

Nineteen Child Homicides

What must change so children are put first in child contact arrangements and the family courts



Women's Aid is the national charity working to end domestic abuse against women and children. Over the past 40 years, Women's Aid has been at the forefront of shaping and coordinating responses to domestic violence and abuse through practice. We empower survivors by keeping their voices at the heart of our work, working with and for women and children by listening to them and responding to their needs. We are a federation of over 220 organisations who provide more than 300 local lifesaving services to women and children across the country.

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Foreword

This report should not need to be written, that much is disturbingly obvious. First, while it is impossible to prevent every killing of a child, when the risks are known no other consideration should be more important – yet there is evidence here that other considerations were rated more highly. Second, starkly similar findings more than 10 years ago led to the publication of guidance which, if followed, would have made these killings less likely. Yet here we are.

Nothing in this report should be used to blame individual professionals for the deaths of these children. Only those who killed them deserve blame. But we have a duty to the children and their families to identify what more should have been done to protect them — particularly when guidance on how to do so has been available since 2008, following the publication of Women's Aid's previous report on child homicides and child contact arrangements, a decade ago.

This report shows, that whatever the stated requirements on the family courts, there is a deeply embedded culture that pushes for contact with fathers at all costs. This is supported by the testimony to Women's Aid of mothers who have survived domestic abuse and the specialist services that support them. The knowledge that severe abuse has taken place does not stop this relentless push to maintain as close a bond between father and child as possible. A father who has abused his child(ren)'s mother is routinely seen as a "good enough" dad. The impact of abuse on the whole family, particularly persistent, coercive and controlling behaviour which continues after the relationship has officially ended, is routinely misunderstood.

The evidence here is a stark reminder of the dangers of power without accountability: perpetrators of abuse who have accumulated all power over their partners' and children's lives, and courts which persist in dangerous misunderstandings and assumptions, effectively colluding in the terrorising – and in some cases serious harm – of women and children.

We call on Government and the senior judiciary to ensure that no more children die as a result of a simple failure to follow the guidance that exists. We call on judges to take responsibility for their own understanding of coercive control, how it works, and how it affects both women and children. And then, finally, to act on that understanding.

In another ten years, we must not yet again be repeating the same investigation, with the same findings. In fact, of course, ten years is far too long.

We must have change now.

Polly Neate, Women's Aid Chief Executive

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Executive summary

Nineteen Child Homicides tells the stories of 19 children who were killed by a parent who was also a perpetrator of domestic abuse, in circumstances relating to child contact (formally or informally arranged). Our focus is on children but, in some of these cases, women were also killed.

The blame for these killings lies with the perpetrators. However, we have concluded that these cases demonstrate failings that need to be addressed to ensure that the family courts, Child and Family Courts Advisory and Support Service (Cafcass), children's social work and other bodies actively minimise the possibility of further harm to women and children.

This study reviewed relevant serious case reviews for England and Wales, published between January 2005 and August 2015 (inclusive). It uncovered details of 19 children in 12 families who were killed by perpetrators of domestic abuse. All of the perpetrators were men and fathers to the children that they killed. All of the perpetrators had access to their children through formal or informal child contact arrangements.

Twelve families:

- Nineteen children killed.
- Two women killed.
- Two children seriously harmed through attempted murder.
- Seven men dead by suicide after committing child homicide.

Key themes

Despite some clear progress on the policy framework around child contact and domestic abuse since the 2004 publication of Women's Aid report *Twenty-nine Child Homicides*, we believe that there are still improvements to be made. Some key themes emerged from our analysis of the serious case review reports identified for this study.

These key themes are:

- 1. The importance of recognising domestic abuse as harm to children.
- 2. Professional understanding of the power and control dynamics of domestic abuse.
- 3. Understanding parental separation as a risk factor.

- 4. The way in which statutory agencies interact with families where there is domestic abuse.
- 5. Supporting non-abusive parents and challenging abusive parents.

Recommendations

This report makes some clear recommendations for each of these key themes, but there are two overarching recommendations that the Government, family court judiciary and Cafcass must urgently act upon:

- Further avoidable child deaths must be prevented by putting children first in the family courts as the legal framework and guidance states.
- There is an urgent need for independent, national oversight into the implementation of *Practice Direction 12J Child Arrangement and Contact Orders: Domestic Violence and Harm.*

Women's Aid believes that to prevent further avoidable child deaths, lessons must be learned from the deaths of these 19 children. This report highlights key failings that need to be addressed in child contact cases involving domestic abuse.

Family courts, Cafcass, children's social work and other agencies must work together to ensure that children and mothers are not at risk of further harm after the parents have separated.

Introduction

In 2004, Women's Aid published the *Twenty-nine Child Homicides* report. This report detailed the findings from a review of public documents relating to 13 families where 29 children had been killed by abusive fathers. The killings happened between 1994 and 2004, and were committed by perpetrators of domestic abuse in circumstances relating to child contact (informally or formally arranged). Its findings prompted a review of judicial practice and the issuing of a new Practice Direction 12J on prioritising the safety of children and non-abusive parents in child contact decisions in the family courts.

Despite some positive advancements, in terms of the policy framework in relation to domestic abuse and contact applications, Women's Aid frequently hears from survivors and domestic abuse services about unsafe child contact arrangements. Both groups urged us to launch a campaign to ensure that children are put at the heart of the family courts. This report therefore forms part of a wider public campaign Women's Aid is conducting to improve the safety of child contact in cases where there is, or has been, domestic abuse.

As part of our **Child First: safe child contact saves lives** campaign, Women's Aid has conducted an investigation into cases where children had been killed by a perpetrator of domestic abuse during, or as a result of, unsafe child contact since the publication of our 2004 report. Our review covers the period January 2005 to August 2015 (inclusive) in England and Wales. We found serious case review reports about 19 children, in 12 families, who had been killed in circumstances relating to child contact by a father who was a perpetrator of domestic abuse. Our report examines the circumstances in which these abusive fathers were given access to their children (either through informal arrangements or by arrangements made in court). We investigate what lessons can be learned for government policy and for agencies working with families where one parent is abusive, including the family court judiciary and Cafcass.

The key recommendations from this report:

- Further avoidable child deaths must be prevented by putting children first in the family courts - as the legal framework and guidance states.
- There is an urgent need for independent, national oversight into the implementation of *Practice Direction 12J Child Arrangements and Contact Order: Domestic Violence and Harm.*

We want to make it clear from the start that, although this report examines the role of statutory and voluntary agencies and lessons that can be learned in child

safeguarding, the culpability for these child homicides lies squarely with the abusive fathers who killed their children.

Women's Aid recognises the importance of safe child contact, when it is proved to be in the best interests of the child(ren) and where the arrangements for contact prioritise the child(ren)'s safety and wellbeing. In all cases of alleged domestic abuse there must be robust and effective assessment by experts of the implications for the child's and the non-abusive parent's safety and wellbeing.

Women's Aid is concerned that the publication of this report should avoid causing further distress to the families involved in these cases. Therefore, we have removed any identifying data, such as serious case review report titles, publication and crime dates, the gender and ages of individual children, place names or people's names (although the latter are usually already redacted in public serious case review reports). However, we are happy to make these data available to the Government for their confidential use. We have attached a 'Case Number' to each serious case review to help structure our research and report-writing. These numbers are randomly assigned and do not relate to the chronology of the reports.

