuge and Safe Houses (12 units in total)

- Volunteer led telephone helpline (not yet active)
- Group work
- Specific activity with children and young people
- Partner Link Worker
- Awareness raising
- Survivors Group
- Standard risk support

The service is available to both female and male victims of domestic abuse. The service works in partnership with a variety of organisations many of which are represented within Torbay's Domestic Abuse Steering Group (which includes sexual violence services) to ensure that victims receive appropriate support. Referrals into the service can be made by any professional, community based worker or victim.