Combined Domestic Homicide and Serious Case Review
Concerning Sue, Hayley, Sarah and Daniel

EXECUTIVE SUMMARY

Report by David Ashcroft, Independent Overview Author

April 2021

Introduction

1. This is the Executive Summary for the combined Review commissioned on behalf of Lincolnshire Safeguarding Children Board (now Partnership) and Lincolnshire Community Safety Partnership (formerly Safer Communities Lincolnshire, now Safer Lincolnshire Partnership).

2. The case concerns the murders of Sue, aged 49, and her daughter, Hayley, aged 13, by her daughter, Sarah and Sarah's boyfriend, Daniel, both aged 14 at the time of incident in April 2016.[1] All were of White British ethnicity. Although there were turbulent relationships between the individuals involved, these were not extraordinary or unusual between adolescents and their parents and carers. All four of these individuals are therefore the principal subjects of this combined Review.

3. Due to the unusual nature of this case and the wish to identify learning for all services and agencies from the circumstances and experience of both victims and perpetrators, it was agreed that this Review would be conducted as a combined enquiry process, meeting the requirements of both a Serious Case Review (in respect of the children involved) and a Domestic Homicide Review (in respect of the domestic nature of the crime resulting in the death of Sue and Hayley).

4. On Thursday 14th April 2016, Daniel and Sarah were reported missing. Sue did not turn up for work and Hayley was missing from School. On Friday 15th April police officers forced entry to the house where Sarah lived with her mother, Sue and her sister Hayley and the bodies of Sue and Hayley were discovered. Daniel and Sarah were arrested on suspicion of murder and at the subsequent trial were both convicted of murder and sentenced with a minimum tariff of 20 years.

5. There was a significant and lengthy history of severe domestic violence in the family backgrounds of both Sarah and Daniel, and this had especially affected Sue, who had fled her husband over 10 years previously, and became extremely anxious when he attempted renewed contact in 2014.

The Review Process and Panel

6. The decision to conduct a Joint Review was made in June 2016, following earlier separate decisions by the LSCB and Safer Communities Lincolnshire that the case should be considered as a SCR and as a DHR. The Home Office and the National Child Safeguarding Practice Review Panel were informed of these decisions. A Joint Panel was convened to oversee the Review which was independently chaired and which met five times.

   The members of the Joint Panel were:
   - Children's Services Manager, Action for Children (Independent Chair).
   - Consultant Nurse Safeguarding and Mental Capacity - Lincolnshire Partnership NHS Foundation Trust (LPFT)
   - Named Nurse Vulnerable Children and Young People - Lincolnshire Community Health Services (LCHS)
   - Deputy Executive Headteacher of South Lincolnshire Academies Trust School

[1] These names have been agreed by the Lincolnshire Partnerships to anonymise the victims and perpetrators.

(Bourne Academy)
- Lincolnshire Police
- Children's Services Manager East Lindsey quadrant, Lincoln and West Lindsey quadrant, EDT and CSC - Children's Services
- Designate Nurse Safeguarding Adults, Children and Looked After Children - South West Lincolnshire Clinical Commissioning Group (SW CCG)
- Children's Services Manager: Education Support - LCC, Education
- Service Manager – Children and Family Court Advisory Support Service (CAFCASS)
- Named Nurse for Safeguarding Children and Young People - ULHT (United Lincolnshire Hospitals NHS Trust)

- <u>Advisers</u>
  - LSCB Business Manager
  - Assistant Chief Legal Officer - Legal Services, Lincolnshire
  - Community Safety Manager, Safer Communities
  - Adviser on domestic violence and abuse research and practice

Author of the Overview Report

7. David Ashcroft was appointed as the Independent Overview Author of this Joint Board Review in June 2016. He has worked at a senior level in children's services for the past 25 years, including operational responsibility for all aspects of safeguarding and children's social care in a number of local authorities. Mr Ashcroft has conducted, as an independent chair and/or overview author and lead reviewer, several SCR, DHR, inspection and investigation assignments. He has undertaken extensive training in review methodologies including the Home Office DHR module and has been an expert adviser to several national projects to develop training and improve standards in reviews and report writing. He has previously completed SCR Overview Reports for Lincolnshire LSCB. He has no managerial connection with the agencies involved in this case or with the LSCB.

