

01. THE REVIEW

- A Partnership Learning Review was commissioned to reflect on the life and circumstances surrounding Little Dan's death.
- The review included direct contact with the family and with the professionals involved at the time.

02. THE CASE

- Little Dan died in February 2022 and his mother was convicted of his murder. It is believed that she also intended to take her own life.
- His parents had separated soon after his birth
- Little Dan died on the day that both of his parents were due to attend court for a hearing in respect of his Father's application for contact.
- Father was prevented from seeing Little Dan since early 2020 by his mother.

03. AGENCY INVOLVEMENT

- Midwives, Health Visitors, GP
- The police were called twice
- Information sharing with MACH
- CAFCASS under Private Law matters
- EVA and Starfish
- Homeless team and a Housing provider

07. QUESTIONS FOR PRACTICE

- Have I considered the impact on the child of acrimony between separated parents?
- Am I aware of the signs of parental alienating behaviour, and how do I approach this?
- Do I consider if a man is a victim of domestic abuse?
- Am I aware of any other agencies involved with the family?
- Do I know the risk indicators for maternal filicide? Including domestic abuse, maternal mental health, maternal isolation and the 'invisibility' of the child from agencies.
- Do I ask or do I know about any traumatic event/history of both parents?
- Am I alert to the signs of escalating stress or mental health and how do I provide or arrange support?



04. LEARNING

- Learning was identified regarding issues of parental alienation and the impact on the child.
- Impact on the child when there are alienating behaviours or implacable hostility in disputes about contact.
 - Awareness that systems providing support to the victims of domestic abuse can be manipulated, either intentionally or due to unwarranted beliefs.
 - That men can be victims of domestic abuse.
 - Information sharing between agencies of parental mental health issues.

06. EXPECTATIONS

It is expected that this 7minute briefing is reviewed within agencies for broader discussion and reflection.

05. RECOMMENDATIONS

1. The National CSPR panel to be asked to consider the learning and whether they need to take any action regarding the inequalities highlighted in this review in respect of eligibility for Legal Aid and the impact on children of the drift in private law proceedings, including when the delay is due to one parent not attending court.
2. To ask all the non-statutory agencies involved with the family to consider this report to establish whether there is any single agency learning for them, and to share the learning from the review within their organisations.
3. CAFCASS to share the learning with the Designated Family Judge in the region.
4. STSCP to consider this review alongside the national CSPR panel practice briefing on safeguarding children in families where there is domestic abuse, published in October 2022, including promoting that men can be victims of domestic abuse.