Progress since publication of Twenty-nine Child Homicides (2004)

2004	Women's Aid's 2004 report gave details of 29 children in 13 families who were killed between 1994 and 2004 in England and Wales.
2005	Her Majesty's Inspectorate of Courts Administration report on Cafcass and the court service handling of domestic violence cases highlighted the problems caused by the emphasis on the presumption of contact rather than the protection of the child.
2006	Lord Justice Wall ⁱ presented a report to the President of the Family Division in response to <i>Twenty-nine Child Homicides</i> . His report focused on the five cases described in the report where the family courts were involved ¹ .
2007	The Family Justice Council published a report to the President of the Family Division which discussed both the Twenty-Nine Child Homicides report and the response from Lord Justice Wall. This report recommended a 'cultural change' in judicial practice in terms of moving away from a presumption of 'contact is best' to a culture of 'contact that is safe and positive for the child is always the appropriate way forward." The Family Justice Council called for a Practice Direction to be issued reflecting recent case law on best practice and clarifying the court's approach to contact where there are allegations of domestic abuse.

2008	The President of the Family Division issued Practice Direction 12J Child Arrangements and Contact Order: Domestic Violence and Harm (first issued in May 2008, later amended) which states that:
	"The family court presumes that the involvement of a parent in a child's life will further the child's welfare, so long as the parent can be involved in a way that does not put the child or other parent at risk of suffering harm." ³
2014	Practice Direction 12J is substantially revised. It now contains a wider definition of domestic abuse that emphasises coercive control; it directs courts to consider a range of ways in which domestic abuse may be evidenced. It requires courts to ensure that, where domestic abuse has occurred, any child arrangements order protect the safety and wellbeing of the child and the parent with care and is in the best interests of the child.

Despite the progress that has been made, there are still very clear barriers to women and children survivors of domestic abuse accessing safe contact through the family courts.

The 'pro-contact' approach taken by the family justice system has seemingly overtaken the need for any contact orders to put the child's best interests first.⁴ The paradox highlighted by survivors of domestic abuse that a parent can be seen as a violent perpetrator of domestic abuse and a good enough father plays out often in the family courts and "neglects the safety needs of children and women, and the impact on them of previous or continuing domestic violence" As the results of this study show, the presumption that contact is always beneficial for children, unless explicitly proven otherwise, is harmful and has contributed to the tragic cases discussed here.

The cultural assumption in the family justice system that contact with both parents is the most beneficial outcome for a child is perpetuated by a public conception of the family courts as being biased against fathers applying for contact. There is no evidence to suggest this is the case. Research shows that the majority of non-resident parents achieve the type of contact and the amount of contact they seek. One study of 203 child contact orders found that there was only one order prohibiting any contact, and only 3% of contact orders were for supervised visiting.⁶

Two recent major changes to the family justice system compound the barriers often faced by survivors of domestic abuse and the increasingly complex and arduous routes to safe child contact.

The first is the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) which has severely curtailed eligibility for legal aid in private family law cases. Although legal aid is available for court proceedings where a party can produce specified evidence of domestic abuse (referred to as the Domestic Violence Gateway), there are many cases in which the necessary evidence under the Domestic Violence Gateway is either unavailable or unobtainable⁷, so that victims of

domestic abuse disputing contact are forced to become Litigants in Persons (LIPs). As a consequence, survivors find themselves being cross-examined by the perpetrator of domestic abuse, or by the perpetrator's barrister, and they may also have to cross-examine the perpetrator themselves. This leaves women in a very vulnerable position where they may not be able to have access to a fair hearing.⁸

Research by Rights of Women, Women's Aid and Welsh Women's Aid found that:

- 38% of women responding to a survey who had experienced or were experiencing domestic violence did not have the prescribed forms of evidence to access family law legal aid.
- 26% of these went on to represent themselves at court.⁹

The second change is the *Children and Families Act 2014* which also introduced three key changes in family law:

I. Presumption of parental involvement

There is now a presumption enshrined in law that children should have ongoing involvement with both parents following separation so long as this does not put the child at risk of suffering harm. This may have the effect of strengthening the courts' emphasis on enabling contact and minimising perceptions of risk.

2. Child arrangement orders

Contact and residence orders have now been replaced with child arrangement orders.

3. Mediation Information and Assessment Meetings (MIAMs)

The requirement to attend a MIAM before entering the family justice system is now statutory except where domestic violence has been alleged in the last 12 months. The introduction of MIAMs has meant that many women feel obliged to take part in mediation before a family court case, or instead of going to court for a hearing. Although mediation could be dangerous where a relationship has been abusive, research has demonstrated that family courts may nonetheless direct parties to attend mediation assessment prior to commencing proceedings, with the result that cases involving domestic abuse may be mediated inappropriately. Exclusion from compulsory MIAMs due to domestic abuse has the same evidence criteria as legal aid, which means many women will be forced into mediation with their perpetrator unless they can produce specific forms of evidence.

There has been much progress in the policy, practice and framework of child contact in domestic abuse cases since the publication of *Twenty-nine Child Homicides* in 2004. However, Women's Aid has significant concerns about the experiences of survivors of domestic abuse and their children in the family courts and through child contact with a perpetrator of domestic abuse. Survivors and their children

frequently report to Women's Aid, and to organisations in our federation of services, that they feel re-victimised and traumatised through the family court and child contact process. Increasingly, since the enshrinement of the presumption of parental involvement in legislation, there are growing concerns amongst some practitioners and academics that the courts are prioritising contact with an abusive parent over the safety of the child and non-abusive parent.¹²

Methodology

In this study Women's Aid aimed to identify those cases where a child had been killed by a perpetrator of domestic abuse in circumstances relating to child contact (formally or informally arranged). In reviewing the relevant serious case reviews, we aimed to identify the key issues around enabling safe child contact. This included exploring the courts' and other statutory agencies' roles in minimising the risk of further harm to adult and child survivors of domestic abuse.

Our study is an exploratory one involving the review of published serious case review reports. Serious case reviews are undertaken by Local Safeguarding Children Boards when abuse or neglect of a child is known or suspected, and either the child has died or has been seriously harmed. We know that a significant proportion of serious case reviews involve domestic abuse: a study of 139 overview reports from serious case reviews found that about two-thirds (63%) of cases featured domestic abuse.¹³

Data collection and analysis

We used the online search engine in the NSPCC National Case Review Repository¹⁴ to identify reports relevant to our research. Our review period was January 2005 until August 2015 (inclusive). This period relates to the dates when the reports were published, rather than the dates of the homicides. We used the following search terms to find relevant reports:

- "Domestic Abuse"
- "Partner Violence"
- "Domestic Violence"
- "Family Violence"
- "CAFCASS".

We then read the synopses of the Case Reviews identified by this search, and identified 29 cases that were possibly relevant to our study. We obtained the serious case review reports for these 29 results either from the NSPCC Library or by requesting them from the relevant Children's Safeguarding Boards. We also included in our study one recent review that had not been identified in the initial online search, but we had been alerted to its publication by a news story. We then read all 30 reports to identify which were relevant to our study. Our criteria for relevance were that the serious case review related to a case from England or Wales in which:

a child had been killed

- the perpetrator was the child's parent and had perpetrated domestic abuse against the other parent
- the parents were separated and child contact had been arranged informally or formally.