Agencies involved and contributing to the Review

8. The Joint Panel agreed the Terms of Reference and KLOE, confirmed the process and proposed timeline, and identified those agencies required to submit agency reports. Following the securing of records, Agency Reports were requested and provided by the following agencies
    - Lincolnshire County Council Children's Services (Social Care and Early Help)
    - Lincolnshire Police
    - Lincolnshire Community Health Services NHS Trust (School Nursing Service)
    - Lincolnshire Partnership NHS Foundation Trust (Mental Health and CAMHS and Steps to Change)
    - United Lincolnshire Hospitals NHS Trust (Acute Hospital Services)
    - CAFCASS
    - Leicestershire County Council (Children and Family Services)
    - Munro Medical Centre (GP Practice)
    - South Holland District Council

- South Lincolnshire Academies Trust (Secondary School)
- Diocese of Lincoln (Parish of St Paul's Spalding)

- Agency reports and chronologies were prepared and submitted and were subject to quality assurance and review by the Panel and Independent author. All the Agency Reports have appropriately identified that their authors were independent of operational management or direct involvement in the case.
- Access to specialist reports provided for the criminal proceedings or identified in the agency reports was sought and agreed and these were provided for the use of the independent author.
- Final revisions were made to the Overview Report, which was subsequently presented for approval to the LSCP and Safer Communities Lincolnshire, on 5 December 2019.[2] Both Executive bodies approved the Report.

Involvement of Family and Friends

9. Invitations to be interviewed were sent to family and friends and these took place where they were requested. Appropriate advocacy support was offered and arrangements were made to seek views of the perpetrators and family members. Daniel was interviewed in April 2019 and Sarah in October 2019, and views obtained from some members of the families and others. Other family members chose not to take up the opportunity to contribute.

Terms of Reference and Key Lines of Enquiry

10. The Review report outlines in detail the purpose, terms of reference and approach in conducting the Review, and sets out a summary of the key events involving the four subjects, principally for the years 2013 to 2016. Analysis against the key lines of enquiry addresses the following issues:

    - Impact of domestic violence
    - Attachment to and contact with significant adults
    - Involvement of Sue's husband and the girls' father
    - The effectiveness of interventions and support
    - The significance of wider networks of support
    - The relationship between Sarah and Hayley
    - The relationship between Sarah and Daniel

    Issues of diversity or social media were not assessed as significant in this case.

[2] During the timespan for this Joint Review the Local Safeguarding Children Board (LSCB) has been replaced by the new Lincolnshire Safeguarding Children Partnership established under the provisions of the Children and Social Work Act 2017 and Working Together 2018.

Summary of Key Issues and Conclusions

11. **No action or engagement with the individuals could have predicted that Daniel and Sarah could or would commit murder. Sarah and Daniel were responsible for the actions they planned and undertook, and for the deaths of Sue and Hayley. There were no actions or interventions by agencies that might have prevented the murders. Their needs during this period did not reach any threshold for intervention that would have removed either of them from the care of their families or led them to be under any form of supervision beyond the day to day care of their families and professional support that was provided to each. At several key points both Sarah and Daniel chose not to engage with the services that were on offer to them.**

12. There was no history of physical violence towards the victims perpetrated by either Sarah or Daniel, although each were capable of displaying disruptive and occasionally aggressive behaviour as ways of expressing their anger, anxieties, and worries. Daniel could be violent and verbally abusive with his brothers, at home and at School. Sarah was verbally abusive towards her mother and other adults but did not apparently display physical violence. She was not seen as a disruptive or violent child. Although of concern, their behaviours were not exceptional for young people in their situation and with their history, and help was offered by a number of professionals over a lengthy period.

13. It is highly significant that Sarah and Daniel had grown up witnessing significant domestic violence and abuse and had suffered loss and trauma as a result. Their separate, but similar, adverse childhood experiences were not appreciated as being as complex and formative as they appear in hindsight. The management and support provided was not always informed by a full awareness of these difficulties, which have now been more clearly identified as a result of this Review. There are aspects of the support offered and delivered that could have been better co-ordinated and it is possible that more consistent engagement, that fully acknowledged the severity of their needs and the impact of trauma, might have ameliorated the behaviours that was seen by others and experienced by Sarah and Daniel and their families. This would be the common experience of many troubled teenagers and their families.

14. Sue did receive support during 2015 to address her anxieties which recognised the trauma of her own direct experience of domestic violence and abuse. She found this a positive experience. The impact of these factors on Hayley is more difficult to assess.