After applying these criteria, 12 out of the 30 reports were found to be relevant.

We did not apply any exclusion criteria regarding the gender of the perpetrator of domestic abuse. However, in all of the relevant cases (12 families) it was the father who was the perpetrator.

Limitations of the methodology

Our study is limited in that we only have access to public, redacted documents. In eight cases we only had access to executive summaries and some of these contained little detail.

It should also be noted that serious case review panels do not have access to family court records and it is not their role to review court proceedings, although they do work with and receive information from Cafcass where the family courts are involved.

It is possible that there may have been some relevant cases that were not revealed by the search terms used or that there were some very recent serious case review reports not yet in the NSPCC repository.

In recognising the limitations of our research, we call for further detailed investigation of the issues highlighted in our findings which will require better data collection and monitoring of cases of domestic abuse in the family courts.

Summary of the 12 cases

Twelve families:

- Nineteen children killed.
- Two women killed.
- Two children seriously harmed through attempted murder.
- Seven men dead by suicide after committing child homicide.

Case One Executive Summary

Two children killed.

Children killed by father during weekend contact visit.

Father found guilty of their murder.

Court-ordered shared residence with the consent of both parents.

Case Two Overview Report

Two children killed.

Children were killed by the father they lived with (arranged through the family court).

Father then committed suicide.

Contact with the mother was at the discretion of the father.

Suggestion that the killer may have wanted to kill the mother too.

Case Three Overview Report

Two children killed.

Children killed by their father during a contact visit.

Father committed suicide.

Contact with father agreed as part of a Non-Molestation Order and Occupation Order.

Case Four Executive Summary

One child killed.

Child was killed by father.

Father committed suicide.

Interim arrangements had been made in family court for child to live with father.

Case Five Executive Summary

Two children killed.

Killed by their father during overnight contact. Father committed suicide.

Contact with father arranged in the family court

Father also attempted (unsuccessfully) to harm or kill step-son and mother.

Case Six Executive Summary

One child killed.

Killed by their father during a weekend stay.

One further child seriously harmed (attempted murder) by their father.

Father was on bail at time of the killing for charges of sexual assault against the mother.

Father convicted of murder and attempted murder.

Contact was informally arranged.

Case Seven Executive Summary

Two children killed.

Mother of children killed.

All killed by father of children.

Father committed suicide.

Children thought to have had informal contact with father (not clear whether the killing happened during a contact visit).

Case Eight Executive Summary

One child killed and one child seriously harmed (attempted murder).

Father attempted suicide.

Father convicted of murder and attempted murder.

The children were resident with their mother and had contact with the father – arranged through the family court.

Case Nine Executive Summary

One child killed.

Child killed by father.

Child lived with mother, contact with father possibly arranged though court (not clear in SCR report).

Father possibly committed suicide (not clear in SCR report).

The Coroner's Court recorded an open verdict.

Case Ten Overview Report

Two children killed.

Killed by father during a contact visit.

Father committed suicide.

Children were living with mother and grandparent, father had interim arrangement (made in family court) for contact twice a week.

Case Eleven Executive Summary

Two children killed.

Children killed by father during a contact visit.

Father committed suicide.

Contact informally arranged.

Case Twelve Overview Report

One child killed.

Mother of child killed.

Both killed by the father of the child.

Child resident with mother and had contact with father.

Father found guilty of their murders.

Father seriously injured – not clear if this was self-inflicted.

One child (from the mother's previous relationship) managed to escape from scene of crime.

Mother had applied to family court for a residence order, it is not clear what contact arrangement were currently in place and whether these were arranged in court.

Key findings

Our review uncovered details of 19 children in 12 families killed by perpetrators of domestic abuse in circumstances relating to child contact (informally or formally arranged). In addition, two other children were seriously physically harmed at the time of these homicides, and two women were killed. These homicides took place in England and Wales and were described in serious case review reports published between January 2005 and August 2015 (inclusive). All of the perpetrators were men and fathers to the children they killed.ⁱⁱ

- There were 28 deaths in 12 families: 19 children and two mothers were killed: seven fathers committed suicide.
- 19 children in 12 families were killed by perpetrators of domestic abuse who had access to their children through formal or informal child contact arrangements.
- All 12 fathers were known to statutory agencies as perpetrators of domestic abuse. Eleven of the 12 fathers were known to the police as perpetrators of domestic abuse in the one remaining case, the report is not clear about whether the police had been involved.
- Two more children were seriously physically harmed (attempted murder) plus one attempt at serious harm of a child was averted, and another child escaped the scene of the killing, avoiding physical harm.
- Two mothers were also killed by the father of their children. One of these mothers had been assessed by the police at "standard" (upgraded to "medium") and "high" risk at different times; the other mother was assessed at "standard" or "moderate" risk at various points.
- The children's ages ranged from just over one year to 14 years (the age of children is not given for three of the 19 children).
- In two cases, it is suggested that the father may have tried (unsuccessfully) to lure the mother to a location to kill or seriously harm her.
- Seven perpetrators committed suicide. In addition, there was one attempted suicide and another case where the perpetrator appears to have committed suicide, but this is not made clear in the serious case review report.
- For 12 children (in seven families) of the 19 children killed, contact with the perpetrator (their father) was arranged in court. This might also be true for two more of the children killed; however, this is unclear in the published serious case review reports. For six families, this contact was arranged in family court hearings (two of these were interim orders) and for one family, contact was decided as part of the arrangements for a Non-molestation Order and Occupation Order.

- A welfare report is known to have been undertaken relating to four children (in two families) of the 12 children where the contact had been arranged in court. In one additional family (two children involved), a welfare report was in the process of being prepared.
- In two families the father was granted overnight contact, and in an additional two families the father was granted a residence order (one of these was an interim order). All of these fathers were known perpetrators of domestic abuse.
- Nine of the 12 perpetrators are known to have committed domestic abuse after separating from the child(ren)'s mother. In addition, for one of the perpetrators, information about post-separation abuse is unclear in the report. For two of the perpetrators, no information is given about whether there was any abuse after separation.
- The types of abuse committed after separation included harassment and threats via letter, telephone and text message; attempted strangulation; sexual assault; threats to abduct children and actual abduction, which are indicators of high risk perpetrator behaviour. In one case, the father had made threats by telephone while in prison for offences that included violence against the mother; he was subsequently granted a residence order concerning his children by the court.
- Seven of the 12 perpetrators were known to have mental health problems.
- Four of the 12 perpetrators were known or suspected to have problematic alcohol or drug use.
- Three of the mothers are described as having mental health problems; in the remaining reports the mental health of the mother is not mentioned or is not clear.
- Two of the mothers were known to have problematic alcohol use.

Excluded reports

Amongst the excluded reports there are three reports that seemed significant to the central themes in our study but did not meet our review criteria:

- I. One report details the case of a mother, who had reported experiencing domestic abuse, and is presumed to have killed her child. The child was due to live with the father who had been granted a residence order by the court. This case was excluded from our study as the presumed killer had reported experiencing domestic abuse and we were looking for cases where the killer was a perpetrator of domestic abuse.
- 2. One report was excluded as it did not relate to contact arrangements. However, it was strongly related to domestic abuse as the father concerned (a perpetrator of domestic abuse) had killed his two children after the mother had left the family home to escape the domestic abuse.