15. The Review concluded that the *extent* of the breakdown of the relationship between Sarah and her mother was not fully recognised by professionals. There is learning from how these families were supported that has wider, useful implications. The profound effects of the domestic violence and abuse perpetrated by his father that Daniel witnessed; the death of his mother; and the challenges his aunt faced in looking after three boys were cumulative adverse experiences that clearly had an impact on Daniel. The significant impact of exposure to domestic violence and abuse, over extended periods and at a young age, on the attachment and behaviours of young people is seen in this case.[3] Loss of a parent through accident or illness is also recognised as having significant

[3] Nicky Stanley, Khatidja Chantler, Rachel Robbins (2019) Children and Domestic Homicide, *The British Journal of Social Work*, Volume 49, Issue 1, Pages 59–76

implications for young people, and is not always adequately addressed. Daniel resisted attempts to provide him with counselling and bereavement support. He felt that these "talked down to him".

16. Sarah and Daniel were troubled young people with significant disruption in their attachments to family and carers. When concerns about their behaviour were raised there was an overreliance by agencies on the capacity of their families to cope with their behaviour, when both Sue and Daniel's aunt were themselves vulnerable. There was a long and complex history of vulnerability and psychological trauma affecting both families which might have been more coherently recognised and might have received more sustained specialist intervention or support. This Review provides an opportunity to highlight this learning in order to develop better future practice.

17. It is not possible to state what effect better sharing of insights and information might have had on the services offered and on the relationships, and wellbeing of the subjects. In general information *was* shared effectively between agencies and professionals, and there were a number of different people seeking to help Sarah and Daniel. Sue also received specific services to address her depression and anxiety, but in strengthening her capacity to address the domestic violence and abuse she had suffered, this may have undermined her empathy for Sarah's uncertain and equivocal reaction to her father' reappearance in her life. Hayley was not in receipt of services herself.

18. There is evidence of some persistent and consistent work by a number of individual practitioners with both Sarah and Daniel which helped them in their relationships and behaviour management. The work of the School nurse with Daniel was sustained over 7 years and she was a constant and stable part of his life, who was able to develop a good understanding of his needs. Her work with him, and in prompting other agencies, resulted in positive changes. There were similar examples of consistent and resilient work from other practitioners with the family – the Targeted Youth Worker in 2013-14; the CAFCASS FCA in 2014-15 – which are examples of good practice.

Lessons to be learned

19. **It is important to stress that although there is learning to be gained from reviewing the circumstances of this case, and assessing the support that was provided to these families, the level of concerns identified was not exceptional for troubled young people and did not indicate any basis for anticipating that Sarah and Daniel would commit murder, or even perpetrate violence towards either Sue or Hayley.**

20. There are several general learning points identified by this review.
    - The long-term effects of domestic violence and abuse on victims and those who are exposed to its effects needs to be better recognised and understood.
    - It is an overall conclusion from this review that greater professional curiosity is needed to look at underlying needs, particularly when considering disruptive behaviour by adolescents.
    - There were several occasions as identified in this report when there were opportunities to assess the risks to, and presented by, Sarah and Daniel, but there is no indication that anything would have prevented the murders they committed.

- Family Group Conference did not facilitate wider family support and a plan to assist aunt.
- The course of events over an extended period for both Sarah and Daniel questions whether the Team Around the Child process was robust enough to identify the full picture of their needs and address underlying causes of adolescent trauma, rather than just presenting behavior

21. The Review makes six recommendations which will be taken forward by the Partnerships. A number of actions have already been taken to develop the services commissioned for troubled young people in Lincolnshire, and there has been careful reflection by all the agencies involved on the broader lessons that this case illustrates.

Recommendations

22. Lincolnshire Safeguarding Partnership to evaluate the capacity and performance of services to address the needs of adolescents with difficult or risky behaviours, but without diagnosed mental health illness.

23. Safer Communities Lincolnshire to review how parent/child abuse is identified and assessed and to seek assurance that domestic violence and abuse is understood to often be a key factor in adolescent trauma and behavior.

24. Lincolnshire Safeguarding Partnership to improve awareness of trauma informed practice and adverse childhood experiences, particularly concerning the long-term impacts of domestic violence and abuse on children and parenting capacity in order to develop strategies for better professional assessment of these.

25. Lincolnshire Safeguarding Partnership to work with faith groups to ensure positive awareness of safeguarding procedures and to encourage participation in joint training.

26. Lincolnshire Children's Services to review how social work expertise is accessed by TAC processes to encourage professional curiosity and to support complex needs where there is not an incident or trigger for direct social work intervention or assessment.

27. Lincolnshire Safeguarding Partnership to seek assurance that cumulative and whole family perspectives are strengthened in assessment and support work, particularly for families who do not meet social care thresholds.