3. One report gave details of a case where a child was removed from the care of a disabled mother from birth by the local authority, and after a time in foster care was subsequently placed in the care of the father. This report was excluded from our study because the child had not been killed and the case did not involve child contact arrangements between the parents; the child had never been in its mother's care. The father had a history of committing domestic abuse and there had been allegations that he had committed sexual abuse against a minor. Injuries to the child were discovered and the child was subsequently removed from the father's care. The father received a community sentence for neglect.

Discussion of key themes

Our discussion of the findings centres around five themes:

- 1. the importance of recognising domestic abuse as harm to children;
- 2. professional understanding of the power and control dynamics of domestic abuse;
- 3. understanding parental separation as a risk factor;
- 4. the way in which statutory agencies interact with families where there is domestic abuse; and,
- 5. supporting non-abusive parents and challenging abusive parents.

We are particularly interested in the lessons learned in these serious case reviews and what insight they provide about how to improve the safety of children and domestic abuse survivors after separation from abusive partners, including in cases where the family courts are involved.

Since May 2008, the family courts and Cafcass have been guided by Practice Direction 12J to "ensure that where violence or abuse is admitted or proven, that any child arrangements order in place protects the safety and wellbeing of the child and the parent with whom the child is living, and does not expose them to the risk of further harm." In reviewing those cases where child contact was arranged through the courts we especially considered how risk from domestic abuse was assessed, what efforts had been made to minimise the "risk of further harm" and what opportunities and barriers there had been to achieving this goal.

I. The importance of recognising domestic abuse as harm to children

"...important opportunities were missed to assess the specific level of risk to the children, particularly during the court proceedings..." (Case One)

The impact of domestic abuse on children

The perpetration of domestic abuse in families where there are children constitutes harm to children, even when the children are not directly physically harmed by the perpetrator. An Expert Court Report about child contact and domestic abuse released in 2000 clearly states that:

"Domestic violence involves a very serious and significant failure in parenting — failure to protect the child's carer and failure to protect the child emotionally (and in some cases physically — which meets any definition of child abuse). 16

The Adoption and Children Act 2002 (section 120) extended the legal definition of "harm" as stated in the Children Act 1989, to include "impairment suffered from seeing or hearing the ill treatment of another." This came into force in January 2005.

There is also evidence of the frequent co-existence of domestic abuse and abuse directly against a child. One study found that 34.4% of under-18s who had lived with domestic violence had also been abused or neglected by a parent or guardian.¹⁷ A study of 139 overview reports from serious case reviews found that about two-thirds (63%) of cases featured domestic abuse.¹⁸

Statutory agencies, domestic abuse and child safeguarding

A common theme in the serious case review reports we reviewed was the lack of consideration of how domestic abuse could pose a specific risk to children. Children's specific experiences of domestic abuse and the impact on their safety, health and mental wellbeing were not often directly assessed or addressed. One report states that:

"There was some very good recording about the two subject children by some professionals but no direct work was undertaken with the children to understand, for example, the impact of domestic violence incidents or their parent's separation." (Case Seven)

Often, assessing and managing the risk to the children was dealt with in an inadequate way. For instance, in one case, a statutory service posted a letter to the non-abusive parent to explain the risk of domestic abuse to children. Three of the reports we reviewed particularly highlighted the lack of direct social work with the children, despite statutory agencies knowing about the domestic abuse being perpetrated by their fathers.

One serious case review report notes that:

"...children were not seen and spoken to on their own by anyone from the statutory agencies until they were seen by Cafcass in [date given]. At that point the conflict surrounding the parents' relationship breakdown and the contact between the children and father had been going on for a year." (Case Eight)

Family courts, domestic abuse and child safeguarding

Lord Justice Wall's comments in 2006, in response to the publication of *Twenty-nine Child Homicides*, continue to be pertinent today:

"It is, in my view, high time that the Family Justice System abandoned any reliance on the proposition that a man can have a history of violence to the mother of his children but, nonetheless, be a good father." ¹⁹

In the cases we reviewed where contact was arranged through the courts, abuse of the mother was often seen as a separate issue from the child's safety and wellbeing, rather than the two being intrinsically linked. Indeed, the mothers themselves were often quoted as also believing that the abusive father would never harm his children.

A study published in 2014 (which comprised an analysis of case law and in-depth interviews with barristers, solicitors and family court advisers employed by Cafcass) found that most professionals and judicial officers continue to endorse a message of 'contact at all costs' after Practice Direction 12J was issued. It also found that domestic abuse that was not very recent and did not involve severe physical violence was often being discounted as irrelevant to the contact arrangements. The study concluded that:

"If we are to achieve the 'cultural shift' called for by the Family Justice Council, we need to acknowledge properly that 'the family' is not always a safe haven but a place where abuse can occur."²⁰

In our review, we found that an abusive parent was often able to successfully present himself to the court or to children's social work professionals as a good father, and be granted unsupervised access to his children or even be granted a residence order. This happened even when the father had perpetrated abuse after separation; even when there had been criminal sanctions for his violence or ongoing criminal proceedings for violence; even when he had made threats to kill the children in the past and even when, in one case, the mother said in her application to the court that the father had previously told her that "he had nothing to live for and intended to commit suicide" and that "he can understand fathers killing their children". (Case Ten)

In one case, the review authors pointed out that no agency had regarded unsupervised contact with the father as posing a risk to the children, despite the fact that the father was on bail for charges of sexual assault against the mother at the time of the killing. (Case Six)

Another report stated that the:

"...father was seen either, as a 'bad person' abusing his partner and involved in drug-use, or, a 'good man' who was working hard to care for his children. In reality, he was both, and the risks associated with his former actions needed to be fully assessed." (Case Two)

This shows a common and concerning perception: that a father who has perpetrated domestic abuse need not be seen as a bad parent, or as having the potential to commit ongoing violence and harassment - including using the family courts and child contact as a vehicle to continue this abuse.

Concerns about this perception were also expressed by Lord Justice Wall in

his 2006 report to the President of the Family Division (cited previously) and subsequently in remarks he made to the Hertfordshire Family Forum in 2007:

"...we should continue to promote the message that it is not possible at one and the same time to be guilty of serious violence to your partner and to hold yourself out as a good parent."²¹

A recent study of family court proceedings also warns against the faulty thinking that abusive behaviour can be separated from parenting ability in any assessment of risk:

"We have seen that the parameters of what constitutes the 'safe family man' are expanding to include increasingly abusive, 'dangerous' fathers, a process that may be exacerbated by the presumption of parental involvement."²²

One of the serious case review reports in our research notes that one of the social workers involved refused to meet the father at his home because of "...concerns expressed about his behaviour..." (Case Ten). Yet subsequently, the father was granted an interim order by the court which meant that his children met with him alone twice a week.

Conversely, women are often seen as being 'implacably hostile' by family court professionals when they are raising concerns about contact. Research suggests that mothers generally want their child(ren) to have contact with their fathers as long as this contact is safe and in the best interests of their child(ren), and when they raise concerns about contact it is because they have well-founded fears around abduction or violence.²³

Children's voices

The extent to which the children's views were ascertained for the court is not always made clear in the reporting in the serious case reviews.

In one case, the Cafcass Officer had only interviewed one of two child siblings before they were killed (while an interim order was in place). In the same case, someone from Children's Social Care met with the children only once, and the children disclosed that their father emotionally abused them and that they were afraid of him. This information was given to the family court and the court subsequently made an interim order for the father to have unsupervised contact with his children twice a week.

In two cases, the serious case reviews suggested that there may have been too much weight given to the children's wishes to see their fathers without sufficient assessment of the risk to their welfare and safety. A careful balance needs to be made between listening to children's wishes and their accounts of their experiences, while not expecting them to weigh up the risks themselves or to manage their own safety and wellbeing.

One report noted:

"Both of the children wanted to see their father and stay for weekends... Neither had fears or concerns about this. Their wishes and feelings in relation to contact were in fact given too much weight in comparison to other factors that they could not understand, given their age and level of development." (Case One)

Recommendations:

- The Government and senior leaders in the family courts and Cafcass need to take action to bring about cultural change within the family court system to ensure that the safety and wellbeing of child(ren) and non-abusive parents are understood and consistently prioritised.
- Children should always be listened to and their safety must always be at the heart of any child contact decision made by the family court judges.
- Children's experiences of domestic abuse and its impact on them should always be fully considered by the family court judiciary with an acknowledgment that post-separation abuse is commonly experienced by non-abusive parents.
- The Ministry of Justice must ensure that all family courts including judges and involved statutory agencies are aware of and fully implement Practice Direction 12J.
- The Government needs to urgently review whether the current workings of the family courts are upholding the human rights of children and non-abusive parents and whether the family courts are fulfilling the State's obligations under Article 2 (The right to life) and Article 3 (No torture, inhuman or degrading treatment) of the *Human Rights Act 1998* and Article 31 (Custody, visitation rights and safety) of the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence.

2. Professional understanding of the power and control dynamics of domestic abuse

"The father showed a pattern of jealous, controlling behaviour which persisted after the separation..." (Case One)

Recognising a pattern of coercive control

Key to understanding domestic abuse is understanding power and control and its manifestations in an abusive intimate relationship. Coercive controlling behaviour in an intimate relationship has been described as "the entrapment of women in personal life" and deliberately restricting a woman's "space for action" A new offence of "controlling or coercive behaviour in an intimate or family relationship" was introduced in the Serious Crime Act 2015 and came into force

in December 2015. The Act describes the offence as happening between two people who are personally connected when one person knowingly "repeatedly or continuously engages in behaviour towards another person (B) that is controlling or coercive" and "the behaviour has a serious effect on B"²⁶. Women may also experience violent and controlling behaviour from multiple family members. A survey of women using specialist BMER (Black, Minority Ethnic and Refugee) domestic abuse services found that in 27% of 75 cases (of women not living in refuge) there had been post-separation harassment and violence from the extended family.²⁷

It is significant that in many of the serious case review reports we examined the perpetrator is described in terms that indicate coercive control; for example as "controlling", "a bully", "jealous" or "intimidating". In one of the serious case reviews we examined, the Cafcass Officer said she felt intimidated by the father who she described as "agitated, unreasonable, intimidating, controlling and aggressive" and refused to meet on her own with him again (Case Ten).

Ongoing coercive control appears to be a significant feature of the domestic abuse in many of the cases. There were many examples in the serious case reviews of efforts by perpetrators to control and coerce the mother (before and after separation) including:

- isolating them from support (in one case the perpetrator stopped visits by a Home-Start volunteer to the mother)
- patterns of jealous behaviour
- monitoring of/obsession with the mother's private life
- coercing the mother into agreeing to child contact
- threats to harm the mother or "make her life hell"
- threats to harm children
- threats to abduct children or actual abduction
- very frequent communications after separation, for example "constantly texting"
- threats to commit suicide
- not letting the mother see professionals on her own (e.g. being with her when she saw health professionals about injuries he had caused)

Conversely, there often seemed to be a dominant focus by statutory agencies on individual incidents rather than a recognition of patterns of abusive and controlling behaviour:

"The assessment of risk to the children [date given] by the police was not robust enough as it dealt with the risk in an episodic way rather than take a longer view of the elements of risk." (Case Eight)

"...his attempts to contact Mother were seen as a one-off incident rather than a course of events which would have led to an arrest." (Case Seven)

Sometimes the absence (or absence of disclosure) of obvious physical injuries meant that agencies were not alerted to the nature of the relationship, for instance one report noted that there was:

"...aggressive behaviour and violence between the parents, although there is never any referral to any agency of physical violence to the children by the adults or any reported physical injuries to mother." (Case Eight)

A recent study of how domestic abuse is dealt with in the family courts also noted a failure to identify seemingly minor incidents as part of ongoing patterns of significant and highly dangerous controlling behaviour, and a failure to understand domestic abuse as gendered power imbalance:

"Domestic violence that is considered to be 'minor' or 'petty' and/or is designated as 'old' or 'historical' is not thought to be relevant to contact because courts and professionals fail to contextualise it within the gendered power and control dynamics of domestic violence."²⁸

There are increasing concerns around survivors of domestic abuse having to represent themselves in the family courts as Litigants In Person (LIPs).²⁹ Allowing a perpetrator of domestic abuse who is controlling, bullying and intimidating to question their victim when in the family court regarding child arrangement orders is a clear disregard for the impact of domestic abuse, and offers perpetrators of abuse another opportunity to wield power and control.

Inadequate assessment of risk of domestic abuse was raised as an issue in the serious case reviews. In one case, there was no risk assessment carried out by Cafcass before an interim order for residence with the father was made. The father killed the child before a risk assessment and permanent contact arrangements were completed. Understanding of the nature and impact of domestic abuse, and the importance of an adequate and expert risk assessment are vital in order to establish what is in the best interests of the child.

Identifying who holds the power

The gender of the perpetrator was male in all of the cases examined and this is significant. Domestic abuse is deeply rooted in gender inequality and oppressive social constructions of the family, and of femininity and masculinity. The domestic abuse is often described in the reports we read in terms of being a characteristic of the relationship between the parents, rather than the abuse of one person against another in an intimate relationship setting. By labelling these relationships

in vague, euphemistic terms the agency of the abuse is fudged. For example, in the reports we read domestic abuse is variously described as "conflictual" (Case Two), "violence between the parents" (Case Eight), "parental disharmony" (Case Nine), "tempestuous relationship" (Case Twelve), "Relationships between the parents were acrimonious" (Case Nine) and "parental discord" (Case Nine).

This failure to identify who holds the power and control is a major barrier in assessing and addressing the safety of the child(ren) and non-abusive parent. It is also a barrier to understanding why the non-abusive parent may sometimes seem 'uncooperative' or 'not engaging' or may agree to contact arrangements despite safety concerns. In one report the mother had told a social worker that unless she allowed the father to have custody he would "hound" her (Case Two). Another mother had told a social worker that she felt "bullied by [father] around contact and agreed to it when she did not want to." (Case Ten) She also agreed to court ordered contact with the father as her legal representative had advised her that "...the court was unlikely to agree to father having no contact..." (Case Ten). In another case, it was reported in the serious case review that a relative of the mother (after she was killed) said that there had been ongoing contact between the mother, children and the father, "... although he believes the mother was coerced into this." (Case Seven) The mother in this case had told some agencies that there was no contact between her and the father.

Post-separation violence and control

There was also a lack of understanding by agencies of how violence and control might continue or escalate after separation (see the following section for further discussion about this) and that pursuing child contact might be a means of enacting this continuing control. In this light, a father killing his children can be seen as the ultimate enactment of power-wielding, rather than 'losing it' in a temporary loss of control. One report commented that by giving the father residence and discretion over how the mother saw her children, the court was perhaps reinforcing his continuing control over the mother:

"...the recommendation to the court that father should manage the contact with the children was problematic. At best this arrangement meant there was on-going direct contact between two individuals who repeatedly showed that they had difficulty maintaining appropriate boundaries. At worst it was enabling father who had previously abused his partner for [number given] years to have significant power over her." (Case Two)

Recommendations:

- All members of the family court judiciary and Cafcass should have specialist training to understand the dynamics of domestic abuse and be able to recognise coercive control.
- The Ministry of Justice and family court judiciary should ensure that survivors of domestic abuse representing themselves in court as LIPs will not be questioned by their abuser, or in turn have to question their abuser.

3. Understanding parental separation as a risk factor

"...those involved thought the separation had reduced the risks to the child." (Case Nine)

The point at which a survivor leaves an abusive partner is a significantly dangerous time for her and her children. 76% (16 out of 21) of homicides by a partner or ex-partner reviewed in a 2003 report involved separation.³⁰ A recent study with domestic abuse service-users in London found that 88% of women (out of 72 women) had experienced some form of post-separation abuse.³¹

Analysis of serious case reviews in a report published by the Government in 2012 highlighted parental separation as a significant risk factor in terms of harm to children:

"This [parental separation] may be a context within which children are at risk of suffering significant harm, particularly where the separation is coupled with ongoing domestic violence or controlling behaviour; where there are conflicts around contact arrangements; or where children are caught in the midst of acrimonious separations. Domestic violence featured prominently in these cases, and it was clear in several cases that the impact on children did not stop when the parents separated, often with ongoing threats or controlling behaviour affecting both the mother and her children. Some of these cases highlighted that acrimonious separations can present direct risks to children's safety and welfare, including risks of homicide."³²

Perceptions of separation and ongoing risk

In the cases we reviewed, agencies often mistook parental separation as equating to an end of the abuse and a reduction in risk for the mother and child(ren). In fact, the risk continued or increased after separation. The faulty thinking in interpreting separation as a protective factor was pointed out in several of the serious case reviews:

"There was consideration that the child might be at risk of physical abuse, but this was discounted as the parents had separated. Wide ranging multiagency understanding of the continued impact of the parental discord following separation was not fully recognised." (Case Nine)

"...the system [storage of risk assessment information] is predicated upon "incident" and not "information" — a fact that is relevant to this case because the impending separation of [father] from his child (caused by [mother's] application to court) was a piece of "information" that should have heightened the awareness of practitioners to her vulnerability, and should have been seen as the "change in circumstances" that increased her risk from "medium" to "high". (Case Twelve)

"A comprehensive assessment of the risks posed to the child by the parental discord after separation of the parents was never fully completed because those involved thought the separation had reduced the risks to the child." (Case Nine)

"In addition, all agencies were reassured by the understanding that the parents had separated, not taking account of known research which suggests separation may indicate increased risk." (Case Seven)

"The significance of parental separation as a risk factor, particularly where there is known controlling behaviour and/or domestic violence is not well understood or integrated into assessment frameworks." (Case Eleven)

In our review, we found plenty of evidence of continuing abuse after separation and sometimes escalating abuse. One report described:

"...a history of sporadic domestic abuse call outs over a long period of time, which intensify when the relationship ends..." (Case Eight)

Nine of the 12 perpetrators are known to have committed domestic abuse after separation from the child(ren)'s mother. For the other three perpetrators, information about post-separation abuse is unclear or not given. In one case the father had made threats by telephone while in prison for offences that included violence against the mother and was charged with malicious communication; he was subsequently granted a residence order for his children's care by the family court (Case Two).

Child contact with the perpetrator often means that women can never completely and safely separate from their abusive ex-partner. In two of the reports the mother was also killed by the father. In two additional reports, there are suggestions that the father may have tried (unsuccessfully) to lure the mother to a location in order to seriously harm or kill her. In one report the mother had successfully managed to break free from an abusive partner by going to live in a domestic abuse refuge and she had established a new life with her children, but her ex-partner found a route back into her life and her children's lives by applying for child contact through the family court. Child contact arrangements gave the perpetrator further opportunities to perpetrate violence and ultimately kill his two children. (Case One)

Recommendation:

• All members of the family court judiciary and Cafcass should have specialist training to understand the dynamics of domestic abuse and be able to recognise coercive control, and the tactics used by abusive fathers to use child contact as a means to further abuse their ex-partner.

4. The way in which statutory agencies interact with families where there is domestic abuse

"The interaction of the different issues was not recognised by the agencies as the inter agency collaboration was limited ..." (Case Eight)

Who knew about the abuse?

In all of the 12 families some statutory agencies were aware of the abuse being perpetrated. In 11 of the 12 families the police knew about the domestic abuse, sometimes responding to multiple incidents. In the one remaining family it is unclear whether the police had been involved.

Health services also had significant knowledge of the abuse — either because of presentation by the mother with physical injuries indicative of abuse, or because of disclosure by the mother or father of mental health difficulties. In six families it is clear that health services (including GP practices, Accident and Emergency services, midwives and health visitors) knew about or had seen evidence of the abuse. However, healthcare professionals did not always share this with other agencies (such as the police or social care) or enquire about suspicious injuries. Nor did they always ask about the impact on the children in the family or instigate child protection procedures.

"The learning identified for health organisations includes the need for greater enquiry about domestic abuse and to consider its impact upon children within the family." (Case Three)

As previously noted, the connection between domestic abuse against a parent and harm to children is a significant one, but this was not always recognised by agencies who knew about the abuse. Several reports conclude that parenting ability was not sufficiently assessed by key agencies, or indeed was not considered at all. One report sums up this lack of attention on the impact on the children in the following way:

"In their decision making and actions the agencies involved focused on their immediate remit and provided services to the adults without considering them in their roles as parents and their abilities to meet their children's needs." (Case Eight)

Information sharing

Several reports comment on problems with information sharing that led to Cafcass and the family courts not having the full picture of the domestic abuse. One report particularly notes that information was not sought from health professionals, which would have revealed the mental health problems of both parents, and the father's problematic alcohol use.

Comments on information sharing from other reports include:

"There should have been more communication and information sharing between Cafcass and Children's Social Care." (Case Ten)

"The concerns of the case conference [child protection conference] were never directly communicated to CAFCASS, the Court Welfare Service." (Case Nine)

"Cafcass system for checking information with other agencies, unless otherwise stated in a court order, is with the police, Children's Social Care Services and schools. If the children are not yet of school age checks are undertaken with Health. The experience of this Review is that consideration should be given to checking older children and their parents with their GP practice in relation to ongoing mental health treatment and substance misuse in cases of disputed contact." (Case Eight)

Another report highlighted that Cafcass had not recognised the case as one where domestic abuse was relevant and Practice Direction 12J should have been followed. This is despite the mother having been in a domestic abuse refuge with her children and previous police and healthcare agencies' knowledge of the abuse. (Case One)

There are also problems noted about information sharing between statutory agencies such as the police, social care, schools, health professionals and some 'silo working' where agencies involved did not link up to create a full picture of the family life of the children. Two reports particularly note the problems involved in information sharing across local authority boundaries.

Recommendations:

- There must be improved communication and information sharing between the family courts and statutory agencies, including the police, health services, social care and schools.
- There must be better information sharing between statutory agencies about domestic abuse that includes a focus on the risks to children.
- Statutory agencies must enquire about any children affected by domestic abuse when they receive a disclosure or evidence of abuse and pass information on to relevant child and adult support and protection agencies.
- Statutory agency professionals, such as social workers, police officers, GPs, nurses and teachers, should receive specialist training and ongoing professional development on domestic abuse.

5. Supporting non-abusive parents and challenging abusive parents

"...at no point did any agency challenge his behaviour or make him aware of the impact of his behaviour on the children." (Case Six)

Support for mothers

In some of the reports the mother had received support from specialist domestic abuse services. However, in many of the serious case reviews it is unclear whether the survivor had been offered or referred to any specialist support, even when the abuse she was experiencing was known to the police or social care. We know that three of the mothers are described as having mental health problems; in the remaining reports the subject of maternal mental health is not covered, or is unclear. These mental health issues are likely to be have been as a result of or exacerbated by the domestic abuse.

In two cases the mother was contacted in an unsafe way by social care who posted a letter that could easily have been intercepted by the perpetrator and provoked a violent backlash. In one case, a letter was sent by social care about domestic abuse to the same woman on five different occasions. Not only is this an unsafe way to offer support, it is unlikely that a woman experiencing domestic abuse will engage with support being offered in this impersonal way. In one of these two cases, the letter sent to the mother included an explanation about how domestic abuse posed a risk for children, yet there is no mention of any such communication to the perpetrator of the domestic abuse.

In the one case where the mother and children had been resident in a domestic abuse refuge, their time in this specialist service is described as a time of "respite and consolidation". The report author remarks that:

"During this time [in a refuge service] the mother was able to rebuild her confidence as a person and as a parent and the children lived calmer, safer lives." (Case One)

Victim-blaming

Victim-blaming is sadly a common theme in the serious case reviews, with statutory agencies sometimes putting the onus on the non-abusive parent to protect their children and/or end the abuse (by ending the relationship), rather than focusing on the actions of the abusive parent and holding them to account.

One report notes that social workers had concerns about the mother's "...abuse of alcohol and her choice of partners" (Case Two). There doesn't seem to have been sufficient consideration that her alcohol abuse might have been a coping mechanism she employed because of her experiences of domestic abuse. Nor does there seem to have been sufficient consideration that concerns should have focused on challenging the violence of her abusive partner and providing support for her, rather than on the implied criticism of her choices.

Two reports particularly note the absence of focus on holding the father to account and on challenging his behaviour:

"After father came out of prison [for offences including violence against the mother] he appears to have quickly established himself in the minds of professionals as a reformed character and the professional memory of his previous behaviour as witnessed by his criminal record was not given sufficient weight..." (Case Two)

"...there was no formal assessment of [Father] and the knowledge of his self-reported concerns was not shared across agencies. He was not provided with any opportunity to change and when he finally met with the social worker to try and get contact with his children, he was advised to seek legal advice." (Case Seven)

Another report notes that there is no record of the father being asked about domestic abuse in his safeguarding interview with Cafcass despite allegations from the mother about his controlling behaviour.

Black and minority ethnic women may face additional barriers in escaping domestic abuse and accessing support. In one case, the report authors note that the mother (who had grown up in another country) risked losing community contacts and support in reporting the abuse.

Support for mental health, drugs and alcohol issues

We found evidence of the "toxic trio" (identified by Brandon et al, 2012,³³ in their analysis of serious case reviews), namely domestic abuse co-existing with alcohol/drug abuse and mental health problems and the particular danger this constitutes for children. Seven of the 12 perpetrators were known to have mental health problems; two of these were granted a residence order. Four of the 12 perpetrators were known or suspected to have issues with problematic alcohol or drug use.

Recommendations:

- The Ministry of Justice and family court judiciary should ensure there is improved communication between the family courts and criminal courts.
- Family courts must ensure there is better access for survivors of domestic abuse to special measures for their protection during hearings.
- Family court judiciary should ensure there is no unsupervised contact for a parent who is awaiting trial for domestic abuse related offences or where there are ongoing criminal proceedings for domestic abuse.

Recommendations

The key recommendations from this report:

- Further avoidable child deaths must be prevented by putting children first in the family courts - as the legal framework and guidance states.
- There is an urgent need for independent, national oversight into the implementation of *Practice Direction 12J Child Arrangements and Contact Order: Domestic Violence and Harm.*

1. The importance of recognising domestic abuse as harm to children

- The Government and senior leaders in the family courts and Cafcass need to take action to bring about cultural change within the family court system to ensure that the safety and wellbeing of child(ren) and non-abusive parents are understood and consistently prioritised.
- Children should always be listened to and their safety must always be at the heart of any child contact decision made by the family court judges.
- Children's experiences of domestic abuse and its impact on them should always be fully considered by the family court judiciary with an acknowledgment that post-separation abuse is commonly experienced by non-abusive parents.
- The Ministry of Justice must ensure that all family courts including judges and involved statutory agencies are aware of and fully implement Practice Direction 12J.
- The Government needs to urgently review whether the current workings of the family courts are upholding the human rights of children and non-abusive parents and whether the family courts are fulfilling the State's obligations under Article 2 (The right to life) and Article 3 (No torture, inhuman or degrading treatment) of the *Human Rights Act 1998* and Article 31 (Custody, visitation rights and safety) of the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence³⁴.

2. Professional understanding of the power and control dynamics of domestic abuse and 3. Understanding parental separation as a risk factor

 All members of the family court judiciary and Cafcass should have specialist training to understand the dynamics of domestic abuse and be able to recognise coercive control. • The Ministry of Justice and family court judiciary should ensure that survivors of domestic abuse representing themselves in court as LIPs will not be questioned by their abuser, or in turn have to question their abuser.

4. The way in which statutory agencies interact with families where there is domestic abuse

- There must be improved communication and information sharing between the family courts and statutory agencies, including the police, health services, social care and schools.
- There must be better information sharing between statutory agencies about domestic abuse that includes a focus on the risks to children.
- Statutory agencies must enquire about any children affected by domestic abuse when they receive a disclosure or evidence of abuse and pass information on to relevant child and adult support and protection agencies.
- Statutory agency professionals, such as social workers, police officers, GPs, nurses and teachers, should receive specialist training and ongoing professional development on domestic abuse.

5. Supporting non-abusive parents and challenging abusive parents

- The Ministry of Justice and family court judiciary should ensure there is improved communication between the family courts and criminal courts.
- Family courts must ensure there is better access for survivors of domestic abuse to special measures for their protection during hearings.
- Family court judiciary should ensure there is no unsupervised contact for a parent who is awaiting trial for domestic abuse related offences or where there are ongoing criminal proceedings for domestic abuse.

Further investigation

- There must be further detailed investigation of the issues highlighted in our findings which will require better data collection and monitoring of cases of domestic abuse in the family courts.
- The Ministry of Justice must set up a process for independent, national oversight, with a clear reporting mechanism, into the implementation of Practice Direction 12J and into the handling and outcomes of family court cases involving domestic abuse.
- The Ministry of Justice and Local Safeguarding Children Boards must ensure that serious case review reports have a consistent approach and the impact of the recommendations made must be evaluated to ensure we are learning lessons from these tragic cases.

Conclusion

In order to prevent further avoidable child deaths, it is essential that the lessons are learned from the deaths of these 19 children and two women, and that real progress is made. There are clear ways forward for the family court judiciary, Ministry of Justice and other relevant agencies to ensure that the same mistakes are not repeated and we see no further avoidable child deaths in circumstances relating to unsafe child contact.

Responsibility for the deaths of the 19 children and two women identified in this report lies squarely with the abusive fathers who killed their children. However, we have concluded that there are failings that need to be addressed to ensure that the family court judiciary, the Ministry of Justice, Cafcass, children's social work and other bodies are minimising the possibility of further harm to women and children. In those cases involving the family courts, the child contact arrangements made contributed to the circumstances in which these children and women were killed.

In the cases we reviewed, the link between the perpetration of domestic abuse and poor parenting seemed seldom to be made by statutory agencies, including Cafcass and the judiciary. A man could be seen as a dangerous perpetrator of domestic abuse, but this was not seen as negating his ability to be an adequate or even good father.

The long-term physical and emotional wellbeing impact that domestic abuse has on children, as well as possible behavioural and developmental impacts, is well documented³⁵. However, the serious case reviews considered here suggest that there was often limited understanding of this by professionals working in statutory agencies, and this impact was not routinely fully considered in the making of legal arrangements for child contact. This must addressed through specialist domestic abuse training for the family court judiciary and statutory agencies. A good understanding of the power and control dynamics of domestic abuse is critical in assessing safe child contact.

Our study highlights the family courts' and other statutory agencies' limited or lack of understanding of the gendered nature of domestic abuse, the pervasive nature of coercive control, and that child contact is often used by perpetrators of domestic abuse as a vehicle to continue abuse after separation. In these 12 families, there were significant missed opportunities to protect and support women and children in abusive relationships. With a new criminal offence of controlling and coercive behaviour that came into force in December 2015, there is an even more pressing need for family courts to understand the nature and impact of coercive control in domestic abuse.

We conclude that, in cases involving a perpetrator of domestic abuse, the family courts need to challenge the existing 'contact at all costs'³⁶ culture in order to always put the child first. Unless this happens, the family courts will continue to enable circumstances that can ultimately cost the lives of the children they are set up to serve, and sometimes their mothers' lives too.

Endnotes

Notes

- (1) At the time of this response Lord Justice Wall was a Lord Justice Appeal, he was subsequently the President of the Family Division and Head of Family Justice, England and Wales.
- (ii) For one of these children (who died whilst in the father's care) the Coroner's Court recorded an open verdict. For this case there is only an executive summary available, containing little detail; however the document does reference evidence on 'filicide-suicide' suggesting that the report's authors regarded this as a case of a father killing himself and his child. This is never made completely clear, however. (Case Nine) For three other cases (where the father had committed suicide) the inquest into the deaths was ongoing or it was unclear whether it had yet concluded. However, all three of these serious case reviews reports indicated that the father was presumed to have killed the child(ren).
- (iii) Not all of the cases reviewed were post-May 2008 (when the Practice Direction was issued) but we thought it was useful to consider the issue of the courts' and Cafcass' role in the minimisation of further harm for all cases.
- (iv) It should be noted that one of the mothers (who was ultimately killed alongside her children) had previously been "convicted of the injuries caused to the half-sibling" (a half-sibling to the children who were killed). This child was removed from her care, later returned and then went to live with the birth father (a different father to the father who killed two younger children). (Case Seven)

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- ² Family Justice Council, Family Justice Council Report to the President of the Family Division on the approach to be adopted by the Court when asked to make a contact order by consent, where domestic violence has been an issue in the case. (Family Justice Council, 2007), p. 3
- ³ PRACTICE DIRECTION 12J CHILD ARRANGEMENTS AND CONTACT ORDERS: DOMESTIC VIOLENCE AND HARM, para. 4
- ⁴ Barnett, A., 'Contact At All Costs? Domestic Violence and Children's Welfare', Child and Family Law Quarterly, Vol 6, Issue 4, (2014)

- ⁵ Thiara, R.K. and Harrison C., University of Warwick, Safe not sorry: Supporting the campaign for safer child contact (Bristol: Women's Aid, 2016), p.2
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- ⁷ Welsh Women's Aid/Rights of Women/Women's Aid Federation of England, Evidencing domestic violence: reviewing the amended regulations, (Published online: Rights of Women, Welsh Women's Aid, Women's Aid Federation of England, 2014); House of Commons Justice Committee 8th Report Impact of changes to civil legal aid under Part 1 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 [section 6] (March 2015); UK Parliament Joint Committee on Human Rights 6th Report Violence against women and girls [Section 5] (February 2015)
- ⁸ Coy, M., Perks, K., Scott, E. and Tweedale, R., *Picking up the pieces: domestic violence and child contact A research report* (London: Rights of Women and CWASU, London Metropolitan University, 2012); Hunter, R. and Barnett, A., 'Fact-finding hearings and the implementation of Practice Direction 12J', *Family Law*, 43 (2013) pp. 431 447; House of Commons Justice Committee (March 2015), *op. cit.*; Trinder, L., Hunter, R., Hitchings, E., Miles, J., Moorhead, R., Smith, L., Sefton, M., Hinchly, V., Bader, K. and Pearce, J., *Litigants in person in private family law cases* (London: Ministry of Justice, 2014)
- ⁹ Rights of Women, Welsh Women's Aid, Women's Aid Federation of England (2014), op.cit.

Findings are from a survey circulated via Rights of Women's website and to member services of both Women's Aid Federation of England and Welsh Women's Aid as well as via partner organisations and social media. The survey received 182 responses.

- ¹⁰ Barlow, A., Hunter, R., Smithson, J. and Ewing, J., *Mapping Paths to Family Justice Briefing Paper & Report on Key Findings* (Published online: University of Exeter, Economic and Social Research Council, University of Kent, 2014)
- ¹¹ See PRACTICE DIRECTION 3A FAMILY MEDIATION INFORMATION AND ASSESSMENT MEETINGS (MIAMS), Para 20; Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (2011), Article 48 Prohibition of mandatory alternative dispute resolution processes or sentencing, p. 21
- ¹² Thiara, R. K. and Harrison C. (2016), op. cit.; Barnett, A., (2014), op. cit.
- ¹³ Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M., *New learning from serious case reviews: a two year report for 2009-2011* (Published online: Department for Education, 2012), pp.36-37. 88 out of 139 (63%).
- ¹⁴ NSPCC National Case Review Repository. https://www.nspcc.org.uk/services-and-resources/research-and-resources/search-library/

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